EVERYDAY WELLNESS
COMPREHENSIVE HEALTH CARE

Laura Torgerson ND

Welcome Letter

Welcome. Thank you for choosing Everyday Wellness Clinic for your health care needs. Doctor Laura Torgerson is happy to share her passion for wellness with you. We are here to assist you with your health care. Please read this letter carefully and sign and date at the bottom.

You must fill out all of the enclosed forms completely prior to your first appointment. Incomplete paperwork will affect your visit with the doctor.

- Intake form
- Consent form ND
- Insurance Benefits Verification form
- Confidential Contact form
- Welcome Letter
- Policies form

This information provides us with a comprehensive picture of your health status and a greater ability to address the health issues which concern you most.

Directions. Everyday Wellness is located on the corner of SW 11th and Yamhill, in the Professional Building, which is directly north of the Central Library. Our building is not wheelchair accessible.

Parking. A SmartPark garage is located on SW 10th and Yamhill for which we validate parking. We do not validate for any other lot. On-street parking, the MAX and the streetcar are very convenient options.

Our philosophy. Our goal is to help you solve your health problems and promote a healthy lifestyle. We spend time with each patient treating them as an individual. We listen carefully to your health concerns, review your medical history and answer your questions about how naturopathic care can address your health problems. Together we will develop an individualized strategy for you to reach your specific health goals. Please do not hesitate to communicate with us and ask questions. We look forward to meeting you.

Naturopathic principles are the basis of our medicine:

- *The Healing Power of Nature*: Trust in the body's inherent wisdom to heal itself.
- *Identify and Treat the Causes*: Look beyond the symptoms to the underlying cause.
- *First Do No Harm*: Utilize the most natural, least invasive and least toxic therapies.
- *Doctor as Teacher*: Educate Patients in the steps to achieving and maintaining health.
- *Treat the Whole Person*: View the body as an integrated whole in all its physical and spiritual dimensions.
- *Prevention*: Focus on overall health, wellness and disease prevention.

Please sign and date below confirming that you have read and understood the content of this letter in its entirety.

Signature _____ Date _____

Sincerely
Dr. Torgerson

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Clinic Policies

Cancellation Policy. We require **48 hours** notice for a changed or cancelled appointment. A $50.00 fee will be applied for a missed appointment or appointments cancelled within 48 hours of the original scheduled appointment.

Insurance. We accept most insurance. As a courtesy our office will bill your insurance company. ***It is your responsibility to call your insurance company in order to understand and verify your coverage.*** This information will aid the physician in using the preferred labs as designated by your insurance company to avoid excess costs. The Insurance Benefits Verification form must be filled out in its entirety before your initial visit. Our office is unable to bill insurance without this information. ***If this form is not filled out, you are responsible for payment at the time of service.*** You are responsible for any services and labs not covered by your insurance plan. Please call if you have questions.

We strongly encourage you to mail or drop off the complete forms prior to your appointment.

Payment is due at the time of service. We accept cash, check, Visa or MasterCard.

Phone Consultations. Phone calls greater than 5 minutes in length with the doctor will be subject to a consultation charge. This fee is non-refundable and is not billable to insurance.

Emails. Emails to Everyday Wellness Clinic are not encrypted and hence not HIPAA compliant. Discussions concerning medical issues are best addressed in an office visit.

Please sign and date below confirming that you have read and understood the content of this letter in its entirety.

Signature _____ Date _____

Sincerely
Dr. Torgerson

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CONFIDENTIAL CONTACT FORM

Full Legal Name _____
Last Name *First Name* *Middle Initial*

Preferred Name _____ Age _____ Date of Birth _____ SSN _____

Sex ☐ Male ☐ Female ☐ Other Preferred Pronouns ☐ She/her ☐ He/him ☐ Other: _____

Address _____
Street #/PO Box *City* *State* *Zip Code*

Telephone (H) _____ (W) _____ (C) _____

Email Address _____

Occupation _____

Emergency Contact _____
Name *Relationship*

Emergency Contact Number (H) _____ (W) _____ (C) _____

COMMUNICATION

What is the best way to communicate with you between office visits? ☐ Email ☐ Home ph. ☐ Work ph. ☐ Cell ph.

