Dr. Kellie Lawler, ND, L.Ac.
Snohomish Natural Health
302 Maple Ave.
Snohomish, WA 98290

360-568-3319 – office
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New Patient Intake Form

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 responses to the following questions will go a long way on assisting my understanding of your health needs. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in assisting you.
This form is completely confidential and cannot be given to anyone outside this office without your written permission.
Please answer all questions completely, and fax or mail it to our clinic prior to your first visit.

Patient Information

Date of Appointment: ______________ (mm/dd/yyyy) Name: ______________ (Last / First / Middle)

Address: ______________ (Street/P.O. Box / Apartment Number)

______________ (City / State / ZIP)

( ) Home phone ( ) Work Phone ( ) Other Phone ( ) Fax

______________ Email

Check All That Apply:

- ☐ Male ☐ Female
- ☐ Single ☐ Married ☐ Separated
- ☐ Divorced ☐ Widowed ☐ Living with a partner
- ☐ Children

Date of Birth: ______________ (mm/dd/yyyy) Age: ______

SSN: ______________

Occupation: ______________ For How Long: ______________

Employer: ______________ ☐ Full Time ☐ Part Time Avg. work week in hours ______

Insurance Company: 1: ______ 2: ______ Subscriber ID #: 1: ______ 2: ______

Name of person on insurance card: ______________ Relationship Date of birth ______________

Person responsible for bill, if not patient: ______________ Phone: ( ) ______________

Address: ______________ (Street/P.O. Box / Apartment Number / City / State / ZIP)

Who may we thank for referring you to our clinic?

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. I also understand that all charges are to be paid at the time of the visit unless other arrangements have been made prior to my scheduled appointment. Payment for all dispensary items is due at the time of the visit. I authorize Dr. Kellie Lawler to release any information required to process my claims.

Signature: Date:

Emergency Contact

Name: ______________ Relationship: ______________

Address: ______________ (Street/P.O. Box / Apartment Number / City / State / ZIP)

( ) Home phone ( ) Work Phone ( ) Other Phone

Primary Health Concerns

In your opinion, what are your most important health issues?

1. ______________ 2. ______________

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3. ______ 4. ______

What health concerns do you want to talk about today? (List in order of importance.)

1. ______ 2. ______
3. ______ 4. ______

How did the above conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or aggravated your health problems? If you prefer, feel free to list these in chronological order on a separate page.

Personal Habits & Lifestyle

Please check all that apply

How many cups, bottles, or glasses do you drink on the average per day?

- ☐ Beer ______
- ☐ Coffee ______
- ☐ Fruit juice ______
- ☐ Herbal tea ______
- ☐ Alcohol ______
- ☐ Milk ______
- ☐ Soft drinks (diet) ______
- ☐ Soft drinks (regular) ______
- ☐ Tea (Black/Green) ______
- ☐ Vegetable juice ______

What is your source of your drinking water? What temp. do you drink it?

- ☐ Bottled (spring)
- ☐ Distilled
- ☐ Filtered
- ☐ Tap
- ☐ Well
- ☐ Hot
- ☐ Cold
- ☐ Room temp.

What is your current weight information?

Present weight: ______
Normal Weight: ______
Weight 1 year ago: ______
Minimum weight: ______ When? ______
Maximum weight: ______ When? ______

What is your energy level?

- ☐ I feel worn out
- ☐ I feel drowsy
- ☐ I have low output
- ☐ I feel slowed down in my thinking
- ☐ I feel energetic
- ☐ I can do lots in a day
- ☐ I feel in good shape
- ☐ I feel rested upon waking
- ☐ I can concentrate well.

Are you on a specific diet? For how long?

- ☐ Non vegetarian ______
- ☐ Vegetarian ______
- ☐ Vegan ______
- ☐ Low carb ______
- ☐ Low fat ______
- ☐ Other: ______

How many times do you eat at restaurants per week?

Do you watch television? ☐ Yes ☐ No
Do you take vacations? ☐ Yes ☐ No
Do you spend time outside? ☐ Yes ☐ No
How many hours of sleep do you get on the average? ______
Do you feel refreshed in the morning? ☐ Yes ☐ No
Do you often feel overworked? ☐ Yes ☐ No

What do you do for exercise? Indicate frequency, intensity and duration.

