SELAH
NATURAL MEDICINE

8375 SW Beaverton/Hillsdale Hwy. Suite C
Portland, OR 97225
info@selahnaturalmedicine.com
Phone: 503-206-6996 Fax: 888-959-9018
selahnaturalmedicine.com

ADULT INTAKE

Name: ____Date: ____________________

Address: ____

City: _________________________ State: ___________ Zip: _____________________

Phone # (home): ______________(cell)______________ (work): ____________________

Email address: ___________________________ Skype name: ______________________

Age: _____ Date of Birth: __________ Gender: F/M Education: _________________________

Married: ___ Separated: ____ Divorced: ____ Widowed: ____ Single: ____ Partnership: ___________

Live with: Spouse: ______ Partner: _____ Parents: _____ Children: _____ Friends: _____ Alone: _____

Occupation: ____ Hours per week: _________

Employer Name and Address: ____

____

How did you hear about this clinic? Another practitioner________________ Google search

Brochure Health talk Health fair ND directory Professional seminar Other________________

Has any other family member already been a patient at this clinic? __________________________

Emergency contact: ______________________________ Relationship: ________________

Phone: _______________________ Address: __________________________________

____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your desire for optimal wellness. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

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CONTEXT OF CARE REVIEW

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed. (Circle Number)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

Describe your health experience in words and/or draw it on the back of this page.

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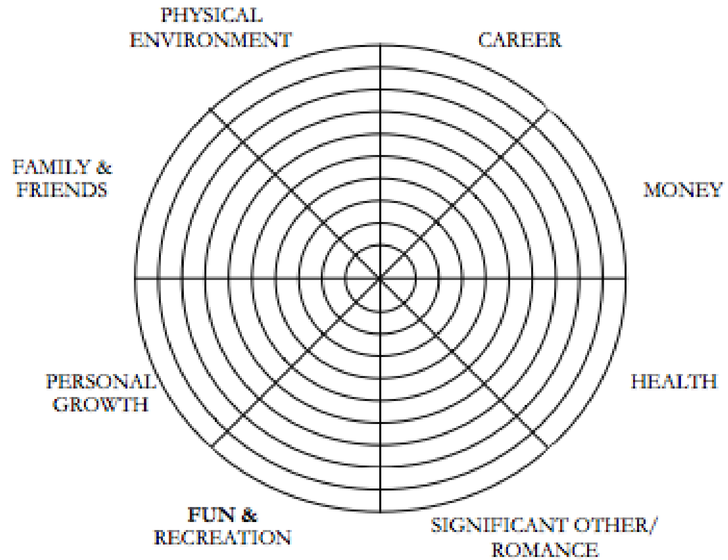
WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.
For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.
Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? ____________________

If no, when and where did you last receive medical or health care? ____________________

What was the reason? ____________________

What are your most important health problems? List as many as you can in order of importance.

1) ____________________

2) ____________________

3) ____________________

4) ____________________

5) ____________________

6) ____________________

7) ____________________

Do you have any known contagious diseases at this time? Yes / No

If yes, what? ____________________

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FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	Chemical Exposure

Any other relevant family history? ____

What is your family heritage? ____

CHILDHOOD ILLNESSES

Birth city & state: __________________________ Birth time: ______________ Birth weight: ___________

Please circle whether you had any of the following as a child:

Rheumatic fever	Diphtheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	Pertussis

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

__________________________ year _______ __________________________________ year_________
__________________________ year _______ __________________________________ year ________
__________________________ year ________ __________________________________ year ________

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? ____

Any foods? ____

Anything in the environmental or chemicals?____

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are
taking:

1) __________________________ 5)__________________________
2) __________________________ 6)__________________________
3) __________________________ 7)__________________________
4) __________________________ 8)__________________________

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GENERAL

Height: ____________________ Weight: ______________Weight one year ago: _____________________

Maximum Weight: ____ When: _______________________

When during the day is your energy the best? _________________________ Worst?_________________

Main interests and hobbies: ____

Exercise: Y / N If so, what kind and how often: ____

Watch TV: Y / N If so, how many hours? ______ Read: Y / N If so, how many hours? ______________

