



# A Renaissance Health Center for Natural Medicine

130 NW Miller St., Gresham, OR 97030 Ph: 503.665.2344

## NATUROPATHIC COMPREHENSIVE INTAKE

### PERSONAL & WORK INFORMATION

Accident or Injury Date: \_\_\_\_\_ (PI or Workman's Comp)  
(Complete PI/Worker's Comp Form)

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security#: \_\_\_\_-\_\_\_\_-\_\_\_\_ M F Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

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

Are you: Single Married Significant Partner Living with: Spouse Significant Partner Parents Relatives Friends Alone

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone(s): \_\_\_\_\_

How did you learn about our practice? Friend Ad Yellow Pages Drive-by Health Professional Referral Other: \_\_\_\_\_

### FINANCIAL & INSURANCE INFORMATION

I will pay my balance in full at time of service. (Cash/Visa/MC/American Express/Checks) \* \$25.00 charge on all returned checks. Please initial \_\_\_\_\_

Do you have Medical Insurance that covers Naturopathic: Yes No If yes, Please check the type of Insurance: Private Insurance Company

Medicare Medicaid Personal Injury/Workman's Comp. (see other form) Other: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Insured Name: : \_\_\_\_\_

Relationship to Insurer: Self Spouse Child Partner Complete the following information about the *Insurer* if other than self: M F

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Address, City, St, Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ Employer Name: \_\_\_\_\_

Address, City, St, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

### RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the **Release of any Information** relating to claims for benefits submitted. I agree and acknowledge that I authorize my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim. Furthermore this authorization permits *A Renaissance Health* to use or disclose to Quality Medical Billing. I (patient) \_\_\_\_\_ hereby authorize (Insurance Co.) \_\_\_\_\_ to pay and hereby assign directly to assigned physician practicing at *A Renaissance Health* all owed benefits. I understand I am financially responsible for all charges incurred \_\_\_\_\_

In the event that I give less than a 24-hour notice of cancellation I understand the fee is \$55.00 \_\_\_\_\_ (Initial). (Initial)

\_\_\_\_\_  
Patient Signature or Guardian if patient is under 18 years of age Relationship to patient Date

### CONSENT FORM & AGREEMENT

Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

\_\_\_\_\_  
Patient Signature or Guardian if patient is under 18 years of age Relationship to patient Date

## Health History Questionnaire

Holistic health care and preventive medicine are only possible when the physician has a complete understanding of your physical, mental, emotional and spiritual nature. Therefore, please take the time to carefully and thoroughly complete your questionnaire. Print all information and mark anything you don't understand with a question mark.

Where did you last receive health care? \_\_\_\_\_ When? \_\_\_\_\_

Reason for last visit: \_\_\_\_\_

Please list your health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list traumatic events in your life that you believe have impacted your health:

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

**Allergies** (Please list any drugs, foods, or substances and your reaction):

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

Do you routinely take?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Hormones	Y	N	Thyroid medication	Y	N
Tranquilizers	Y	N	Sleeping pills	Y	N	Antidepressants	Y	N

Please list (or submit a copy of your list) of all prescription medications, over the counter medications, vitamins or other supplements you are currently taking: \_\_\_\_\_

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

**Exposure** Are you aware or do you suspect that you have been exposed to toxic substances in your home or work environment?

Please describe \_\_\_\_\_

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

**Childhood illnesses:**

Rheumatic fever	Y	N	Measles- 2 week	Y	N	German measles-3 day	Y	N
Chicken pox	Y	N	Eczema	Y	N	Asthma	Y	N
Ear infections?	Y	N	Do you have your tonsils?	Y	N	Other _____		

**Immunizations:**

Diphtheria	Y	N	Tetanus (within past 10 yrs)	Y	N	Measles/Mumps/Rubella	Y	N
Pertussis	Y	N	Last PPD _____			Other _____		

**FAMILY HISTORY:**

Check those applicable	Father	Mother	Brother	Sister	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health: G=good P=poor	_____	_____	_____	_____	_____	_____
Cancer (type?)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart attack or heart failure	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____	_____
Asthma, hay fever, hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Rheumatoid arthritis	_____	_____	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____	_____	_____
Age deceased	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

