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natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

ADULT INTAKE

Name:_____Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home):_____ (cell): _____

E-mail address: _____

Age: _____ Date of Birth: _____ Gender: Female/Male

Married: _____Separated: _____ Divorced: _____ Widowed: _____Single: _____ Partnership: _____

Live with: Spouse: _____ Partner:_____ Parents: _____Children: _____Friends: _____ Alone: _____

Occupation: _____ Hours per week: _____ Retired: _____

Employer Name and Address: _____

How did you hear about this clinic? _____

Has any other family member already been a patient at the clinic? _____

Emergency contact: _____ Relationship: _____

Address: _____

Phone: _____

Insurance? Yes / No Insurance Name: _____ Phone # _____
Policy/ID Number: _____ Group Number: _____
Secondary Insurance Yes / No Insurance Name: _____

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Flow Natural Health Care.

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apple to insurance companies that I am under contract with.

Signature:_____ Date: _____

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CONTEXT OF CARE REVIEW

Successful health care and preventative 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 truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

What *three* expectations do you have from *this* visit to your 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 1 to 10, 10 being 100% committed.

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 that are undermining your health and adhering to the therapeutic protocols that 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?

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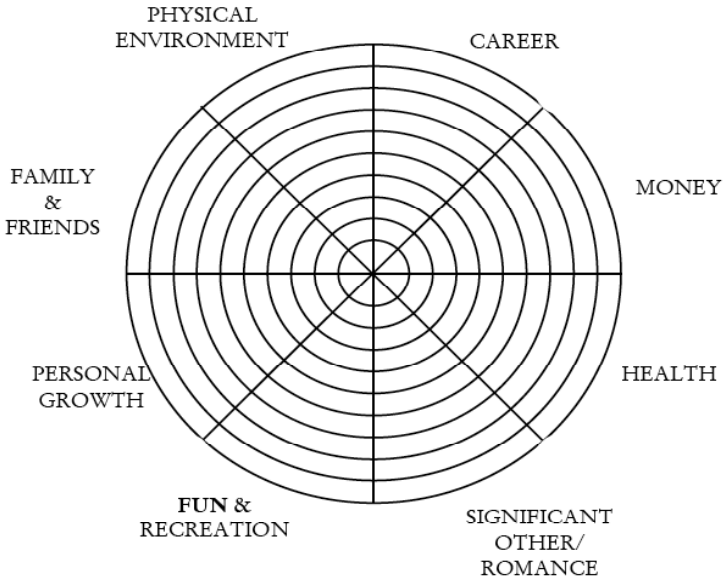
WHEEL OF BALANCE

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 65% 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 contagious disease 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			

Any other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESSES

Weight at birth: _____

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

Scarlet fever	Diphtheria	Mumps	Measles
German measles	Rheumatic fever	Chicken pox	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKG's have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

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CURRENT MEDICATIONS

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

Laxatives	Pain relievers	Antacids	Birth Control Pills
Cortisone	Appetite suppressants	Antibiotics	Hormone Replacement
Tranquilizers	Thyroid medication	Sleeping pills	

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

1)_____ 4) _____

2)_____ 5) _____

3)_____ 6) _____

7)_____ 8) _____

GENERAL

Height: _____Weight:_____ Weight 1 year ago: _____

Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

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 = condition you have now **N** = never had **P** = significant problem in the past **S** = sometimes a problem

GENERAL

Do you sleep well?	Y N P S
Average 6-8 hrs. sleep?	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
Treated for alcoholism?	Y N P S
Do you 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 foods?	Y N P S

MENTAL/EMOTIONAL

Treated for emotional problems?	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
Reactions to immunizations?	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
Earaches?	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
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

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

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

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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

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

NOSE AND SINUSES

Frequent colds?	Y N P S
Stuffiness?	Y N P S
Sinus problems?	Y N P S
Nose bleeds?	Y N P S
Hay fever?	Y N P S
Loss of smell?	Y N P S

MOUTH AND THROAT

Frequent sore throat?	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

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

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 lying down?	Y N P S
Pain when breathing?	Y N P S
Emphysema?	Y N P S
Tuberculosis?	Y N P S

CARDIOVASCULAR

Heart disease?	Y N P S
High/low blood pressure?	Y N P S
Blood clots?	Y N P S
Angina?	Y N P S
Murmurs?	Y N P S
Phlebitis?	Y N P S
Fainting?	Y N P S
Palpitations/Fluttering?	Y N P S
Rheumatic fever?	Y N P S
Chest pain?	Y N P S
Swelling in ankles?	Y N P S