Do you have a religious or spiritual practice? Y / N If so, what kind? _______________________________

TYPICAL FOOD INTAKE

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink:____

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FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now **N**=no/never had P= problem in the past **S**=sometimes a problem now

GENERAL

Do you sleep well?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S
Awake rested?	Y	N	P	S
Have a supportive relationship?	Y	N	P	S
Have a history of abuse?	Y	N	P	S
Experienced a major trauma?	Y	N	P	S
Use recreational drugs?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
Use tobacco?	Y	N	P	S

If in the past, how many years? ___________
How many packs per day? _______________

Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Eat three meals a day?	Y	N	P	S
Do you go on diets often?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Do you drink coffee?	Y	N	P	S
Drink black/green tea?	Y	N	P	S
Drink soda?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S
Do you add salt to your food?	Y	N	P	S

NEUROLOGIC

Seizures?	Y	N	P	S
Muscle weakness?	Y	N	P	S
Loss of memory?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S
Paralysis?	Y	N	P	S
Numbness or tingling?	Y	N	P	S
Easily stressed?	Y	N	P	S
Loss of balance?	Y	N	P	S

ENDOCRINE

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S

ENDOCRINE CONT.

Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

IMMUNE

Reactions to immunizations?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S
Slow wound healing?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S
Chronic infections?	Y	N	P	S
Night sweats?	Y	N	P	S

EARS

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Ear aches?	Y	N	P	S

EYES

Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Glaucoma?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S

HEAD

Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S

NOSE AND SINUS

Frequent colds?	Y	N	P	S
Stuffiness?	Y	N	P	S

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NOSE AND SINUS CONT.

Sinus problems?	Y	N	P	S
Nose bleeds?	Y	N	P	S
Hayfever?	Y	N	P	S
Loss of smell?	Y	N	P	S

NECK

Lumps in neck?	Y	N	P	S
Goiter?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

SKIN

Rashes?	Y	N	P	S
Acne/boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S

RESPIRATORY

Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath when lying down?	Y	N	P	S
Pain in breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S

Bowel movements: how often? __________
Is this a change?________________________

Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S

MENTAL/EMOTIONAL

Treated for emotional problem?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S

URINARY

Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S

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BLOOD

Anemia?	Y N P S
Easy bleeding or bruising?	Y N P S
Cold hands/feet?	Y N P S
Deep leg pain?	Y N P S
Thrombophlebitis?	Y N P S
Varicose veins?	Y N P S

FEMALE REPRODUCTIVE

Age of first menses:____________________
Age of last menses (if menopausal):________
Length of cycle:____________________days
Duration of menses:_________________days

Are your cycles regular?	Y N P S
Painful menses?	Y N P S
Heavy or excessive flow?	Y N P S
PMS?	Y N P S

Symptoms:_____________________________
____

Bleeding between cycles?	Y N P S
Clotting?	Y N P S
Endometriosis?	Y N P S
Ovarian cysts?	Y N P S
Vaginal odor?	Y N P S
Vaginal discharge?	Y N P S

Date of last pap smear:_________________

Abnormal PAP?	Y N P S
Cervical dysplasia?	Y N P S
Are you sexually active?	Y N P S

Sexual orientation:_____________________
Birth control? Type:____________________

Pain during intercourse?	Y N P S
Gonorrhea?	Y N P S
Herpes?	Y N P S
Chlamydia?	Y N P S
Genital warts?	Y N P S
Syphilis?	Y N P S
Difficulty conceiving?	Y N P S

Number of pregnancies:________________
Number of live births:_________________
Number of miscarriages:_______________
Number of abortions:__________________

Do you do self breast exams?	Y N P S

FEMALE REPRODUCTIVE CONT.

Breast pain/tenderness?	Y N P S
Breast lumps?	Y N P S
Nipple discharge?	Y N P S
Menopausal symptoms?	Y N P S

MALE REPRODUCTIVE

Are you sexually active?	Y N P S

Sexual orientation:____________________
Birth control? Type:___________________

Discharge or sores?	Y N P S
Chlamydia?	Y N P S
Gonorrhea?	Y N P S
Genital warts?	Y N P S
Herpes?	Y N P S
Syphilis?	Y N P S
Hernias?	Y N P S
Testicular masses?	Y N P S
Testicular pain?	Y N P S
Prostate disease?	Y N P S
Impotence?	Y N P S
Premature ejaculation?	Y N P S

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Consent Form

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent To Treatment

I, ____(patient's name), hereby voluntarily request and willingly consent to receive treatment, receive physical examinations and procedures, perform diagnostic procedures, order diagnostic lab work and medical imaging and receive diagnosis by a Physician at Selah Natural Medicine, LLC.

