# Seattle Naturopathic and Acupuncture Center

Dr. Diane Lee, ND, L.Ac

## Health History Questionnaire

By completely filling out this form, you will help us help you. All answers will be *absolutely confidential*.
If you have any questions, please don't hesitate to ask. Thank you!

Name: _____ Today's Date: _____ DOB: _____

Age: _____ Sex: M / F Primary phone: Cell / Home / Work _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Occupation: _____

Parents' names *(if patient is a minor)*: _____ _____

Who referred you to our clinic? _____

### Name(s) of other healthcare provider(s)

Medical: _____ Naturopathic: _____

Chiropractic: _____ Other: _____

### Primary Health Concerns

Why are you coming to our clinic today? _____
_____

When did your problem(s) begin? Be specific. _____
_____
_____
_____

### Patient Medical History

*Please circle and date.*

| | | |
|---|---|---|
| Allergies (drugs, chemicals, foods) | High blood pressure | Seizures |
| Cancer | Hepatitis | Significant trauma *(auto accidents, falls, etc.)* |
| Diabetes | Rheumatic Fever | Venereal Diseases |
| Heart Disease | Surgeries | Other major illness(es) |

### Family Medical History

*Please indicate family member, and if on (F)ather or (M)other's side of family.*

| | | | |
|---|---|---|---|
| Allergies | Cancer | High blood pressure | Seizures |
| Asthma | Diabetes | Heart Disease | Stroke |

## Occupational stress

(chemical, physical, psychological)

_____
_____
_____

## Describe your weekly exercise

_____
_____
_____

## Current medicines

List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.

_____
_____
_____

## Known allergies

_____
_____

## Diet

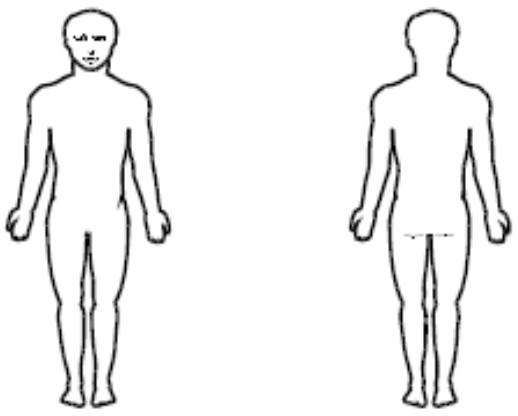
Are you or have you ever been on a restricted diet? Y / N
If so, what kind? _____

Please describe your average daily diet.
*Morning:* _____
_____
*Afternoon:* _____
_____
*Evening:* _____
_____

How many packs of cigarettes do you smoke each week? _____

How many servings of the following do you drink per week? Coffee _____ Soda _____ Tea _____ Alcohol _____

Please indicate painful or distressed areas on the diagram to the right.



*Please check if the following symptoms are a current or recurring problem.*

**General**

| | | |
|---|---|---|
| Poor appetite | Night sweats | Weight gain |
| Poor sleep | Sweat easily | Weight loss |
| Fatigue | Change in appetite | Chills |
| Cravings | Bleed or bruise easily | Fevers |
| Sudden energy drop (if so, when?) | Strong thirst | Peculiar tastes or smells |

Other? _____

**Skin and Hair**

| | | |
|---|---|---|
| Rashes | Change in hair or skin texture | Recent moles |
| Itching | Loss of hair | Ulcerations |
| Eczema | Dandruff | Pimples |

Other hair or skin problems? _____

**Head, Eyes, Ears, Nose, and Throat**

| | | |
|---|---|---|
| Using glasses | Earaches | Sinus problems |
| Color blindness | Poor hearing | Nose bleeds |
| Night blindness | Ringing in ears | Headaches |
| Eye strain | Mercury tooth fillings | Concussions |
| Eye pain | Tooth pain | Jaw clicks or pain |
| Blurry vision | Recurrent sore throats | Facial pain |
| Cataracts | Sores on lips or tongue | Neck pain |

Other? _____

**Cardiovascular**

| | | |
|---|---|---|
| High blood pressure | Fainting | Cold hands or feet |
| Low blood pressure | Chest pain | Swelling of hands |
| Irregular heartbeat | Varicose veins | Swelling of feet |
| Dizziness | Blood clots | Other _____ |

**Respiratory**

| | | |
|---|---|---|
| Difficulty breathing | Asthma | Coughing blood |
| Cough | Bronchitis | Pain with deep breathing |
| Production of phlegm (if so, what color?) | Pneumonia | Other _____ |

