Essential Wellness
Integrative Medicine and Acupuncture

Patient Information Form

Last Name:_____ First Name:_____ M.I.____Date of Birth:_____Sex:____
Other names or nicknames your records may be kept under:_____

Address:_____ Apt.#:_____

City:_____ State:_____ Zip code:_____ Country:_____

Occupation:_____ Employer/School:_____

Preferred Contact Number: ☐ Cell ☐ Home ☐ Work
Can we leave a confidential message on voicemail: ☐ Cell ☐ Home ☐ Work Text message okay?: ☐ Yes ☐ No

Cell Phone: (___)_____ Home Phone: (___)_____ Work Phone: (___)_____

Social Security #:_____ Email:_____

Parent Name (minors only)_____ **Parent Name (minors only)**_____

Emergency Contact:_____ Contact's Phone #:_____

Are you hearing impaired? Y N Are you visually impaired? Y N Do you have special needs?: Y N

Do you have non-English language needs?_____ How did you hear about us?_____

Pharmacy:_____

Insurance Information

Please notify us if processing Labor and Industry (L & I) or Personal Injury Protection (PIP) Claims

Please complete this section if we will be billing your insurance.

1. Does your insurance have naturopathic benefits/coverage? Yes No
2. Does your insurance have acupuncture benefits/coverage? Yes No

Who is your primary care provider (PCP)?:_____ Phone #:_____

Clinic address:_____ City:_____ State:_____ Zip Code:_____

3. Primary Insurance Company & Plan Name:_____

ID Number:_____ Group/Policy Number:_____

Name of policy holder:_____Policy holder's date of birth:_____

Relationship to policy holder:_____Is your primary: (circle) POS PPO EPO HMO

4. Secondary Insurance Company & Plan Name:_____

ID Number:_____ Group/Policy Number:_____

Name of policy holder:_____ Policy holder's date of birth:_____

Relationship to policy holder:_____Is your secondary insurance: (circle) POS PPO EPO HMO

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic unless prior arrangements have been made. I understand that if I am providing insurance billing information, I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Essential Wellness Integrative Medicine and Acupuncture to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Guardian (required for minors) Date
Relationship to patient:_____

3204 Smokey Point Dr. Suite 102 Arlington, WA 98223 P: (360) 436-6303 F: (360)633-3637

HEALTH HISTORY

THIS INFORMATION WILL BE CONTAINED IN YOUR CONFIDENTIAL MEDICAL RECORD

Last Name:_____ First Name:_____
Today's Date:_____ Birthdate:_____ Sex:_____
Height:_____ Weight:_____ Weight change in past 12 months: gain_____lbs loss_____lbs
Allergies, sensitivities, severe/life threatening reactions to medications, foods, chemicals, animals or anything else? Y N
If YES, please explain: _____

Please list in order of importance your chief concerns/reason for visit:
1.)
2.)
3.)
4.)
5.)

_____
What goals do you have for your visit today?_____
_____
Have you ever been treated using (circle): naturopathic care acupuncture massage nutrition counseling HCG diet
Date of last complete checkup:_____Diagnosis, if any:_____Last blood work:_____

Please list prescription medications that you are currently taking, with dosages:		
1.)	3.)	5.)
2.)	4.)	6.)

Please list vitamins, minerals, herbs, homeopathics or supplements that you are currently taking, with dosages:		
1.)	3.)	5.)
2.)	4.)	6.)

Personal Habits

What does your typical diet consist of:
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Do you follow any particular diet regimens or restrictions? _____

Caffeine: Coffee _____cups per day Tea _____cups per day
Smoking: Packs per day:_____ Number of years:_____ Years stopped:_____ cigs/pipe/cigar/chew
Alcohol: What type? _____ How often? _____
Other: Soft drinks? Energy drinks? What type and how much per day? _____
Recreational drugs: What type?_____ How much each week?_____

Do you exercise regularly? ▫ YES ▫ NO If yes, what type? _____
How Long?_____ How Often? _____
How many hours do you sleep?_____