Naturopathic therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise and pose certain risks to me. 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 allergic reaction to pharmaceuticals and/or supplements prescribed to me, muscle soreness following a physical medicine procedure, inflammation, soft tissue injury or bruising, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also 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 agree to contact a staff member of Selah Natural Medicine, LLC immediately if I believe any adverse reaction may be occurring due to a treatment that was recommended or performed at the clinic. I will inform my healthcare practitioner of any previous allergic reaction I have had to any pharmaceutical, nutritional supplement, herbal supplement, homeopathic supplement or topical medicine.

Notice to Women: I understand that certain pharmaceutical, nutritional and herbal supplements may be harmful to pregnant women and/or their unborn child. I will inform my healthcare practitioner at Selah Natural Medicine, LLC if/when I become pregnant, if there is a chance that I may be pregnant, or if I am lactating.

I have read and understand the above statements regarding treatments and that Naturopathic Medicine is generally very safe and effective, but I realize that there is no guarantee of cure for my medical condition and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been giving to me by Selah Natural Medicine, LLC or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or as otherwise permitted or required by law.

____
Patient Name (PRINT)

____
Guardian/Personal Representative (PRINT)

____
Signature

____ Patient
Guardian/Personal Representative Signature

____
Relationship/ Representative Authority

____ Date

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RELEASE OF MEDICAL RECORDS REQUEST

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. Selah Natural Medicine does not offer reimbursement for records received.

Patient Name (Please Print): ______________________________ Date of Birth:___/___/___

____

(Address) (Phone)

Physician and Clinic: ______________________________

____

(Address)

____

____

(Phone) (Fax)

******************** Please release the following information: ********************

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_______ All Medical Records Necessary for the Continuity of Care

_______ Labs and Diagnostic Imaging Only

_______ Other: ______________________________

Patient Signature: ______________________________ Date: ___/___/___
Parent/Guardian Signature (if applicable):______________________________ Date: ___/___/___

**************************** Confidential Information *************************

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to Selah Natural Medicine. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

______________________ HIV/AIDS test results and related information, including high risk behavior documentation.
Patient Signature

______________________ Drug/Alcohol diagnosis, treatment, or referral information.
Patient Signature

______________________ Mental Health information.
Patient Signature

Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of the above information is to be disclosed. Please provide a description of this information:

____

____

____

******************** Please mail or fax as soon as possible to: *******************

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___**Please** do not phone me at home. Use this alternate phone number: ______________________

___**Please** do not phone me at work. Use this alternate phone number: ______________________

___**Please** do not leave messages on my answering machine.

___**Please** do not contact me by email.

___**Please** send mail, including my bills, to this alternate address: ________________________________

____

Other request (please describe): ____

Patient/Guardian Signature Date

Patient Name (Please Print. Include parent/guardian name if patient is a minor)

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Dear New Patient,

Welcome to Selah Natural Medicine. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

________ Payment for all services and medicinary items is due at the time of the visit. We accept cash and checks. Returned checks will be subject to a $35.00 NSF fee.

________ You will receive a bill that you may submit to your insurance company for reimbursement.

________ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. Phone and email charges are not billable to insurance.

_______ You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or late cancellations (less then 24 hours notice).

_______ I understand that I am expected to have a local primary care physician if I am conducting my appointments with my Selah Natural Medicine practitioner(s) by phone, Skype, or any other electronic means.

_______ Your health care provider may prescribe medication, which may be purchased at Selah Natural Medicine or elsewhere.

Most insurance companies do not cover the pharmacy items that we prescribe and dispense.
I have read and understand the above-stated policies of Selah Natural Medicine and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

____ _____/_____/______
Patient Signature (Parent/guardian signature if minor) Date