**Gastrointestinal**

| | | |
|---|---|---|
| Indigestion | Abdominal pain or cramps | Rectal pain |
| Gas | Nausea | Hemorrhoids |
| Bad breath | Vomiting | Blood in stool |
| Constipation | Chronic laxative use | Diarrhea |

Other? _____

**Genito-Urinary**

| | | |
|---|---|---|
| Frequent urination | Unable to hold urine | Kidney stones |
| Urgency to urinate | Decrease in flow | Impotency |
| Pain upon urination | Distinctive or odd color urine | Sores on genitals |
| Blood in urine | Waking to urinate | Other _____ |

**Gynecology and Pregnancy**

| | | |
|---|---|---|
| Unusual menses | Irregular periods | Clots |
| Heavy | Painful periods | Vaginal sores |
| Light | Breast tenderness | Vaginal discharge |

Changes in body or emotions prior to menstruation: _____

Do you practice birth control? Y / N
If yes, what type and for how long? _____

| | |
|---|---|
| _____ Number of pregnancies | _____ Age of first menses |
| _____ Number of births | _____ Duration of menses |
| _____ Number of miscarriages | _____ Days between menses |
| _____ Number of abortions | _____ Start date of last menses |
| | _____ Date of last PAP exam |

**Musculoskeletal**

| | | |
|---|---|---|
| Neck pain | Back pain | Shoulder pain |
| Knee pain | Foot/ankle pain | Hip pain |
| Hand/wrist pain | Muscle pain | Muscle weakness |

Other joint or bone problems: _____

**Neuro-psychological**

| | | |
|---|---|---|
| Loss of balance | Depression | Concussion |
| Quick temper/irritability | Susceptible to stress | Seizures |
| Poor memory | Dizziness | Areas of numbness |
| Anxiety | Lack of coordination | Other _____ |

Have you ever been treated for emotional problems? Y / N

Have you ever considered or attempted suicide? Y / N

Any other neurological or psychological problems? Y / N

Please describe any other problems you would like to discuss:

_____
_____
_____
_____
_____
_____
_____
_____

# CONTEXT OF CARE

1. Why did you choose to come to this clinic?

2. What three expectations do you have for this visit to our clinic?

3. What long-term expectations do you have for working with this clinic?

4. What expectations do you have for me personally as your physician?

5. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please rate 1-10, 10 being 100% committed)

6. What behaviors or lifestyle habits do you currently engage in regularly that believe support your health? (Please list.)

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are detrimental to your health? (Please list.)

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

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

10. What do you LOVE to do?

**Dr. Diane Lee, ND**
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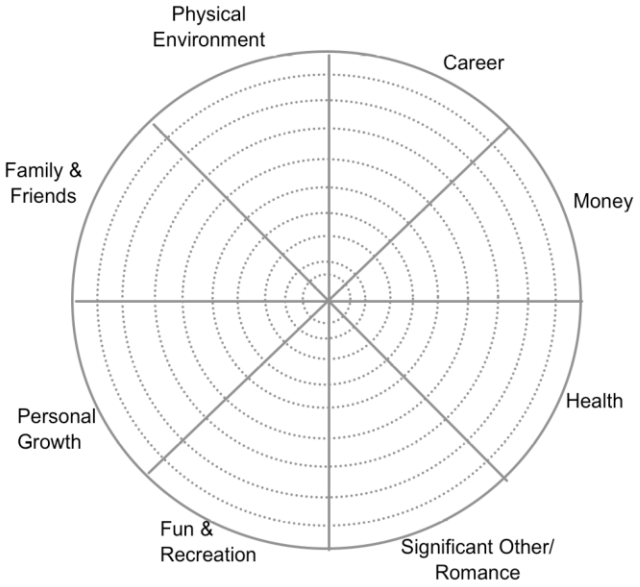
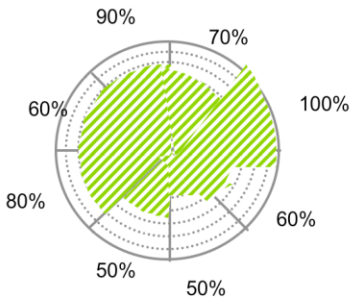
# Wheel of Balance





Example:




## 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 extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

# CONSENT FOR TREATMENT

I hereby authorize Dr. Diane Lee to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **General Diagnostic Procedures** including, but not limited to, venipuncture, pap smears, radiography, blood and urine labwork, general physical exams, neurological and musculoskeletal assessments
- **Psychological Counseling**; **Lifestyle Counseling**; **Exercise Prescriptions**
- **Herbs/Natural Medicines**- prescribing of various therapeutic substances, including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, or tinctures (may contain alcohol), topical creams, pastes, plasters, washes, suppositories, or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
- **Dietary Advice and Therapeutic Nutrition**- use of foods, diet plans, or nutritional supplements for treatment, which may include intramuscular vitamin injections
- **Soft Tissue and Osseous Manipulation**- use of massage, neuro-muscular techniques, muscle energy stretching, or visceral manipulation, as well as manipulations of the extremities and spine, including traction and craniosacral therapy
- **Thermal Therapies**, including the use of cupping, moxa (warming or indirect burning of an acupuncture point), and hydrotherapies

**Potential risks**: Pain; discomfort; blistering; discoloration; infection; burns; loss of consciousness; deep tissue injury from needle insertions, topical procedures, heat, or frictional therapies, electromagnetic- and hydro-therapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; aggravation of pre-existing symptoms

**Potential benefits**: Restoration of health and the body's maximal functional capacity; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression

**Notice to pregnant women**: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used couple present a risk to the pregnancy. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedure, realizing that no guarantees have been given to me by Dr. Diane Lee. Further, I will hold Dr. Lee harmless and will not ask for indemnity for any of the side effects that may be caused. 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

| _____ | _____ | _____ |
|---|---|---|
| Patient's name (PRINT) | Patient's signature | Date |
| _____ | _____ | _____ |
| Guardian/Representative's name (PRINT) | Guardian/Representative's signature | Date |

_____
Relationship/Representative's Authority

**Notice of Privacy Practices**

I have received a copy of the Privacy Practices. I consent to the personal use of my personal health information for the purposes of treatment, payment, and clinic healthcare operations. I am aware that a detailed description of the Privacy Practices of this clinic is available upon request and that a copy is available for my access at www.seattlenaturopathiccenter.com.

**Initials** _____ **Date** _____

**Payment**

I agree to pay for any fees for services, costs of supplements and remedies, costs of laboratory tests, or other costs or fees that are not covered by my insurance plan. I furthermore understand that any amount paid at the time of service is not a guarantee of coverage, nor is it indicative of the entire amount that may be owed by me in the event that my insurance does not cover the full amount owed. I understand that there is a 24 hour cancellation policy and that I will therefore be charged a $60 cancellation fee if changes to my appointment are made without 24 hours notice and that I will be charged a $100 "no show" fee for any appointments that I miss without 24 hours notice. For patients without health insurance, payment is due in full at the time of service.

**Initials** _____ **Date** _____

# ELECTRONIC COMMUNICATIONS AUTHORIZATION FORM

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers take reasonable measures to safeguard your Protected Health Information (PHI) at all times. This includes securing your PHI as much as possible when it is communicated electronically via facsimile, text, or email. Unfortunately, even with appropriate safeguards in place, it is impossible to ensure that electronic communications are entirely safe at all times. In order to accommodate requests for electronic communications for purposes such as appointment scheduling, billing, health record transmission, and marketing, HIPAA requires that we obtain your written authorization.

We understand that you are on a path to better well-being and we would like to facilitate that process as much as possible. Electronically transmitting copies of your Electronic Health Record saves you time and money. Authorizing us to quickly communicate with you and/or others involved in the handling of your care will help us to better serve you. Please carefully read the risks listed below and ask any questions of us that you may have. You may revoke these authorizations at any time by speaking with our office staff.

**Risks and Conditions of Using Electronic Communication:**

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the provider or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

□ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Seattle Naturopathic and Acupuncture Center to communicate with me via email for the purpose of health care operations.

□ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Seattle Naturopathic and Acupuncture Center to communicate with me via email for marketing purposes.

□ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Seattle Naturopathic and Acupuncture Center to communicate with my Primary Care Provider as listed in my New Patient Intake.

□ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Seattle Naturopathic and Acupuncture Center to transmit my Electronic Health Record to those involved in the handling of my care with my signed authorization. I understand that I will be notified beforehand so as to ensure that my PHI is sent only to the appropriate parties as requested by me.

□ ***I understand the risks associated with secured and unsecured electronic transmissions and therefore reserve my right to opt out of any electronic communications regarding my health care.***

_____ _____ _____

Name (Printed) Signature Date

_____ _____

My email address My cell number