Is there any place you do NOT want us to leave a message?

May our practitioner(s) discuss your private medical information with you via email*? ☐ **Yes** ☐ **No**

May we send you educational/promotional materials such as newsletters via email? ☐ **Yes** ☐ **No**

***NOTE: Please be aware that email is not a secure communication and that discussion of your medical care will become part of your medical record.**

Certain laboratories that the clinic may use participate in anonymous or coded genetic research with samples submitted by this clinic. Please indicate whether you would like to opt-out from having these laboratories use your samples or health information for their research.

☐ opt-out ☐ permission to use specimens

INSURANCE

Please provide a copy of the front and back of your Insurance card.

Insured's Address (if different from above):

Insurance Company:

Do you have any secondary or additional Insurance plans? ☐ **Yes** ☐ **No**

Name and Address of Insurance plan: Phone:

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature Date

INSURANCE BENEFITS VERIFICATION
(Please allow 1 hour for this form)

In order for our office to bill your insurance, this form must be completed before your appointment. Otherwise payment is due at time of service.

Everyday Wellness is committed to providing the best care for our patients. As a service we bill most primary insurance carriers directly. However, patients are responsible for all charges resulting from treatment provided by their physician. **We bill primary, but we do not bill secondary insurance.** We provide all the necessary paperwork for the patient to submit to their insurance. **If after 90 days Everyday Wellness Clinic has not received payment from the insurance company, the patient is responsible for the account balance.**

Providing correct insurance information is the responsibility of the patient. All patients must complete the insurance verification form before seeing the doctor. It is vital that this form is filled out in its entirety in order for the billing process to proceed smoothly. If your insurance changes, please present your insurance card at the next visit.
It is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximum.

Please complete the following 2 pages in their entirety and attach a front & back copy of your insurance card.

I. This is a: ☐ New Insurance Application ☐ Change of Insurance Application

A. Patient Name

Address

City State Zip

Phone: Work Cell Home

Social Security # DOB:

B. Insured's Name (if different)

Insured's Date of Birth / / Relationship to Patient

Address

City State Zip

Phone: Work Cell Home

C. Name of Insurance Company

Claims Address

City State Zip

Phone Group or Policy #

Insurance ID #

II. **Follow steps 1-9 when calling to verify out benefits and eligibility.**
To start, call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services. Ask the representative the following questions.

1. **With whom am I speaking?** (This is important if there are any problems with coverage.)
Name of the representative Date

2. **When did my coverage begin and when did it end?**
Beginning Date of Coverage Ending Date of Coverage

3. **Is the doctor in my plan (Laura Torgerson, ND)?**
If they say no, ask, **Is Everyday Wellness Clinic** in my plan? ☐ **Yes** ☐ **No**

4. **Is the doctor "in network" ☐ or "out of network?" ☐**
If the doctor and the clinic are "out of network," ask **Can I see a naturopathic doctor/physician and/or acupuncturist "out of network?" ☐ Yes ☐ No**

5. **Are my alternative claims billed to American Specialty Health**, and **Do I have ND coverage**?
☐ **Yes** (If yes, **What is my co-pay?** $ ☐ **No**

6. **Is a naturopathic doctor considered a primary care provider (PCP) on my plan?** (This is important. NDs are licensed primary care providers (PCPs) in the state of Oregon, however insurance companies may not cover them as primary care providers.)
☐ **Yes** ☐ **No**

7. **Do I need a *referral* from a medical doctor, primary care provider (PCP), for alternative services?**
☐ **Yes** ☐ **No**

8. **Can my naturopathic doctor perform my annual physical or gynecological exams?**
☐ **Yes** ☐ **No**

9. **Does my insurance cover an annual wellness exam?** ☐ **Yes** ☐ **No** With labs? ☐ **Yes** ☐ **No**