- ☐ Aerobics ______
- ☐ Bicycling ______
- ☐ Breathing exercises ______
- ☐ Gardening ______
- ☐ Jogging ______
- ☐ Swimming ______
- ☐ Walking ______
- ☐ Weightlifting ______
- ☐ Yoga ______
- ☐ Other: ______

What do you do to relieve stress?

How would you describe your present level of personal stress?

- ☐ Minimal
- ☐ Average
- ☐ Considerable
- ☐ Unbearable

What is the main stressor?

- ☐ Expectations
- ☐ Family Members
- ☐ Financial
- ☐ Health
- ☐ Other: ______
- ☐ Interpersonal
- ☐ Job related
- ☐ Marriage
- ☐ Spiritual

Have you ever used recreational drugs? ☐ Yes ☐ No
If so, how much and how often? ______
Years since quitting: ______

Have you ever used tobacco? In what form? ☐ Yes ☐ No
If so, how much and how often?
Years since quitting: ______

Prescribed Medications, Over-the-Counter Medications & Supplements

Please list all prescribed medications, over-the-counter medications and supplements you are currently taking.

	Prescriptions:	OTC Medications:	Vitamins:	Minerals:	Homeopathics:	Herbs:
1.						
2.						
3.						
4.						
5.						
6.						

Are you allergic to any medications? If yes, please list: 1.

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2. ______
3. ______

List any chronic problems you have that may have resulted from a prior medication. Please list the medication, the dosage and what problem developed:
1. ______
2. ______

Previous Medical History

Please check all that apply

Surgeries:

- ☐ Abdomen
- ☐ Adenoids
- ☐ Appendix
- ☐ Cataract
- ☐ Gall Stones
- ☐ Heart
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Joint Replacement
- ☐ Kidney Stone
- ☐ Prostate
- ☐ Stomach
- ☐ Tonsils
- ☐ Uterus

Other: ______

Please Explain ______

Accidents:

Any major accidents or injuries to the body or head?

______

Any occasions of unconsciousness?

______

Trauma:

- ☐ Grief
- ☐ Major disappointments
- ☐ Nervous breakdown
- ☐ Serious shock
- ☐ Severe fright
- ☐ Stress overload

Other: ______

Family History

Has any Blood Relative had any of the following?

	Father	Mother	Brothers	Sisters
In Good Health	☐	☐	☐	☐
Age of Death				
Allergies	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Gall Stones	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mononucleosis	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐
Seizure/Epilepsy	☐	☐	☐	☐
Sickle cell anemia	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid (Hyper/Hypo)	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐

Allergies & Allergy Testing

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Do you have allergies or sensitivities to foods, drugs or other allergens in your environment? Please check all that apply

☐ Cat	☐ Dust	☐ Grass	☐ Mold
☐ Citrus	☐ Egg	☐ Insects	☐ Peanuts/Nuts
☐ Corn	☐ Fungus	☐ Latex	☐ Pollen
☐ Dog	☐ Grains	☐ Milk	☐ Wheat

Other: ______

What prior types of allergy or food intolerance testing have you had?

☐ Blood IgE inhalant/food	☐ Electroacupuncture (VEGA, MORA)	☐ Scratch
☐ Blood IgG food	☐ Intradermal	☐ None
☐ Elimination Diet	☐ Kinesiology	☐ Other:

X-Ray & Special Studies

What diagnostic Imaging studies have you had and when?

- ☐ Bone Density Scan Date: ______
- ☐ CT Scan Date: ______
- ☐ Electrocardiogram Date: ______
- ☐ Electroencephalogram Date: ______
- ☐ Mammogram Date: ______
- ☐ MRI Date: ______
- ☐ Ultrasound Date: ______
- ☐ X-Ray Date: ______
- ☐ Other: ______

Chemical Exposure & Reactivity

If you have ever worked in any of the following occupations or have any of these as hobbies, please note how long you have been involved with them.