**Hospitalizations and Surgeries (list reason &/or type of surgery and date):**

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Last blood work (type & date) \_\_\_\_\_

Last Pap smear & result \_\_\_\_\_ Last mammogram \_\_\_\_\_

Last bone densitometry \_\_\_\_\_ Last testicular/prostate exam \_\_\_\_\_

Last physical \_\_\_\_\_ Last EKG \_\_\_\_\_

Last chest x-ray \_\_\_\_\_ Last spinal x-ray \_\_\_\_\_

Please circle: **Y**= a condition/circumstance you have now. **N**= never had condition **P**= Past condition/circumstance

**General:**

Weight \_\_\_\_\_

Weight 1 yr ago \_\_\_\_\_

Satisfied with weight? \_\_\_\_\_

Height \_\_\_\_\_

Fatigue \_\_\_\_\_

Night sweats \_\_\_\_\_

Y N P

Y N

Y N P

Y N P

Y N P

Rashes

Eczema, hives

Acne, boils

Itching

Color change

Lumps

Herpes

**Head:**

Tension headaches

Y N P

Y N P

Y N P

Y N P

Y N P

Y N P

Y N P

Y N P

**Skin:**

Migraines Y N P  
 Hair loss Y N P  
 Head injury Y N P

**Eyes:**

Change in vision Y N P  
 Double vision Y N P  
 Glaucoma Y N P  
 Cataracts Y N P  
 Eye pain Y N P  
 Tearing or dryness Y N P  
 Glasses or contacts Y N P

**Ears:**

Hard of hearing Y N P  
 Ringing Y N P  
 Dizziness Y N P  
 Earache Y N P

**Nose/sinuses:**

Frequent colds Y N P  
 Stuffiness Y N P  
 Sinus infections Y N P  
 Hay fever Y N P  
 Frequent nose bleeds Y N P

**Mouth & throat:**

Frequent sore throat Y N P  
 Sore/swollen tongue Y N P  
 Difficulty swallowing Y N P  
 Hoarseness Y N P  
 Frequently clear throat Y N P  
 Bleeding/receding gums Y N P  
 Dental cavities Y N P  
 Toothache/sensitivities Y N P

**Neck:**

Lumps Y N P  
 Swollen glands Y N P  
 Goiter Y N P  
 Pain or stiffness Y N P

**Respiratory:**

Asthma Y N P  
 Emphysema Y N P  
 Frequent cough Y N P  
 Productive cough Y N P  
 Bronchitis Y N P  
 Shortness of breathe Y N P  
 Wheezing at night Y N P  
 Wheezing lying down Y N P  
 Wheezing on exertion Y N P  
 Pain on breathing Y N P  
 Pneumonia Y N P  
 Pleurisy Y N P  
 Tuberculosis Y N P

**Cardiovascular:**

Heart failure Y N P  
 Heart attack Y N P

Chest pain/angina Y N P  
 High blood pressure Y N P  
 High cholesterol Y N P  
 Fluttering in chest Y N P  
 Heart murmur Y N P  
 Rheumatic fever Y N P  
 Swelling in ankles Y N P

**Gastrointestinal:**

Frequent indigestion Y N P  
 Vomiting Y N P  
 Vomiting blood Y N P  
 Blood in stool Y N P  
 Abdominal pain Y N P  
 Gallbladder pain Y N P  
 Liver disease/hepatitis Y N P  
 Frequent belching/gas Y N P  
 Heartburn Y N P  
 Ulcers Y N P  
 Hemorrhoids Y N P  
 Constipation Y N P  
 Diarrhea Y N P  
 Bowel movements How often? \_\_\_\_\_  
 Is this a change? \_\_\_\_\_

**Urinary:**

Pain on urination Y N P  
 Increased frequency Y N P  
 Frequency at night Y N P  
 Dribble urine Y N P  
 Frequent infections Y N P  
 Kidney stones Y N P

**Breasts:**

Do you do self-exam? Y N P  
 Lumps Y N P  
 Pain or tenderness Y N P  
 Nipple discharge Y N P