10. If you are female ask: **Does my insurance cover gynecological care by a naturopathic doctor?**
☐ **Yes** ☐ **No**

11. Ask about your deductible. **What is the amount and has any or all of it been met?**
Deductible $ Amount of Deductible met so far $ Date

What year is my deductible based on? Calendar year ☐ Fiscal year ☐

12. **What are the preferred laboratories?** LabCorp, Providence, Quest, Legacy, other:

13. What are your benefits? This is very important. **Do have a co-pay or do I owe a percentage? Do I have a maximum amount that can be spent?** Be sure to find out which benefits apply to the doctor you are seeing. There will be different benefits depending on whether the doctor is In-Network or Out-of-Network, and whether your plan includes Out-of-Network benefits.

Naturopathic:

Office Visit	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Lab Work	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Physical Medicine/Chiropractic	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Supplements	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Acupuncture	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Massage	_____	% Covered or	$	_____	Co-pay	Year Max	_____

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGMENT

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Everyday Wellness Clinic (EWC). I also understand that all out-of-network (non-contracted) insurance billing services provided by EWC on my behalf are performed on a courtesy basis and can be discontinued by either myself or EWC, with written notice, at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to EWC. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature Date

Must be signed or verification is void.

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COMPREHENSIVE HEALTH CARE

Laura Torgerson ND

INFORMED CONSENT FOR PURPOSES OF TREATMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Everyday Wellness Clinic, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Everyday Wellness Clinic, LLC. I understand that diagnosis or treatment of me by my physician(s) at Everyday Wellness Clinic, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Everyday Wellness Clinic, LLC is not required to agree to the restrictions that I may request. However, if Everyday Wellness Clinic, LLC agrees to a restriction that I request, the restriction is binding on Everyday Wellness Clinic, LLC and my physician(s) at Everyday Wellness Clinic, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Everyday Wellness Clinic, LLC or Everyday Wellness Clinic, LLC has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health, or condition that identifies me, or there is reasonable basis to believe the information may identify me.

Naturopathic therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, bumps, and temporary worsening of symptoms. More serious complications are extremely rare. It is our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for specific cure or result.

Signature _____ Date _____

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CONFIDENTIAL PATIENT INFORMATION *please print*

Name	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	Age	Sex ☐ M ☐ F ☐ Other
Address	City	State	Zip Code
Telephone (H)	(W)		(C)
Email	SSN	Date of Birth	

Most Recent Primary Care Information:

Physician's Name		Phone	
Address	City	State	Zip Code

How did you hear about us?

HEALTH CONCERNS *List,* ***in order of importance*** *your health concerns and how long you have had these concerns or condition(s):*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

What do you believe is the cause of condition #1?

If you were treated (self or doctor), what method or medicine? And what results?

Please check the box for condition #1 above:

- ☐ Is getting worse
- ☐ Is constant
- ☐ Is worse in the morning
- ☐ Is worse in the afternoon
- ☐ Is worse in the evening
- ☐ Interferes with school/work
- ☐ Interferes with sleep
- ☐ Interferes with movement and/or exercise
- ☐ You have had this or similar conditions in the past
- ☐ Notice it more during

When was your last visit to a doctor's office, medical clinic, or hospital? What was the reason?

Date of last physical exam: Any abnormal findings? ☐ **Yes** ☐ **No** *If yes*, please explain:

Are you under the care of a health care practitioner? *If yes*, please explain

Are you currently under the care of or have you been treated in the past by a naturopathic physician or Chinese medicine practitioner? If yes, please give the names of providers and dates of treatment.

Date of last dental exam: Dentist:

MEDICATIONS *List all pharmaceutical medication(s) and dosage(s) that you are currently taking*

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, please list:

What is your reaction to these medications?

Do you have any other allergies to foods, drugs or other allergens in your environment (e.g. cats, mold, dust)?

What allergies did you have as a child?