______ Agriculture	______ Chemical	______ Foundry	______ Pottery
______ Art	______ Construction	______ Hairdressing	______ Printing
______ Auto Manufacturing	______ Dentistry	______ Mortician	______ Ship Repair
______ Auto Repair	______ Dry Cleaning	______ Painting	______ Silk-screening
______ Asbestos	______ Electronics	______ Gardening	
______ Auto Body	______ Farming	______ Photography	

Others: ______

Have you ever lived in a mobile home? ☐ Yes ☐ No If so, when? ______ For how long? ______

Have you ever had to change your residence or job due to health reasons? ☐ Yes ☐ No If yes, please explain: ______

Have you ever used pesticides? ☐ Yes ☐ No Do you use them now? ☐ Yes ☐ No

Have you ever lived in an area that was regularly sprayed with pesticides or herbicides? ☐ Yes ☐ No

If so, when? ______ For how long? ______

Are you exposed to chemicals at work or at home? ☐ Yes ☐ No If so, please list: ______

Please list any chemicals or other items that cause you any type of reaction when you smell or handle them ______

How many silver fillings do you have? ______ When where they put in? ______

Do you have implants of silicone, Teflon, etc? ☐ Yes ☐ No When where they put in? ______

Diet

Please list the foods that you normally eat for each meal. After each food, note how often you eat it.
Please mark "1xd" for once a day; "1xw" for once weekly, etc. Do the same for all beverages consumed.

Breakfast	Cold cereal (What type?)	Other

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	Hot cereal (What type?)	______	Other	______
	Eggs	______	Beverage	______
	Breads	______	Nuts/ Seeds	______
Snack	______			
Lunch	Sandwich (What type?)	______	Other	______
	Salad (What type?)	______	Beverage	______
	Soup (What type?)	______	Nuts/Seeds	______
Snack	______			
Dinner	Beans	______	Poultry	______
	Beef	______	Salad (What type?)	______
	Cheese	______	Salad Dressing	______
	Eggs	______	Rice	______
	Fish	______	Other grains	______
	Vegetables	______	Beverage	______
	Potato	______	Other	______
Snack/ Dessert				

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Review of Systems

Please mark (0) = No longer a Problem, (1) = Mild, (2) = Moderate, or (3) = Severe next to the following symptoms which apply to you now and in the past.

Hematopoietic, Lymph, Immune

Now	Past		Now	Past	
______	______	Anemia	______	______	Frequent illness
______	______	Bleeding from unusual places	______	______	Lymph node removal
______	______	Bruising easily	______	______	Painful lymph nodes
______	______	Difficulty stopping bleeding	______	______	Wounds heal slowly
______	______	Fluid retention			

____________ Date of last blood test

Cardiovascular

Now	Past		Now	Past	
______	______	Abdominal swellings	______	______	High blood pressure
______	______	Angina	______	______	Leg pain when walking
______	______	Ankle swelling	______	______	Leg vein problems
______	______	Bruise easily	______	______	Must prop self up at night
______	______	Chest pain when sitting/lying	______	______	Numbness in arms or legs
______	______	Chest pain when walking	______	______	Ringing in ears
______	______	Cold hands or feet	______	______	Shortness of breath
______	______	Frequent nose bleeds	______	______	Sigh frequently
______	______	Heart murmur	______	______	Tingling in arms or legs
______	______	Heart palpitations	______	______	Want open windows in a closed room

Have you had rheumatic fever or syphilis? ☐ Yes ☐ No

Date of last exercise stress test: ____________ Results: ____________

Date of last echocardiogram: ____________ Results: ____________

How far can you walk? ____________

How many stairs can you climb before having to stop? ____________

What makes you stop? ____________

Ears

Now	Past		Now	Past	
______	______	Discharge from ears	______	______	Ringing in ears
______	______	Hearing problems	______	______	Sensitivity to noise
______	______	Ear infections	______	______	Vertigo
______	______	Pain in ears			Itchy ears

____________ Date of last hearing check

Head & Neck

Now	Past		Now	Past	
______	______	Dizziness	______	______	Mild headaches
______	______	Fainting spells	______	______	Neck pain or stiffness
______	______	Goiter	______	______	Severe headaches
______	______	Head injury	______	______	Seizures, convulsions
______	______	Lumps on neck	______	______	Swollen glands
______	______	Migraine			

