



11630 SE 40<sup>th</sup> Ave. Suite C  
Milwaukie OR 97222  
503.974.9283

## ADULT INTAKE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (cell): \_\_\_\_\_

May we leave phone messages relating to your visits? YES NO

E-mail address (this is not shared): \_\_\_\_\_

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: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

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

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Are you receiving other treatments of health care? (Please list type of care and names).

\_\_\_\_\_  
\_\_\_\_\_

Are you **hypersensitive** or **allergic** to:

Medications? \_\_\_\_\_ Foods? \_\_\_\_\_

Environmental/chemicals? \_\_\_\_\_



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**Medical History**

Current Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Energy Level (1-10): \_\_\_\_\_  
 Date of last physical exam: \_\_\_\_\_ Date of last Bone Dexa Scan: \_\_\_\_\_  
 Date of last mammogram (f): \_\_\_\_\_ Date of last colonoscopy: \_\_\_\_\_  
 Date of last pap smear (f): \_\_\_\_\_ Date of last prostate exam: \_\_\_\_\_  
 Date of last EKG/ cardiac testing: \_\_\_\_\_  
 Surgeries? \_\_\_\_\_  
 \_\_\_\_\_

**Medications**

Do you take or use any of the following?

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Laxatives     | <input type="checkbox"/> Pain relievers        | <input type="checkbox"/> Antacids         | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Cortisone     | <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> Antibiotics      | <input type="checkbox"/> Hormone Replacement |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Thyroid medication    | <input type="checkbox"/> Sleeping pills   | <input type="checkbox"/> Blood pressure meds |
| <input type="checkbox"/> Diuretics     | <input type="checkbox"/> Anti depressants      | <input type="checkbox"/> Cholesterol meds |  |

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

\_\_\_\_\_  
 \_\_\_\_\_

**Family History**

Do you or anyone in your family have a history of any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Heart Disease                                   |   |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Kidney Disease                                  | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Mental Illness       |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Anemia  | <input type="checkbox"/> Autoimmune condition |
| <input type="checkbox"/> Asthma/Hay fever/Hives | <input type="checkbox"/> Cancer (please list type of cancer & who) _____ |   |
| <input type="checkbox"/> Other:                 | _____  |   |

\_\_\_\_\_  
 \_\_\_\_\_

**Social History**

Tobacco use (amount and years or list stop date): \_\_\_\_\_

Alcohol (drinks per week): \_\_\_\_\_

Religious/Spiritual practice: \_\_\_\_\_



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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 discuss 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.
- 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 all that apply:

- Please do not phone me at \_\_\_\_\_ Use this alternate phone number: \_\_\_\_\_
- Please do not leave messages at/on:    Cell phone        Work        Home.
- Please do not contact me by email.
- Please send mail, including my bills, to this alternate address:

\_\_\_\_\_

\_\_\_\_\_  
Patient name (Please print. Include parent/guardian name if patient is a minor).

\_\_\_\_\_  
Patient Signature (Parent/guardian signature if a minor)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date



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## OFFICE POLICIES & FINANCIAL AGREEMENT

Please read and **initial** the following statements:

- \_\_\_\_\_ Payment for all services and medicinal items is due at the time of your visit. In the event that your insurance company denies benefits or makes a partial payment, you are responsible for any balance due.
- \_\_\_\_\_ We accept cash, checks, Visa or MasterCard. Returned checks will be subject to a \$35.00 NSF fee.
- \_\_\_\_\_ Most insurance companies do not cover pharmacy items that may be prescribed and/or dispensed at Flow Natural Health Care or elsewhere.
- \_\_\_\_\_ You will be charged a Missed Appointment Fee of \$40.00 for any missed appointments or cancellations of less than 24 hours notice. Insurance companies do not cover late cancellation fees.

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

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

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

Date

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### For Patients with Insurance:

**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 apply to insurance companies that I am under contract with.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_