Please check any of the following that you take:

- ☐ Antacids (Rolaids, Tums)
- ☐ Antihistamines (Claritin, Benadryl)
- ☐ Cortisone (cream or pills)
- ☐ Cough & cold medications
- ☐ Diet pills, appetite suppressants
- ☐ Laxatives
- ☐ Oral contraceptives or HRT
- ☐ Pain relievers (aspirin, Tylenol, Aleve, Motrin)
- ☐ Sleeping pills
- ☐ Thyroid medication

What hospitalizations or surgery have you had? Please give dates and reasons:

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No** Was it ☐ *your blood* taken previously or a ☐ *donor's blood*?

What diagnostic imaging studies have you had?

- ☐ Bone Density Scan (DXA)
- ☐ Colonoscopy/Sigmoidoscopy
- ☐ CT Scan
- ☐ Endoscopy
- ☐ Electrocardiogram (ECG/EKG)
- ☐ Electroencephalogram (EEG)
- ☐ Echocardiogram (Echo)
- ☐ Laparoscopy
- ☐ Mammogram
- ☐ MRI
- ☐ Ultrasound
- ☐ X-ray
- ☐ Other

What immunizations have you had? Include international travel vaccinations if applicable.

- ☐ Diphtheria
- ☐ Diphtheria, Tetanus
- ☐ Diphtheria, Tetanus, Pertussis
- ☐ Endoscopy
- ☐ Tetanus, single
- ☐ Haemophilus Influenza type b
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HPV
- ☐ Influenza (flu shot)
- ☐ Measles, single
- ☐ Mumps, single
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Polio ☐ Inactive (IPV) ☐ Oral (OPV)
- ☐ Rubella, single
- ☐ Varicella (Chicken Pox)
- ☐ Other

If you are a child or healthcare worker, are your immunizations current? ☐ **Yes** ☐ **No**

If not, please explain:

Have you had the following childhood illnesses? Check if you have, leave blank if unsure:

- ☐ Diphtheria
- ☐ German Measles
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Strep Throat
- ☐ Other

My blood type is: ☐ A+ ☐ A– ☐ AB+ ☐ AB– ☐ O+ ☐ O– ☐ Don't know

SUPPLEMENTS *List all homeopathic remedies, herbs, vitamins and minerals with dosage that you are currently taking.*

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

SOCIAL HISTORY

Occupation ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disability

Employer / School

Status: ☐ Single ☐ Married ☐ Long-term relationship ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:

Live: ☐ Alone ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Housemates ☐ Other:

Name of partner: Number of children and ages:

Have you traveled outside the US? ☐ **Yes** ☐ **No** *if yes*, where? When?

Describe your support network:

Have you been abused or assaulted verbally, sexually, or physically? ☐ **Yes** ☐ **No**
Have you experienced a significant loss or traumatic event? ☐ **Yes** ☐ **No**

If you answered yes above, would you like to share more?

Health Habits	Yes	No	If yes, for how long and/or how often per week?
Do you exercise?			
Do you apply sunscreen?			
Do you smoke tobacco? Past or present use?			
Do you drink alcohol?			
Do you use recreational drugs?			
Do you have guns in the house?			Ammo? Y N Locked? Y N In a safe? Y N
Have you been treated for drug/alcohol dependence?			Explain:
Do you drink coffee, soda, or black tea?			
Do you drink “diet” sodas or eat “diet” foods?			
Are you familiar with “safe sex practices”?			
Do you follow any dietary modifications?			Describe:
Do you follow a spiritual practice?			
Do you have any hobbies/interests?			Describe:

General Review				
Do you...	**Yes**	**No**	**General Review - cont.**	
Sleep well?			Current weight	
Wake feeling rested?			Weight one year ago	
Eat three meals daily?			Max adult weight, date:	
Enjoy your work?			Min adult weight, date:	
Spend time outside?			Max adult height	
Take vacations?			Best energy level (time of day)	
Watch Television? Hours/week:			Lowest energy level (time of day)	
Read? Hours/week:			Do you feel your temperature runs hot or cool?	
Use a computer? Hours/day:			Are you a morning, afternoon, or night person?	