Eyes

Now	Past		Now	Past	
______	______	Cataracts	______	______	Glaucoma
______	______	Double vision	______	______	Impaired vision
______	______	Eye pain	______	______	Macular Degeneration
______	______	Far sighted	______	______	Near sighted
______	______	☐ Glasses ☐ Contacts ☐ LASIK	______	______	☐ Tearing ☐ Drying

____________ Date of last eye exam ____________ Date of last glaucoma check

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Nose & Sinuses

Now	Past		Now	Past	
		Dry nose			Nose bleeds
		Frequent colds			Postnasal drip
		Hay fever			Sinus problems
		Loss of smell			Stuffiness

Mouth & Throat

Now	Past		Now	Past	
		Bleeding gums			Loss of voice
		Chronic throat pain			Mercury amalgam fillings
		Cold sores or blisters			Persistent hoarseness
		☐ ↑ saliva ☐ ↓ saliva			Recurrent strep throat
		Difficulty swallowing			Sore lips
		Frequent sore throat			Sore mouth
		Jaw clicks			Sore tongue
		Loss of teeth			Speech difficulties
		Date of last dental visit			Teeth grinding

Respiratory

Now	Past		Now	Past	
		Asthma			Pneumonia
		Bronchitis			Productive cough
		Chest congestion			Shortness of breath at night
		Chest pain when breathing			Shortness of breath lying down
		Daily cough			Shortness of breath with exercise
		Dry sweats			Spitting up blood
		Emphysema			Tuberculosis
		Night sweats			Unexplained fever
		Pleurisy			Wheezing

Have you ever been exposed to T.B. (tuberculosis)? ☐ Yes ☐ No

When was your last T.B. test? ______ Results: ______

When was your last chest X-ray? ______ Results: ______

Have you even been tested for lung function/capacity? ☐ Yes ☐ No Results: ______

How many pillows do you sleep on? ______

Skin

Now	Past	
		☐ Bumpy ☐ Dry ☐ Itchy ☐ Rough ☐ Scaly
		☐ Cysts ☐ Skin Tags ☐ Rashes ☐ Warts ☐ Night sweats
		☐ Moles
		☐ Light patches ☐ Dark patches Have any changed in size or color lately? ______
		Pimples List location(s): ______
		Nails ☐ Color changes ☐ Pits ☐ Ridges ☐ White spots
		Hair Loss List location(s): ______
		Hives What causes them? ______
		Scars List location(s) ______

Urinary

Now	Past		Now	Past	
		Blood in urine			Kidney stones
		Difficult starting urine			Night urination
		Difficulty holding urine, dribbling			Painful urination
		Foul smelling urine			Sudden urges
		Frequent urination			Urinary tract infection
		Dates of cystoscopy, IVP, KUB, X-rays	Results:		

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Gastrointestinal

Now	Past	I.	Now	Past	
____	____	Feeling that bowels do not empty completely	____	____	Hard, dry or small stool
____	____	Lower abdominal pain, better passing gas or stool	____	____	Coated tongue or "fuzzy" debris on tongue
____	____	Diarrhea	____	____	Pass large amounts of foul smelling gas
____	____	Constipation	____	____	More than 3 bowel movements daily
____	____	Alternating constipation with diarrhea	____	____	Use of laxatives
		II.			
____	____	Excessive belching, burping, bloating	____	____	Difficult bowel movements
____	____	Gas or indigestion immediately following a meal	____	____	Sense of fullness during and after meals
____	____	Offensive breath	____	____	Difficulty digesting fruits and vegetables; undigested food found in stool
		III.			
____	____	Stomach pain, burning or aching 1-4 hours after eating	____	____	Frequent use of antacids
____	____	Digestive problems subside with rest	____	____	Temporary relief from antacids, food, milk, carbonated beverages
____	____	Heartburn when lying down or bending forward	____	____	Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, caffeine
____	____	Feeling hungry an hour or two after eating	____	____	
		IV.			
____	____	Roughage and fiber causes constipation	____	____	Nausea and or vomiting
____	____	Indigestion and fullness lasts 2-4 hours after eating	____	____	Excessive passage of gas
____	____	Pain, tenderness, soreness on left side of rib cage	____	____	Frequent urination
____	____	Stool undigested, foul-smelling, mucous-like, greasy or poorly formed	____	____	Increased thirst and appetite
____	____	Difficulty losing weight	____	____	
		V.			
____	____	Stool color alternates from clay colored To normal brown	____	____	Distress from fatty or greasy foods
____	____	Lower bowel gas or bloating several hours after eating	____	____	Jaundice or yellowish cast to eyes
____	____	Bitter metallic taste in mouth, Especially in the morning			Reddened skin, especially palms
____	____	Unexplained itchy skin			Dry or flaky skin and or hair
		History of gallbladder attacks or stones			Gallbladder removal