Past History

Hospitalizations: _____
_____

Serious Illnesses and Injuries: _____
_____

Family History

Please list family members with the following? ▫ Diabetes_____ ▫ Heart Disease_____
▫ High Blood Pressure _____ ▫ Thyroid_____ ▫ Stroke _____
▫ Cancer _____ ▫ Alcoholism/Drug Addiction_____ ▫ Mental Illness_____
What are your children's names and ages? _____
_____

Review of Systems: Check if you currently have any of the symptoms listed below:

General:
▫ Tiredness, weakness
▫ Sudden energy drop, time of day
▫ Weight loss/gain
▫ Eating disorder
▫ Appetite change
▫ Fever
▫ Sweating at night
▫ Sweating when tired
▫ Bleeding tendency
▫ Bruise easily
▫ Poor sleep
▫ Strong thirst (for hot or cold?)
▫ Cravings

Eye/Ears/Nose/Throat
DATE of last eye exam:_____
▫ Disturbances of vision
▫ Red or itchy eyes
▫ Loss of hearing
▫ Ringing in ears
▫ Pain in ears
▫ Disturbances of speech
▫ Trouble swallowing
▫ Sore or dry throat
▫ Lip or mouth sores
▫ Nosebleeds
▫ Nose or sinus problems
▫ TMJ
▫ Loss of taste or smell
▫ Headache
▫ Problems with teeth/dentures
DATE of last dental exam:_____

Respiratory System:
▫ Cough
▫ Asthma
▫ Chest pain
▫ Shortness of breath
▫ Rib pain

Skin and Hair
▫ Rash
▫ Oozing skin sores
▫ Eczema
▫ Loss of hair

Gastrointestinal System:
▫ Constipation
▫ Diarrhea
▫ Blood in stool
▫ Hemorrhoids
▫ Nausea, vomiting
▫ Heartburn
▫ Indigestion
▫ Abdominal pain/discomfort
▫ Gas & bloating
▫ Jaundice (yellowing of skin and eyes)

Genitourinary System:
▫ Lower abdominal pain
▫ Kidney problem
▫ Hernia
▫ Sexually transmitted disease
▫ Urinary Tract Infection
▫ Pain on urination
▫ Inability to hold urine
▫ Blood in urine
▫ Urethral discharge

Musculoskeletal System:
▫ Joint pain, swelling
▫ Pain in neck, shoulder, back, arm, hand, hip, buttock, leg, knee, ankle, foot (circle all that apply)
▫ Cold hands or feet
▫ Pins and needles sensation

Cardiovascular System:
DATE of last EKG:_____
DATE of last Chest X-ray:_____
▫ Palpitations
▫ Blood pressure problems
▫ High cholesterol
▫ History or heart murmurs
▫ Swollen ankles or feet
▫ Blood clots

Central Nervous System:
▫ Fainting
▫ Convulsions
▫ Weakness/paralysis
▫ Loss of feeling or function in body part
▫ Disturbances of balance ▫ Dizziness
▫ Light-headedness
▫ Headaches

Emotional:
▫ Worry
▫ Moodiness
▫ Irritability
▫ Nervousness
▫ Depression
▫ Grief

Women's Issues:	***Men's Issues:***
DATE OF LAST PERIOD:_____ TYPE OF BIRTH CONTROL:_____ DATE OF LAST MAMMOGRAM_____ ▫ Painful periods ▫ PMS ▫ Irregular periods ▫ Excessive bleeding ▫ Abnormal lack of menses ▫ Hot flashes ▫ Vaginal dryness ▫ Sexual difficulties ▫ Painful breasts ▫ Lumps in breasts ▫ Pregnancy#___	▫ Prostate problems ▫ Sexual difficulties ▫ Testicular pain/swelling ▫ Penis pain or discharge

Additions to Health History:

_____

_____

_____

_____

PATIENT SIGNATURE:_____ DATE: _____

CLINIC POLICIES

Informed Consent to Treat

I hereby authorize the physician(s) at Essential Wellness Integrative Medicine and Acupuncture to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:
General Diagnostic Procedures: including but not limited to venipuncture blood draws, pap smears, radiographic imaging, general physical exams, and urine assessments.
Diet and Lifestyle Coaching/Counseling & Exercise Rx: including but not limited to HCG diet protocol
Acupuncture: including but not limited to the use of acupuncture needles, cupping, and moxa
Herbs and Natural Medicines: including but not limited to the prescription of various therapeutic substances including vitamins, minerals, homeopathics, plants, minerals, and other natural substances in the form of teas, pills, powders, tinctures (may contain alcohol), injections, topical crèmes, suppositories, and other forms.