FOOD AND DIET *Please describe your typical food intake.*

Breakfast	Lunch	Dinner	Snacks	Beverages
				Water /day Filtered? Y N

Favorite Foods:

List the 3 healthiest foods you eat during an average week:

List the 3 worst foods you eat during an average week:

Do you consider yourself a picky or an adventurous eater?

What flavors do you like? ☐ sweet ☐ salty ☐ bitter ☐ sour ☐ aromatic ☐ spicy ☐ bland

Do you purchase packaged food? ☐ **Yes** ☐ **No** What % of your diet is packaged/pre-made/to-go ? %

Do you read labels? ☐ **Yes** ☐ **No**

Do you follow a certain type of diet? ☐ **Yes** ☐ **No** Please explain.

Have you or do you regularly fast? ☐ **Yes** ☐ **No** Please explain.

Do you or have you ever had an eating disorder? ☐ **Yes** ☐ **No** *If yes*, please explain.

PAST MEDICAL HISTORY
Please mark **P** (past) or **C** (current) for any of the following that you or your family members have had:

Condition	Self	Father	Mother	Sibling(s)	Aunt/ Uncle	Grand-parent	Child
ADD/ADHD							
Alcoholism							
Anemia/Blood Disorder							
Anxiety/Depression							
Arthritis							
Asthma							
Autoimmune Disease							
Blood Vessel Disorder							
Cancer (type)							
Chemical Sensitivities							
Diabetes							
Drug/Other Addiction							
Eating Disorder							
Epilepsy/Seizures							
Food Poisoning (type)							
Gallbladder Disease							
Gastrointestinal Disorder							
Glaucoma/Cataracts							
Gum Disease							
Gynecological Disorder							
Headaches/Migraines							
Heart Disease/Event/Cholesterol							
Heart Murmur							
High Blood Pressure							
Hypoglycemia							
Infertility							
Kidney Disease							
Liver Disease							
Lung Disease/TB							
Menstrual Disorder							
Mental Illness							
Mouth, Throat Disease							
Muscular Disorder							
Neurological Disorder							
Pain, Chronic							
Skeletal Disorder							
Skin Disorder							
Stroke							
Thyroid Disorder							
Ulcer							
Urinary Disorder							
Vision Problems							
Yeast Infections							

Family's Health	Mother	Father	Sibling(s)	Grandparents
Good				
Average				
Poor				
Age, if living				
Age, when deceased				
Cause of death				
Ethnicity/country of origin				

REVIEW OF SYSTEMS

Please check the box for any conditions that you currently experience: ☐ for Current, ○ for Past

Blood/Peripheral Vascular

C P
- ☐ ○ Anemia
- ☐ ○ Cold hands/feet
- ☐ ○ Deep leg pain
- ☐ ○ Easy bleeding/bruising
- ☐ ○ Thrombophlebitis
- ☐ ○ Varicose veins

Cardiovascular

- ☐ ○ Chest pain/pressure
- ☐ ○ Fainting/light-headed
- ☐ ○ Heart disease
- ☐ ○ High blood pressure
- ☐ ○ High cholesterol
- ☐ ○ Heartbeat, irregular
- ☐ ○ Heart murmur
- ☐ ○ Palpitations, fluttering
- ☐ ○ Rheumatic fever
- ☐ ○ Swelling in ankles

Endocrine

- ☐ ○ Fatigue
- ☐ ○ Heat or cold intolerance
- ☐ ○ Hypo/hyperglycemia
- ☐ ○ Hypo/hyperthyroid
- ☐ ○ Increasing hunger
- ☐ ○ Increasing thirst
- ☐ ○ Seasonal depression

Neck

- ☐ ○ Goiter
- ☐ ○ Lumps
- ☐ ○ Pain or stiffness
- ☐ ○ Whiplash injury

Neurologic

C P
- ☐ ○ Loss of memory
- ☐ ○ Numbness or tingling
- ☐ ○ Paralysis
- ☐ ○ Seizures
- ☐ ○ Tremor