URINARY

Increased frequency of urination?	Y N P S
Inability to hold urine?	Y N P S
Pain with 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

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 (yellow skin)?	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
Diarrhea?	Y N P S
Blood in stools?	Y N P S
Bowel movements: how often?	_____
Is this a change? Y / N	

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MUSCULOSKELETAL

Joint pain of 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

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

MALE REPRODUCTIVE

Are you sexually active? Y N P S
Sexual orientation? _____
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 mass? Y N P S
Testicular pain? Y N P S
Prostate disease? Y N P S
Impotence? Y N P S
Premature ejaculations? Y N P S

FEMALE REPRODUCTIVE

Age of first menses: _____

Age of last menses (if menopausal): _____

Length of cycle: _____

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 annual PAP smear: _____
Abnormal PAP? Y N P S
Cervical dysplasia? Y N P S
Are you sexually active? Y N P S
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: _____

Ectopic pregnancies: _____

Do you do self breast exam? Y N P S
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

Thank you for taking the time to complete this intake form.

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INFORMED CONSENT & REQUEST FOR NATUROPATHIC MEDICAL CARE

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Hamilton and/or Dr. Lok, having had the opportunity to discus the potential benefits, risks and hazards involved.

I, _____ , hereby request and consent to examination and treatment with naturopathic medicine by Drs. Hamilton and/or Lok, and/or other licensed doctors of naturopathic medicine who may serve as substitutes in their absence, hereafter called allied health care provider.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Hamilton and/or Dr. Lok, and/or with the allied health care provider who acts as a substitute in their absence:

1. My suspected diagnosis(es) or condition(s).
2. The nature, purpose, goals and potential benefits of the proposed care.
3. The inherent risks, complication, potential hazards or side effects of treatment(s) or procedure(s).
4. Reasonable available alternatives to the proposed treatment procedure.
5. Potential consequences if treatment or advice is not followed and/or nothing is done.

I understand that as part of the practice of naturopathic medicine, evaluations and treatment may include, but are not limited to:

- Physical exams (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments).
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva).
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intramuscular injections).
- Botanical/herbal medicines, prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, pastes, plasters, washes or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances).
- Hydrotherapy (use of hot and cold water).
- Counseling for improved lifestyle strategies.
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians).

Potential benefits: Restoration and improvement of the body's functioning and healing capacity, relief of pain and other disease symptoms, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, aggravations of pre-existing symptoms.

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Notice to all pregnant women: All female patients must alert the provider if they have a confirmed or suspected pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace maker and /or cancer, for your safety it is vital to alert your provider of these conditions.

Please read and INITIAL the following:

_____ I understand that Drs. Hamilton & Lok are not licensed to prescribe any controlled substances.
_____ I understand that Drs. Hamilton and/or Lok will only prescribe medications if they believe that they are in the best interest of myself, the patient.
_____ I understand the US Food and Drug Administration has not approved all nutritional, herbal and homeopathic substances that may be prescribed.
_____ I understand that Drs. Hamilton & Lok are not psychologists or psychiatrists. Counseling services are provided for improved lifestyle strategies. I do not expect Drs. Hamilton and/or Lok, and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on known facts.
_____ I understand that it is my responsibility to request that Drs. Hamilton and/or Lok explain therapies and procedures to *my* satisfaction.
_____ I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me.

By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment by Drs. Hamilton and/or Lok. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____
Patient printed name

_____
Parent/guardian printed name (if patient is a minor)

_____
Patient Signature (or parent or guardian of patient is a minor)

_____
Date

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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 to best contact you when needed. If you have no specific requests we will use your information provided on the intake form. Please check <u>all</u> 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 name (Please print. Include parent/guardian name is patient is a minor).

_____ ____ / ____ / ____

Patient Signature (Parent/guardian signature if a minor) Date

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OFFICE POLICIES & FINANCIAL AGREEMENT

Dear New Patient,

Welcome to Flow Natural Health Care LLC. I look forward to providing you with your health care needs. I 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 your visit. We accept cash, checks, Visa or MasterCard. Returned checks will be subject to a $35.00 NSF fee.

____ I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

____ As your health care provider I may prescribe medication, which may be purchased at Flow Natural Health Care LLC or elsewhere. Most insurance companies do not cover pharmacy items that I prescribe and dispense.

____ You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or cancellations of less than 24 hours notice. Insurance companies do not cover late cancellation fees.

I have read and understand the above stated policies of Flow Natural Health Care LLC and will comply with them in all respects.

_____

Patient Name (Please print. Parent or guardian if patient is a minor).

_____ _____

Patient signature (Parent or guardian if patient is a minor) Date