

Date: _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential.

Main problem you would like help with: _____

When did the problem begin (be specific): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____

Have you been given a diagnosis for the problem? If so, what? _____

What kind of treatments have you tried? _____

Other concurrent therapies: _____

Past Medical History – please note dates:

Cancer: _____ HIV/AIDS: _____ Thyroid Disease: _____

Diabetes: _____ High Blood Pressure: _____ Rheumatic Fever: _____

Hepatitis: _____ Heart Disease: _____ Venereal Disease: _____

Surgeries (types & dates): _____

Significant Traumas: _____

Other: _____

Allergies (drugs, chemicals, foods, etc.) _____

Family Medical History

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

Medications

What medications and/or supplements are you currently taking? _____

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

- Recurrent Infections
- Night Sweats
- Sweat easily
- Bleed or bruise easily
- Strong thirst (prefer hot or cold?)
- Thirst with no desire to drink
- Fatigue
- Sudden energy drops
Time of day _____
- Poor Sleep
- Tremors
- Poor Balance
- Edema
- Underweight
- Overweight

Skin

- Rashes
- Itching
- Eczema

Cardiovascular

- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Chest discomfort/pain
- Heart Palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood Clots
- Spider veins
- Fainting
- Other _____

Respiratory

- Difficulty breathing
- Pain with breathing
- Shallow breathing
- Shortness of breath
- Production of phlegm
color _____
- Recurrent cough
- Bronchitis
- Pneumonia
- Asthma/Wheezing
- Status asthmaticus
- Other _____

- Oozing
- Pimples
- Dry skin / scalp
- Recent moles
- Changes in hair/skin
- Other _____

Head/Eyes/Ears/Nose/Throat

- Headaches
Where _____
When _____
- Migraines
- Dizziness
- Discharge from ear
- Poor hearing
- Ringing in ears
- Blurry vision
- Night blindness
- Color blindness
- Spots in front of eyes

Genito-urinary

- Pain on urination
- Urgency with urination
- Frequent urination
- Blood in urine
- Decrease in urinary flow
- Unable to hold urine
- Incontinence at night
- Dribbling urination
- Kidney stones
- Prostate problems
- Impotency
- Changes in sexual drive
- Rashes
- Do you wake at night to urinate?
How many times? _____
- Other _____

Gynecological

- # of pregnancies _____
- # births _____
- # premature births _____
- # abortions _____
- Age of 1st menses _____
- # days between menses _____
- Duration of menses _____
- 1st day of last menses _____
- Age of menopause _____
- Date of last PAP _____

- Eye Pain
- Excessive Tearing
- Squint
- Glasses
- Sore eyes
- Facial Pain
- Nose bleeds
- Nasal discharge
- Blocked nose
- Snoring
- Grinding teeth
- Teeth problems
- Recurrent sore throat
- Hoarseness
- Tonsillitis
- Swollen glands
- Sores on lips/mouth
- Other _____

Musculoskeletal

- Neck ache/pain
- Back ache/pain
- Knee ache/pain
- Shoulder pain
- Elbow/Forearm pain
- Hand/Wrist pain
- Foot/Ankle pain
- Joint/Bone problems
- Torn tissues
- Prostheses
- Muscle pain/weakness
- Hernia
- Other _____

Neurological

- Seizures
- Nerve damage
- Paralysis
- Stroke
- Sleep disorder
- Concussion
- Vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty in concentrating

Digestion

- Bad breath
- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Belching
- Abdominal pain or cramps
- Weight gain
- Weight loss
- Loose stools / Diarrhea
- Strong smelling stools
- Bloody stools
- Pale stools
- Green stools
- Black stools
- Constipation
(not daily, or difficult)
- Pain with passing stools
- Gas
- Rectal pain
- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Other _____

- PMS
- Irregular periods
- Painful periods
- Light periods
- Heavy periods
- Clots
- Fibroids
- Endometriosis
- Infertility
- Vaginal discharge
- Vaginal sores
- Postcoital bleeding
- Breast lumps
- Nipple discharge
- Other _____

Do you practice birth control?
 yes no
 what type and for how long?

Are you pregnant now?
 yes no

Behavioral

- Vacant
- Moody
- Easily susceptible to stress
- Aggressive/Bad temper
- Lose control of emotions
- Anxiety
- Panic Attacks
- Depression
- Fear
- Substance abuse
- Other _____

Have you ever been treated for emotional problems?
 yes no

Have you ever considered or attempted suicide?
 yes no

Please note the severity of your problem right now:

No Problem Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No Problem Worst Imaginable

SNOHOMISH NATURAL HEALTH REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Email address:				Are you interested in receiving clinic newsletters/special offers via email?			

INSURANCE INFORMATION							
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: ()	
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Welfare (Please provide coupon)		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Kellie Lawler or insurance company to release any information required to process my claims.</p>				
<hr/> <i>Patient/Guardian signature</i>			<hr/> <i>Date</i>	

NATUROPATHIC MEDICINE and ACUPUNCTURE INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Kellie Lawler N.D., L.Ac. to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.

Minor office procedures: e.g., dressing a wound, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Psychological Counseling

CONTRACEPTION

Immunization

Acupuncture: The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body

Cupping: Glass cups are placed on the skin with a vacuum created by heat or suction device

Electroacupuncture: Using very small amounts of electricity to stimulate specific acupuncture points

Physical medicine: Including facilitated stretching, light massage, Tui na style massage, application of infrared heat over a specific area in the body, application of hot and cold hydrotherapeutics

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

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., drugless relief of presenting symptoms and improved balance of body physiology.

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.

Notice to individuals with Pacemakers or Bleeding disorders: Please inform practitioner if you have a bleeding disorder or a pacemaker prior to treatment

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantee has been given to me by Dr. Kellie Lawler regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

Date

Signature of Patient

Original to: Chart

Copy to: Patient (if requested)

Signature of Patient Representative or

Guardian

Dr. Kellie Lawler, ND, L. Ac. received both her Medical degree and Master's Degree in Acupuncture from Bastyr University in 2004. She has passed the national board exam for Naturopathic physicians and is licensed to practice medicine in Washington State under license NT1381. She passed the National Board Exam for Acupuncture and is a designated Diplomat of Acupuncture by the NCCAOM. She is a Licensed Acupuncturist in the State of Washington holding Acupuncture License number AC2631