

Patient Information Form

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____ SS#: _____ - _____ - _____

Date of Birth (required): ____ / ____ / ____ Gender: _____

Address: _____ Unit #: _____ City: _____

State: _____ ZIP: _____ Email: _____

Other name(s) that records may be kept under: _____

Phone *Appointment reminders will be send to 1st preference*

1. Home Work Cell (_____) _____ 2. Home Work Cell (_____) _____

*Confidential voicemails OK? Yes No

*Confidential voicemails OK? Yes No

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Are you currently employed? No Yes Employee/Address: _____

Are you a Bastyr employee or student, or significant other of one? No Yes Please specify: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber/Relationship _____ Date of Birth (required): ____ / ____ / ____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber/Relationship _____ Date of Birth (required): ____ / ____ / ____

Please check below if applicable

Auto Accident Workers Compensation Date of accident or injury: _____ Claim #: _____

Parent/Guardian/Information

To be filled out if patient is a minor, or if someone other than the patient is medically and financially responsible for the patient.

Mother's Name (minors only): _____

Legal Guardian? Yes No Date of Birth (required): ____ / ____ / ____

Father's Name (minors only): _____

Legal Guardian? Yes No Date of Birth (required): ____ / ____ / ____

Other Legal Guardian Name: _____

Relationship to Patient: _____ Date of Birth (required): ____ / ____ / ____

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

Patient Signature (18 and older): _____ Date ____ / ____ / ____

Parent/Guardian Signature : _____ Date ____ / ____ / ____

Demographic Data Collection

Bastyr is committed to providing quality care for all patients. We are asking you to provide your marital status; your racial and ethnic background; the language you prefer to use when speaking with your doctor; and whether you are or were military. Your answers are both voluntary and private. Thank you for your cooperation.

What is your marital status?

- Single Married Significant other Widowed

Do you consider yourself Hispanic or Latino? Please check one:

- I AM Hispanic or Latino I don't know
 I am NOT Hispanic or Latino Decline to answer

Which category best describes your race? You may check one or more:

- White or Caucasian American Indian Other race
 Black or African American Alaskan Native I don't know
 Asian Native Hawaiian or other Pacific Islander Decline to answer

What is your preferred language when speaking with your doctor?

- English Other (please specify): _____

Do you need an interpreter? Yes No

Are you active military or veteran?

- Yes
 No
 Decline to answer

How did you hear about us?

- Friend/Patient External Referral Walk By
 Event/Health Fair Staff/Student Website
 Shuttle/Bus Current Patient Social Media
 Physician/Specialist Radio/TV Yelp

PSR initials: _____

Patient Profile

Patient name: _____ Date of Birth ____ / ____ / ____

Preferred name: _____ Gender/Preferred pronoun: _____

A note to our patients: Please complete this questionnaire as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.

What goals do you have for your visit at the clinic today?

Who is your Primary Care Provider? _____ Phone: (____) _____

Please list other providers/specialists involved in your care and their clinic phone number:

If you are seeking adjunctive cancer support, who is your oncologist?

Oncologist? _____ Phone: (____) _____

When was your last physical? _____ When did you last have bloodwork? _____

Please indicate the type of care you are seeking

- Primary management of my health Adjunctive care for my health
 Ongoing management of my health One time advice for my health
 I don't know at this time

Have you ever consulted a Naturopathic or Ayurvedic Physician, Acupuncturist, Nutritionist or Counselor before?

Yes No

If YES, please circle which type of practitioner you've previously consulted with.

In general would you say your health today is: Excellent Very Good Good Fair Poor

Social History

Do you consume alcohol?: Yes No If yes, how many drinks per week? _____

Do you use cannabis?: Yes No If yes, for ____ medicinal or ____ recreation use, or ____ both

How often do you use cannabis in a given week? _____ In what forms?: _____

Other drug usage, past or present: _____

Current or past tobacco use: Amount/packs per day: _____ How long: _____ Quit date: _____

Do you have children? Yes No If yes, what are their ages: _____

Do you exercise regularly? Yes No If yes, please describe type of exercise and how often below:

Patient Profile

Patient name: _____ Date of Birth ____ / ____ / ____

Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition (MGM = maternal grandmother; MGF = maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather).

Condition	Self	Mother	Father	Sibling	MGM	MGF	PGM	PGF
Allergies								
Anemia								
Anxiety								
Arthritis								
Asthma								
Blood transfusion								
Cancer								
Cataracts								
Congestive heart failure								
Clotting disorder								
COPD								
Depression								
Diabetes								
Emphysema								
GERD								
Glaucoma								
Heart attack								
Heart murmur								
HIV/AIDS								
Hypertension								
Irritable bowel syndrome								
Kidney disease								
Meningitis								
Nerve/muscle disease								
Osteoporosis								
Parkinson's/Alzheimer's								
Seizures								
Sickle cell anemia								
Stroke								
Substance abuse								
Thyroid disease								
Tuberculosis								
Ulcers								
Other								
Other								

Holistic Health Assessment

Patient name: _____ Date of Birth ____ / ____ / ____

In order to complete a Holistic Health Assessment, please answer the following questions:

Digestion

Please check any issues you have with digestive function: None

Gas, bloating, flatulence, burping Mild Moderate Severe

Abdominal pain or cramping Mild Moderate Severe

How often do you have a bowel movement? _____ times per day/week (circle)