Mental/Emotional

- ☐ ○ Anxiety, nervousness
- ☐ ○ Poor memory
- ☐ ○ Depression
- ☐ ○ Concentration, difficult
- ☐ ○ Contemplate suicide
- ☐ ○ Critical of others
- ☐ ○ Critical of self
- ☐ ○ Experience loneliness
- ☐ ○ Mood swings
- ☐ ○ Tension, stress
- ☐ ○ Treatment for mental/ emotional concerns

Head

- ☐ ○ Headaches
- ☐ ○ Head injury
- ☐ ○ Jaw; TMJ problems
- ☐ ○ Migraines

Nose and Sinuses

- ☐ ○ Hay fever
- ☐ ○ Nose bleeds
- ☐ ○ Red nose
- ☐ ○ Runny nose
- ☐ ○ Sinus problems
- ☐ ○ Stuffiness, congestion

Eyes

C P
- ☐ ○ Blurriness
- ☐ ○ Cataracts
- ☐ ○ Color blindness
- ☐ ○ Diminished night vision
- ☐ ○ Dryness, excessive
- ☐ ○ Itchy eyes
- ☐ ○ Eye pain
- ☐ ○ Glasses or contacts
- ☐ ○ Glaucoma
- ☐ ○ Retinal Detachment
- ☐ ○ Spots in eyes
- ☐ ○ Tearing, excessive

Ears

- ☐ ○ Dizziness/vertigo
- ☐ ○ Earache
- ☐ ○ Ear infections
- ☐ ○ Ears, itchy
- ☐ ○ Hearing, impaired
- ☐ ○ Ringing, tinnitus
- ☐ ○ Wax, excessive

Mouth and Throat

- ☐ ○ Bad breath
- ☐ ○ Dental cavities/fillings
- ☐ ○ Dentures
- ☐ ○ Frequent sore throat
- ☐ ○ Frequent clearing throat
- ☐ ○ Gum problems
- ☐ ○ Hoarseness
- ☐ ○ Metallic taste in mouth
- ☐ ○ Mouth sores
- ☐ ○ Saliva, excess
- ☐ ○ Sore tongue, lips
- ☐ ○ Teeth grinding

Respiratory

C P

- ☐ ○ Asthma
- ☐ ○ Bronchitis
- ☐ ○ Cough, chronic
- ☐ ○ Difficulty breathing
- ☐ ○ Emphysema
- ☐ ○ Pain on breathing
- ☐ ○ Pneumonia
- ☐ ○ Pleurisy
- ☐ ○ Shortness of breath
  - ☐ ○ At night
  - ☐ ○ Lying down
  - ☐ ○ With exercise/exertion
- ☐ ○ Spitting up blood
- ☐ ○ Sputum
- ☐ ○ Wheezing

Urinary

- ☐ ○ Bed wetting
- ☐ ○ BPH
- ☐ ○ Frequency at night
- ☐ ○ Frequent infections
- ☐ ○ Increased frequency
- ☐ ○ Inability to hold urine
- ☐ ○ Kidney stones
- ☐ ○ Kidney, back pain
- ☐ ○ Low force of urine
- ☐ ○ Pain with urination
- ☐ ○ Urine retention
- ☐ ○ Urgency with urination

Gastrointestinal

C P

- ☐ ○ Abdominal pain, cramps
- ☐ ○ Alternating diarrhea/constipation
- ☐ ○ Belching
- ☐ ○ Blood in stool
- ☐ ○ Change in stool
- ☐ ○ Bowl movements, how often?
  - # per day / 2 days / 3 days / week
- ☐ ○ Bulimia
- ☐ ○ Change in appetite
- ☐ ○ Change in thirst
- ☐ ○ Constipation
- ☐ ○ Diarrhea
- ☐ ○ Fatigue after eating
- ☐ ○ Flatulence/gas
- ☐ ○ Heartburn
- ☐ ○ Hemorrhoids
- ☐ ○ Hepatitis
- ☐ ○ Jaundice
- ☐ ○ Liver disease
- ☐ ○ Nausea
- ☐ ○ Pain in rectum
- ☐ ○ Painful stool
- ☐ ○ Parasites, diagnosed
- ☐ ○ Reflux
- ☐ ○ Stomach pain
- ☐ ○ Trouble swallowing
- ☐ ○ Vomiting