__________ Date of last Hemoccult Results: __________

__________ Date of last sigmoidoscopy Results: __________

__________ # of bowel movements/day

Stools ☐ Yellow ☐ Grey ☐ Green ☐ Foul ☐ Black
☐ Straining ☐ No urge

Now	Past	VIII.	Now	Past	IX.
____	____	Cannot stay asleep	____	____	Cannot fall asleep
____	____	Bronzing of the skin	____	____	Hot flashes
____	____	Chronically fatigued	____	____	Increased blood pressure
____	____	Crave salt	____	____	Excessive perspiration
____	____	Dizziness when standing up quickly	____	____	Increased perspiration with little activity
____	____	Slow starter in the morning	____	____	Weight gain when under stress
____	____	Easily stressed	____	____	Rheumatism
____	____	Facial hair (women)	____	____	Tired upon rising
____	____	Feel worse or headache with exercise or stress			Poor circulation
____	____	Afternoon fatigue or headaches			Wakes tired even after much sleep
		Nails weak and with ridges			Experiencing high amounts of stress

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Now	Past	X.	Now	Past	XI.
____	____	Sensitive to cold / hands, feet, whole body	____	____	Heart palpitations
____	____	Constipation/difficult or Infrequent BM's	____	____	Increased pulse even at rest
____	____	Decreased appetite	____	____	Insomnia
____	____	Difficulty losing weight/weight gain easily	____	____	Irritable/Restless/Inward trembling
____	____	Dry or scaly skin or scalp	____	____	Flush or get hot easily
____	____	Easily fatigued/ mental sluggishness	____	____	Nervousness and Emotional
____	____	Feel better after exercise	____	____	Nightsweats
____	____	Depression/lack of motivation	____	____	Underweight or Increased appetite
____	____	Requires extra sleep to function properly	____	____	
____	____	Morning headaches wear off as day goes on	____	____	
____	____	Falling out or thinning hair on eyebrows, head, genital area	____	____	
____		Date of last thyroid test			

Now	Past	XII.	Now	Past	XIII.
____	____	Abnormal thirst	____	____	Increased sexual desire
____	____	Chunky hips or waist	____	____	Splitting headaches
____	____	Decreased sexual desire	____	____	Low sugar tolerance
____	____	Failing memory	____	____	Low blood pressure
____	____	Increased ability to eat sugar without symptoms	____	____	
____	____	Menstrual disorders or lack of menstruation	____	____	

Now	Past	VI.	Now	Past	VII.
____	____	Craves sweets during the day	____	____	Fatigue after meals
____	____	Irritable or light-headed if meals are missed	____	____	Craves sweets during the day
____	____	Depend on coffee to get started or keep going	____	____	Eating sweets does not relieve craving For sweets
____	____	Eating relieves fatigue	____	____	Increased appetite or thirst
____	____	Easily upset, agitated or nervous	____	____	Must have sweets after meals
____	____	Poor memory, forgetful	____	____	Difficulty losing weight
____	____	Blurred vision	____	____	Frequent urination
		Fell shaky, jittery, tremors			Waist girth is equal to or larger than hips