**Female reproductive:**

Ave. # of days of cycle \_\_\_\_\_ Length of cycles \_\_\_\_\_  
 Regular cycles Y N P  
 Skipped cycle(s) Y N P  
 Breakthrough bleeding Y N P  
 Menopausal symptoms Y N P  
 Sexually active Y N P  
 Pain with intercourse Y N P  
 Birth control? What type \_\_\_\_\_ Y N P  
 # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_  
 # of miscarriages \_\_\_\_\_ # of abortions \_\_\_\_\_  
 Difficulty conceiving Y N P  
 Sexually transmitted disease Y N P  
 Sexual difficulties Y N P  
 Freq. vaginal infections Y N P  
 Sexual preference:  
 Heterosexual \_\_\_\_\_ Y N P  
 Bisexual \_\_\_\_\_ Y N P  
 Homosexual \_\_\_\_\_ Y N P

**Male reproductive:**

Hernias	Y	N	P
Testicular lump	Y	N	P
Testicular pain	Y	N	P
Prostate disease	Y	N	P
Sexually active	Y	N	P
Birth control? What type_____	Y	N	P
Sexually difficulties	Y	N	P
Difficulty conceiving	Y	N	P
Sexually transmitted disease	Y	N	P
Sexual preference:			
Heterosexual _____	Y	N	P
Bisexual _____	Y	N	P
Homosexual _____	Y	N	P

**Musculoskeletal:**

Joint pain/stiffness	Y	N	P
Arthritis	Y	N	P
Broken bones	Y	N	P
Osteoporosis	Y	N	P
Muscle spasms/cramps	Y	N	P
Muscle weakness	Y	N	P
Loss of coordination	Y	N	P

**Peripheral vascular:**

Blood clots	Y	N	P
Anemia	Y	N	P
Easy bleeding/bruising	Y	N	P
Varicose veins	Y	N	P
Cold hands/feet	Y	N	P
Raynauds disease	Y	N	P

**Neurologic:**

Head injury	Y	N	P
Stroke	Y	N	P
Seizures	Y	N	P
Fainting	Y	N	P
Paralysis	Y	N	P
Numbness or tingling	Y	N	P
Memory loss	Y	N	P
Loss taste or smell	Y	N	P
Loss of balance	Y	N	P

**Endocrine:**

Hyperthyroid	Y	N	P
Hypothyroid	Y	N	P
Heat/cold intolerance	Y	N	P
Diabetes	Y	N	P
Excessive thirst	Y	N	P
Excessive hunger	Y	N	P
Excessive urination	Y	N	P
Excessive fatigue	Y	N	P

**Emotional:**

Depression/sadness	Y	N	P
Mood swings	Y	N	P
Feel out of control	Y	N	P
Feel stressed out	Y	N	P
Feel nervous	Y	N	P
Indecisive	Y	N	P
Feel isolated	Y	N	P

Uncontrolled anger	Y	N	P
Feel afraid	Y	N	P
Loss of self-esteem	Y	N	P
Feel victimized	Y	N	P
Anorexia/bulimia	Y	N	P
Do you sleep well	Y	N	P
Awaken rested	Y	N	P
Average 6-8 hrs sleep	Y	N	P
Work unusual hours	Y	N	P
Enjoy your work	Y	N	P
Take vacations	Y	N	P
Spend time outdoors	Y	N	P
Exercise routinely	Y	N	P
What forms? _____			
How often _____			
Use tobacco, how much _____	Y	N	P
Drink alcohol, how much _____	Y	N	P
Treated for alcoholism	Y	N	P
Use recreational drugs	Y	N	P
Treated for drug abuse	Y	N	P

**Diet:**

Do you eat three meals daily?            Y   N

Blood Type?    **A**    **B**    **AB**    **O**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Reactions to specific foods that you are aware of:

\_\_\_\_\_

\_\_\_\_\_

Type of Drinks in a day? \_\_\_\_\_

How many glasses of water do you drink daily? \_\_\_\_

Do you drink caffeinated products?    Y   N

If so, what kind? \_\_\_\_\_

How many in a day? \_\_\_\_\_

Hobbies: \_\_\_\_\_

Spiritual Practices: \_\_\_\_\_



If you could set 3 goals for your physical, mental and emotional health and there were no limitations, what would be the most important?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