Please check all that apply about your bowel movements:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Difficult to pass | <input type="checkbox"/> Contain undigested food | <input type="checkbox"/> Small and hard | <input type="checkbox"/> Formed |
| <input type="checkbox"/> Loose | <input type="checkbox"/> Fatty or oily | <input type="checkbox"/> Contains blood | <input type="checkbox"/> Easy to pass |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Incomplete | <input type="checkbox"/> Dark in color/tar-like | <input type="checkbox"/> Feels complete |

How often have you taken antibiotics in your life: Never Rarely Sometimes Often

When was the last dose of antibiotics taken: _____

Have you traveled outside the country? If so, where and when?: _____

Have you ever had food poisoning? If so, when?: _____

Please check any that apply to you:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Diverticulosis or diverticulitis | <input type="checkbox"/> Irritable bowel syndrome (IBS) | <input type="checkbox"/> Small intestine bacteria overgrowth (SIBO) |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Swollen gums |
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Heartburn or GERD | <input type="checkbox"/> Oral allergy syndrome | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Hiatal hernia | | |

Immune Defense and Repair

How often do you get sick? Rarely Sometimes Often

Do you feel you get sick more than others around you? Yes No

Do you have any chronic inflammatory conditions (arthritis, autoimmune disease, eczema ...)?

Please list: _____

Do you heal quickly after injury or surgery? Yes No Unsure

Sleep

Do you have any difficulty sleeping? Yes No _____

Please check any that apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> Snoring | <input type="checkbox"/> Have trouble waking up |
| <input type="checkbox"/> Trouble staying asleep / wake frequently | <input type="checkbox"/> Stop breathing at night | <input type="checkbox"/> Feel rested in the morning |
| <input type="checkbox"/> Night terrors | <input type="checkbox"/> Use a C-PAP machine | <input type="checkbox"/> Sleep well generally |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Feel tired in the morning | |

Circulation

Do you have swelling in any part of your body? Yes No If yes, describe _____

Check all that applies: Varicose veins Spider veins Cold hands and feet

Patient name: _____ Date of Birth ____ / ____ / ____

Biotransformation and Elimination

Are you routinely exposed to any chemicals through your living situation, recreation or work (solvents, pesticides, cigarette smoke...)? Yes No Unsure If yes, please describe: _____

Check all that you are sensitive to: Caffeine Perfume Cigarette smoke Other _____

Check all that apply to you:

- Lived on a farm or where any agricultural or insect-controlling chemicals were
- Lived in a home built prior to 1975
- Ate fish, mollusks or crustaceans more than twice a week
- Worked in any industry where you could smell chemicals
- Have had any significant exposure to chemicals you know of
- Worked with any toxic metal including dentistry
- Lived or worked in an area that was or became a Superfund site
- Lived or worked where you could see or smell any burning of fuel, metal, rock or wood

Hormone Balance

Check all that apply to you:

- Acne
- Anxiety
- Crave sugar or salt
- Depression
- Difficulty concentrating
- Do not feel rested in the morning
- Dry skin
- Feel unusually cold or hot
- Forgetfulness or memory problems
- Hypoglycemia

Females only:

- PMS
- Unwanted facial hair
- Infertility
- Menopause
- Fibroids
- Endometriosis

Structural Integrity

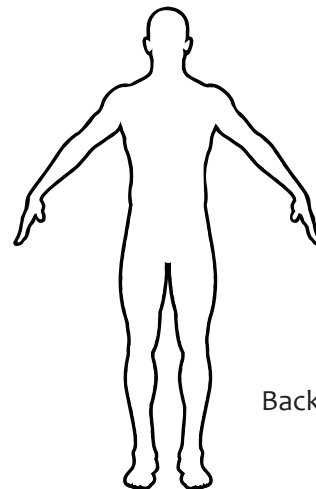
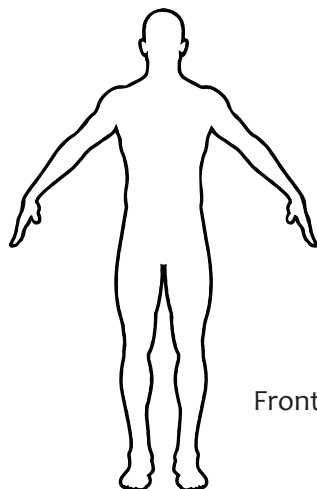
Do you bruise easily? Yes No

Do you get headaches? No Rarely Sometimes Frequently

Do you have any skeletal or muscular pain? If so where? _____

Rate the current intensity of your pain on a scale of 1-10, with 10 being the most intense: _____

Please circle where you feel pain below:



Holistic Health Assessment

Patient name: _____ Date of Birth ____ / ____ / ____

Spiritual/Emotional/Social

Do you have a spiritual practice that you follow: Yes No If yes, please list _____

Do you have a good support system in your life (friends, loved ones)? Fair Good Excellent

With whom do you live: _____

What do you dedicate yourself to (work, school, parenting, significant hobbies ...): _____

How would you rate your stress level overall: Low Medium High Extreme

What are your major stressors? _____

What do you do to cope with stress? _____

Signatures

Patient/Guardian (Print Name): _____ Date _____

Patient/Guardian Signature: _____ Date of birth _____

Reviewed by Provider and ready to be scanned to EPIC (Initials): _____ Date: ____ / ____ / ____