I hereby authorize Essential Wellness Integrative Medicine and Acupuncture to perform routine emergency medical procedures as necessary to facilitate me or my child's diagnosis and treatment. This includes the following: common diagnosis procedures, minor office procedures, use of pharmaceutical, botanical, nutritional, and homeopathic medicine, manual/physical medicine, acupuncture and immunizations.

I recognize there are potential risks and benefits of these procedures. This authorization will be in effect until revoked in writing by me.

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

INITIAL THAT YOU HAVE READ AND CONSENT TO THE ABOVE: _____

Financial Policies

Insurance Billing: You are required to provide proof of insurance coverage (insurance card) at the time of your visit. For patients with insurance coverage in which our practitioners are a participating provider, we bill insurance directly and accept their payment plus any co-payments, co-insurance, deductibles and payments for non-covered services as payment in full. If your policy has an office visit co-payment, you agree to pay the co-payment at the time of your visit. **Patients are responsible to know the terms of their insurance and whether naturopathic services are covered.** If services are not covered, patients are responsible for payment.

For patients with an insurance plan in which our practitioners are not contracted, we will be happy to courtesy bill your insurance company. Please provide us with the necessary information. It will be your responsibility to follow-up with your insurance company should they deny payment for any reason. Keep in mind that you will receive statements from us until payment is received and that; ultimately your account balance is your responsibility.

In the case of default of payment, I am responsible for full payment of the balance, and any collection costs and legal fees incurred to collect on this account. I have filled out and understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan. I, the undersigned, have read, understand, and accept the information and conditions hereby specified.
Time of service discount: All patients paying in full at time of service will receive a discount on office visits. This discount does not extend to non-service products such as supplements. If receiving a TOS discount, the visit cannot be submitted for insurance reimbursement and will not count toward your deductible.

Supplements return policy: Supplements may be returned, unopened, within 30 days of purchase for a credit on your account.

Late Cancellations and No Show Fee Policy: If you are unable to make your appointment, please give our office 24 hours notice so that we may give another patient that time. For appointments on Mondays, that means you must give notice on Friday. **Patients that "no show" or do not cancel 24 hours prior to their appointment may be assessed an appointment charge of $50.** This charge is your responsibility. Insurance companies do not pay for missed appointments.

Returned Checks: We charge $35 for returned checks to cover banking costs. Patients who incur NSF/returned check charges will be required to make future payments by cash, credit card or cashier's checks.

Multiple Households: When a child of divorced parents is seen, we will expect payment from whichever parent accompanies that child. We will not bill ex-spouses or parents who live outside the area.

INITIAL THAT YOU HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES ABOVE: _____

Health Insurance Portability and Accountability Act (HIPAA)

I understand that Essential Wellness Integrative Medicine and Acupuncture will use and disclose health information about the patient in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. I have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. My signature below acknowledges I am aware of my rights in accordance to HIPAA.

INITIAL THAT YOU WERE OFFERED A NOTICE OF PRIVACY PRACTICES:_____

Release of Health Information

We keep a record of the health care services we provide you and your child. You may ask to see and copy that record (copy charges may apply). We will not disclose you or your child's record to others unless you direct us to do so.

After Hours Service

For urgent medical concerns after hours that cannot wait until the next business day you may contact the doctor at (360) 436-6303. If you have a medical emergency that cannot wait, call 911. Please reserve calls for routine or non-urgent concerns to business hours.

I acknowledge that I have read and understand the information above.

_____

Patient Name

_____ _____

Patient/Parent/Guardian Signature **Date**