



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)

Cancer

Diabetes

Heart Disease

High blood pressure

Hepatitis

Rheumatic Fever

Surgeries

Seizures

Significant trauma (auto accidents, falls, etc.)

Venereal Diseases

Other major illness(es)

Family Medical History

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

Allergies

Asthma

Cancer

Diabetes

High blood pressure

Heart Disease

Seizures

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: _____

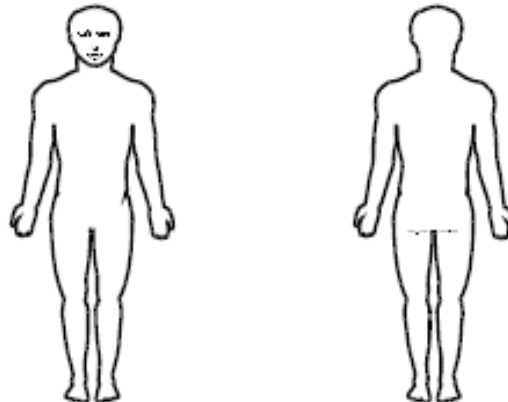
Afternoon: _____

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 Asthma

Difficulty breathing	Bronchitis	Coughing blood
Cough	Pneumonia	Pain with deep breathing
Production of phlegm (if so, what color?)		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
Heavy
Light

Irregular periods
Painful periods
Breast tenderness

Clots
Vaginal sores
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
_____ Number of births
_____ Number of miscarriages
_____ Number of abortions

_____ Age of first menses
_____ Duration of menses
_____ Days between menses
_____ Start date of last menses
_____ Date of last PAP exam

Musculoskeletal

Neck pain
Knee pain
Hand/wrist pain

Back pain
Foot/ankle pain
Muscle pain

Shoulder pain
Hip pain
Muscle weakness

Other joint or bone problems: _____

Neuro-psychological

Loss of balance
Quick temper/irritability
Poor memory
Anxiety

Depression
Susceptible to stress
Dizziness
Lack of coordination

Concussion
Seizures
Areas of numbness
Other _____

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

Have you ever considered or attempted suicide? Y / N

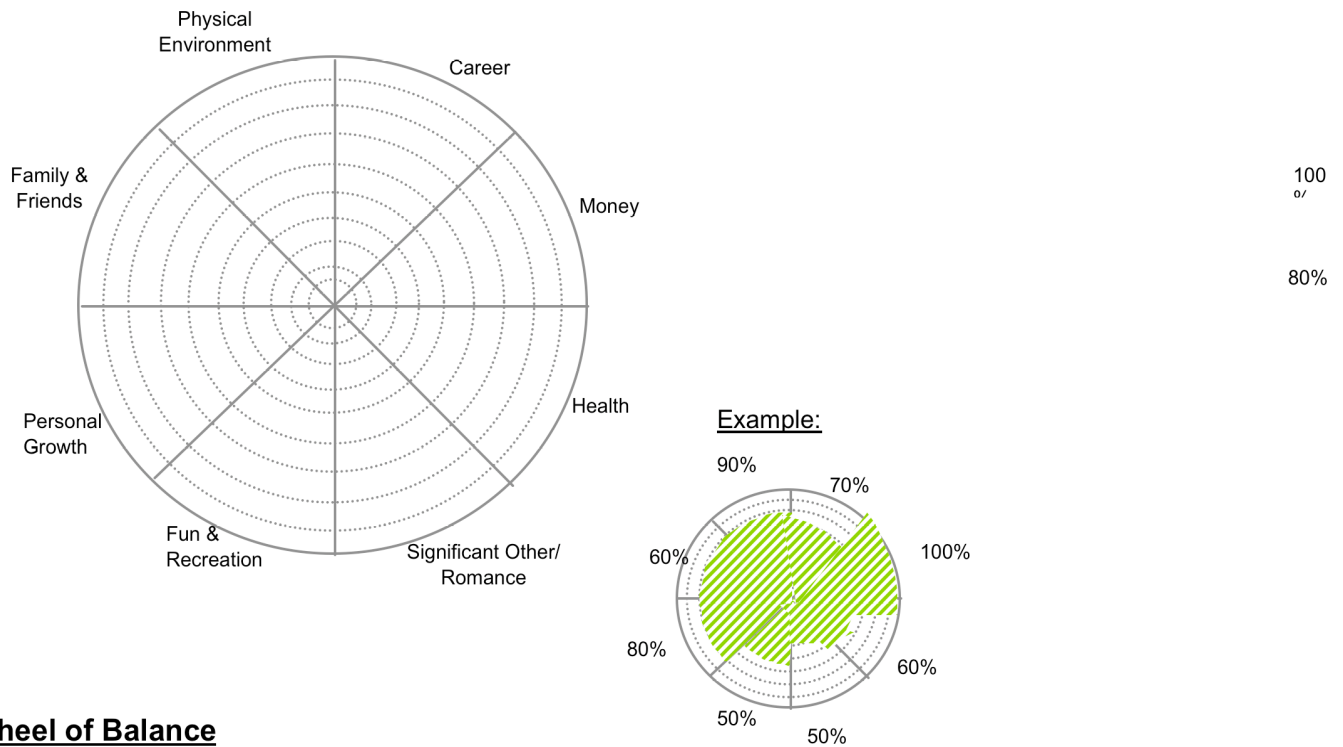
Any other neurological or psychological problems? Y / N

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?

Wheel of Balance



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 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

ASSIGNMENT OF INSURANCE BENEFITS

I, _____, the undersigned, have insurance coverage with _____

And assign directly to Seattle Naturopathic and Acupuncture Center all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Seattle Naturopathic and Acupuncture Center to release all information necessary to secure the payment benefits. I give permission to the Seattle Naturopathic and Acupuncture Center to release information to my other health care providers. I authorize the use of this signature on all of my insurance submissions.

Signature _____

Date _____

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I would like to receive a reminder for future appointments via: *(Please Initial)*

____ Text

____ Email

____ Opt out of reminder

It is okay to leave a detailed voice message on the phone number I have provided on my intake paperwork. *(please initial)*

____ Yes

____ No

Please list any individuals with whom we may disclose information concerning your private health information:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

By listing an individual(s) above you have granted Seattle Naturopathic and Acupuncture Center permission to disclose your private health information to those listed. This information includes and is not limited to information regarding appointments, current diagnoses, treatment plan, and financial matters.

Patient Signature

Date