Male Reproductive

Now	Past	I.	Now	Past	
____	____	Decrease in sexual arousal	____	____	Infertility
____	____	Decrease in spontaneous morning erection	____	____	Spells of mental fatigue
____	____	Decrease in fullness of erection	____	____	Inability to concentrate
____	____	Difficulty maintaining erection	____	____	Episodes of depression
____	____	Difficulty with premature ejaculation	____	____	More emotional than in the past
____	____	Painful erection or sex	____	____	Hernias
____	____	Discharge or sores on penis	____	____	Herpes
____	____	Burning urination	____	____	Swelling, lumps, pain in testicles
____	____	.Frequent night urination	____	____	.Prostate problems
____	____	.Feeling of incomplete bowel movement	____	____	.Pain inside of legs or heels
____	____	.Urinary difficulty or dribbling	____	____	.Restless legs at night
____	____	Increase in fat distribution around chest and hips	____	____	Muscle soreness
____	____	Decrease in physical stamina	____	____	Unexplained weight gain
		Sweating attacks			

Are you currently sexually active ☐ Yes ☐ No Current form of contraception ____________

Sexual preference ☐ Heterosexual ☐ Bisexual ☐ Homosexual

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Female Reproductive

Now	Past		Now	Past	
		(Menstruating women)			
		Infertility			
____	____	Difficulty feeling sexual arousal	____	____	Menses scanty flow
____	____	Painful sex	____	____	Menses excessive flow
____	____	Vaginal itching/burning	____	____	Menses regular
____	____	Discharge from vagina	____	____	Cycle greater than 32 days
____	____	Herpes	____	____	Cycle less than 24 days
____	____	Genital eruptions	____	____	Alternating menses cycle length
____	____	Venereal disease	____	____	Bleed/spotting between periods
____	____	Nipple discharge	____	____	Pain and cramping during menses
____	____	Lumps in breast	____	____	Breast pain and swelling during menses
____	____	Menses absent	____	____	Water retention during menses
____	____		____	____	
____	____	**(Menopausal women)**	____	____	
____	____	How many years have you been menopausal?	____	____	Mental fogginess
____	____	Have you had uterine bleeding since menopause?	____	____	Disinterest in sex
____	____	Hot flashes	____	____	Mood swings
____	____	Painful intercourse	____	____	Depression
____	____	Increased vaginal pain, dryness or itching	____	____	Facial hair growth
____	____	Decreasing breast size	____	____	Acne

________________ Date of last mammogram

Have you ever used birth control pills? ☐ Yes ☐ No If so, for how long? ________________

Side effect? ________________

Have you ever used an IUD? ☐ Yes ☐ No If so, for how long? ________________

Side effect? ________________ What kind of IUD? ________________

Are you currently sexually active ☐ Yes ☐ No Current form of contraception ________________

Did you have a normal puberty? ☐ Yes ☐ No Age of first menstruation ________________

Are your periods regulars ☐ Yes ☐ No Periods occur every ________ Days

Date of last period: ________________ Do you do breast self-exams? ☐ Yes ☐ No

Date of last PAP smear: ________________ Was it normal? ☐ Yes ☐ No

Have you had in the past or currently have problems with infertility? ☐ Yes ☐ No ________________

# of pregnancies ________ # of births ________ # of miscarriages ________ # of abortions ________

Any complications ofpregnancy? ☐ Yes ☐ No If yes, please explain: ________________

Sexual preference ☐ Heterosexual ☐ Bisexual ☐ Homosexual

Musculoskeletal

Now	Past		Now	Past	
____	____	Arthritis	____	____	Joint swelling
____	____	Backaches	____	____	Muscle spasms or cramps
____	____	Broken bones	____	____	One arm or leg shorter
____	____	Burning on soles of feet	____	____	Unusual redness of palms
____	____	Joint pain	____	____	Weakness
____	____	Joint stiffness			

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Central and Peripheral Nervous System

Now	Past		Now	Past	
______	______	Blurred/doubled vision	______	______	Loss of memory
______	______	Continual headache	______	______	Numbness
______	______	Convulsions (seizures)	______	______	Paralysis
______	______	Dizziness regularly	______	______	Temporary loss of sensation
______	______	Fainting	______	______	Tingling
______	______	Lack of strength	______	______	Tremor (shaking, trembling)
______	______	Loss of balance			