Musculoskeletal

C P

- ☐ ○ Arch supports/heel lifts
- ☐ ○ Arthritis
- ☐ ○ Back pain
- ☐ ○ Broken bones
- ☐ ○ Joint pain or stiffness
- ☐ ○ Joint swelling
- ☐ ○ Muscle pain
- ☐ ○ Muscle spasms/cramps
- ☐ ○ Muscle weakness, tiredness
- ☐ ○ Osteoporosis/osteopenia
- ☐ ○ Sciatica

Skin

- ☐ ○ Acne
- ☐ ○ Boils
- ☐ ○ Cancer
- ☐ ○ Color change
- ☐ ○ Eczema
- ☐ ○ Flushing/hot flashes
- ☐ ○ Hair loss
- ☐ ○ Hives
- ☐ ○ Itching
- ☐ ○ Lumps
- ☐ ○ Night sweats
- ☐ ○ Moles
- ☐ ○ Psoriasis
- ☐ ○ Rashes
- ☐ ○ Rosacea
- ☐ ○ Skin Tag

MALE REPRODUCTIVE

Please check the box for any which apply to you:

- ☐ Birth control, type? _____
- ☐ BPH
- ☐ Ejaculation concerns
- ☐ Fertility concerns
- ☐ Impotence
- ☐ Other: _____
- ☐ Penile discharge
- ☐ Penile sores
- ☐ Prostate disease
- ☐ Sexually active
- ☐ Sexual difficulties
- ☐ Sexually transmitted infection(s) _____
- ☐ Testicular masses
- ☐ Testicular pain

Date of last prostate exam? _____

Sexual orientation: ☐ Heterosexual ☐ Gay ☐ Queer ☐ Bisexual ☐ Transgender ☐ Other: _____

Please complete Health Goals on the next page.

REPRODUCTIVE, FEMALE

Age of first menses Avg. length of blood flow (days)

Number of days between menstrual cycles (days) Date of last menstrual period

Are cycles regular? ☐ **Yes** ☐ **No** Are you pregnant? ☐ **Yes** ☐ **No** Age of last period (if menopausal)

Mother's age at menopause

Date of last annual exam/PAP Do you do self-breast exams? ☐ **Yes** ☐ **No** *If yes*, how often?

Please specify number of: Pregnancies Live Births Miscarriages Abortions

Sexual orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Queer ☐ Bisexual ☐ Transgender ☐ Other: _____

Please check the box for any which apply to you:

- ☐ Abnormal PAP
- ☐ Birth control, type? _____
- ☐ Bleeding between cycles
- ☐ Breast lumps, fibrocystic changes
- ☐ Cervical dysplasia
- ☐ Clotting
- ☐ Cramping with menses
- ☐ DES exposure
- ☐ Difficulty getting pregnant
- ☐ Endometriosis
- ☐ Genital warts
- ☐ Heavy menstrual flow
- ☐ Hormone replacement therapy
- ☐ Hysterectomy, oophorectomy
- ☐ Hysterectomy, ovaries intact
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Irregular cycles
- ☐ Menopausal symptoms
- ☐ Nipple discharge
- ☐ Other _____
- ☐ Ovarian cysts/PCOS
- ☐ Painful intercourse
- ☐ Painful periods
- ☐ Premenstrual Syndrome (PMS)
- ☐ Scanty menstrual flow
- ☐ Spotting between periods
- ☐ Sexual difficulties
- ☐ Sexually active
- ☐ Sexually transmitted infection(s) _____
- ☐ Uterine fibroids
- ☐ Vaginal discharge

HEALTH GOALS

What are your health goals?

What is your level of motivation regarding your healing?

What do you expect from your practitioner?