Mental Status

Now	Past		Now	Past	
______	______	Afraid when left alone	______	______	Loneliness
______	______	Anxiety	______	______	Making many mistakes
______	______	Assertive	______	______	Mental confusion
______	______	Confident	______	______	Mood swings
______	______	Critical of others	______	______	Neatness & cleanliness
______	______	Decreased comprehension	______	______	Organized
______	______	Decreased concentration	______	______	Restlessness
______	______	Depression	______	______	Secure
______	______	Despair	______	______	Self-critical
______	______	Discontent	______	______	Sensitive to noise
______	______	Excessive worry	______	______	Shy
______	______	Forgetfulness	______	______	Suicidal attempts
______	______	Intimate with others	______	______	Suicidal thoughts
______	______	Jealous	______	______	Suspicious
______	______	Lack of self-confidence	______	______	Timid

Anger

Do you get angry often/easily? ☐ Yes ☐ No

What makes you angry? ______________________________

Do you experience uncontrollable rage? ☐ Yes ☐ No

Do you have difficulty expressing anger? ☐ Yes ☐ No

How do you express anger? ______________________________

Sadness

Do you cry easily/often? ☐ Yes ☐ No

What makes you sad? ______________________________

Do you cry when sad? ☐ Yes ☐ No

Does being consoled help? ☐ Yes ☐ No

Would you rather be left alone when sad? ☐ Yes ☐ No

Grief

List major experiences of grief/loss in your life:

____

____

____

____

Fears

What fears do you have? Are any unmanageable?

____

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Context of Care

Please answer the following as much as possible

Why did you choose to come to this clinic?

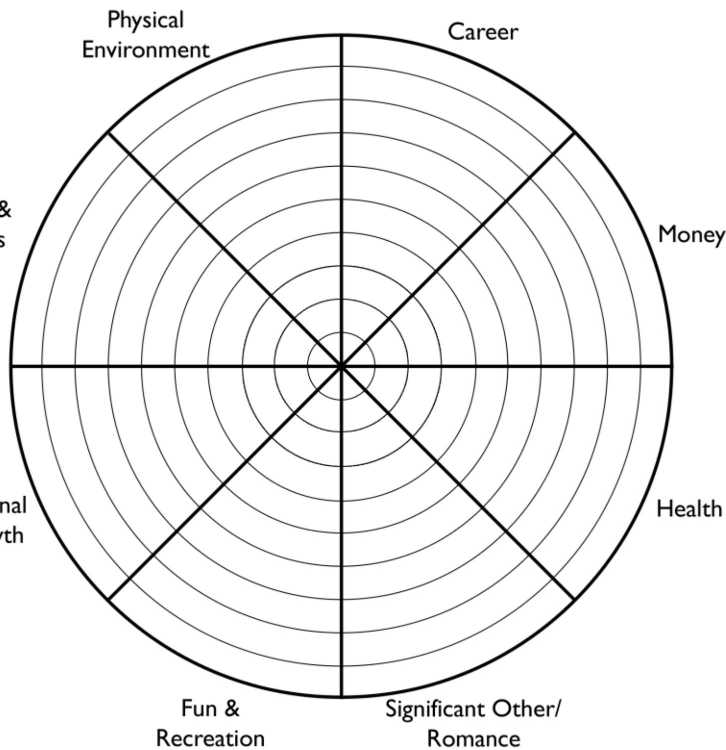
What expectations do you have with this visit to our clinic?

What long-term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

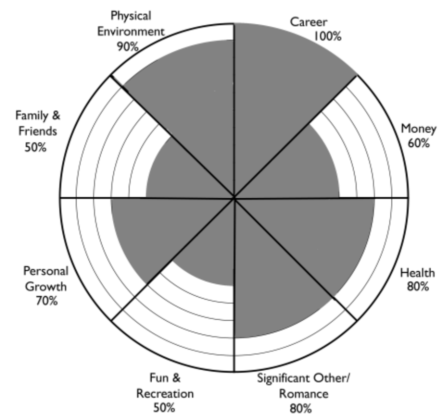


Wheel of Balance

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 extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Dr. Kellie Lawler, ND, L.Ac.,

SNOHOMISH NATURAL HEALTH REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ 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):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ 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?	❑ Yes	❑ No

Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]

❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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.: ( )

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.

Patient/Guardian signature *Date*

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 hydrotherpeutics

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