

Patient Health History Questionnaire

Natural medicine health care works best when the physician completely understands the person's physical, mental, and emotional conditions. The information you provide helps us understand your needs and how to help you reach your health goals.

Please write legibly, and mark anything you may have questions about.

Thank you for your time and thoroughness, and welcome to your journey to vibrant health!

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

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

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

Phone (home, cell, work): \_\_\_\_\_

Do we have your permission to leave confidential messages on your voicemail?: \_\_\_\_\_

E-mail: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship of emergency contact person to you \_\_\_\_\_

If the patient is a minor (under the age of 18), please provide the name(s) and signature(s) of parent(s)/legal guardian(s):

Occupation & employer: \_\_\_\_\_

Employer's address \_\_\_\_\_ Hours per week: \_\_\_\_\_

Live with:  Spouse  Partner  Parents  Children  Friends  Alone  Other (pets, etc) \_\_\_\_\_

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

Who can we thank for referring you to us (name and phone number if applicable)?

When was your last visit to a clinic or hospital? Why? \_\_\_\_\_

What are your most important health concerns currently? \_\_\_\_\_

To what extent do these health issues interfere with your daily activities (work, sleep, eating, physical movement, etc)?

Are there others in your family with the same or similar conditions? \_\_\_\_\_

What are your long-term health goals (physically, mentally, emotionally, spiritually)? \_\_\_\_\_

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please circle):

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support and strengthen your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to therapy and guidance provided here? \_\_\_\_\_

What do you believe to be the root cause(s) of your health condition(s)? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify having caused or aggravated your health problems?

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Have you previously sought other forms of healthcare for your health problems (MD, DO, acupuncture, chiropractic, naturopathy, homeopathy, massage, etc)?

What hospitalization or surgeries have you had? When and why?

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Do you have allergies to drugs, food, airborne (dust, mold, pollen), or other allergens? What happens when you have a reaction?

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### Family history:

Do you have a family history of any of the following (please circle)?

alcoholism	allergies	anemia	arthritis	asthma	cancer	cataracts
diabetes	epilepsy	gallbladder disease		glaucoma	goiter	hayfever/hives
heart disease	high blood pressure	HIV/AIDS	kidney disease		liver disease	mental illness
stroke	tuberculosis					

Father's health status, age, (or cause/age of death):

Mother's health status, age, (or cause/age of death):

Siblings health status, age(s):

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### Childhood Health:

Please circle if you have/had any of the following conditions as a child/adolescent:

chicken pox	diphtheria	measles	mumps	pertussis	rubella	polio
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Please list any vaccinations/immunizations you have had:

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### Past medical history:

Please circle any of the following conditions you have had **in the past**:

Appendicitis	alcoholism	arthritis	anemia	malaria	epilepsy	cancer
Tuberculosis	diabetes	heart disease	high cholesterol		mental illness	pleurisy
Pneumonia	sexually transmitted infections	goiter		low back pain		rheumatic fever
Influenza	mononucleiosis	chronic viral infections		chronic pain or fatigue		eczema
Hepatitis	others					

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### Review of systems:

Please circle any of the following issues or conditions that you **currently have**:

headaches/migraines	head injury	TMJ/jaw pain	ringing in the ears	dizziness	earaches			
ear infections	impaired hearing	goiter	swollen lymph nodes or glands		neck pain/stiffness			
blurred vision	eye strain	cataracts	glaucoma	color-blindness	prescriptive lenses			
nasal congestion	hayfever or allergies	sinus infections	loss of smell		frequent colds			
sore throats	dental cavities	vocal hoarseness		gum disease	coldsores			
asthma	cough	shortness of breath	coughing up blood or sputum		difficulty breathing			
chest pain	heart palpitations	blood clots	murmur	fainting	high/low blood pressure			
skin rashes	itching	acne	hair loss	eczema	hives	night sweats		
joint pains	muscle spasms	arthritis	muscle weakness	sciatica	fractures			
diarrhea	constipation	ulcers	jaundice	heartburn	gas/bloating	hemorrhoids	appetite changes	
urinary incontinence		kidney stones		painful urination	frequent urination		discharge	
anemia	cold hands/feet		easy bruising	varicose veins			intolerance to temperature extremes	
seizures	memory loss	numbness/tingling	anxiety	depression			mood swings	
hernias	prostate issues		sexual difficulties	breast tenderness or lumps			menstrual pain	PMS

# MEDICATION/SUPPLEMENT LIST

If you are currently taking any medications (prescriptive or over-the-counter), supplements, herbs, vitamins, birth control pills, etc, please list each item, dosages, and adverse reactions.

Pharmacy name, phone number \_\_\_\_\_

*Drug allergies?* \_\_\_\_\_

<u>Start date</u>	<u>End date</u>	<u>Medication name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Adverse effects</u>
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## Financial Policies

**Health Insurance:** I understand that if I have insurance which covers naturopathic medicine, my provider(s) can offer to bill services to my insurance company for reimbursement as a courtesy extended to me. I understand that it is my responsibility to confirm my coverage by calling my health insurance customer service representative before my first appointment. Except in the case of in-network coverage, I agree to accept full responsibility for all amounts not paid for by my insurance company and agree to pay the treating provider(s) for all services provided to me which the insurance company denies due to their usual and customary policy or for other reasons. I agree to pay the copay plus any costs for supplements, pharmacy, medicinal items, laboratory fees not covered by my insurance plan in full at the time of the visit. Payments for office visits, procedures, medicinal items, etc can be made using cash, check, Visa, or Mastercard.

**Private Pay:** If not covered by insurance, I agree to pay for any fees for services, costs of supplements and medicines, cost of laboratory tests, or other fees out of pocket at the time of the visit. It is my responsibility to ask about fees for services before or during my first appointment. I understand that the terms of this office are to pay the balance within 30 days of the most recent statement. Balances not paid within 30 days may be charged a rebilling fee. If a balance is not paid within 90 days, and my account is not sent to a collection agency, I understand that I am responsible for any additional collection and/or attorney fees related to my delinquency, and I hereby authorize my provider(s) to release information necessary to secure payment. Discounts and/or payment extension plans are only offered on an individual basis, based on financial need, and it is my responsibility to request any discounts. Payments for office visits, procedures, medicinal items, etc can be made using cash, check, Visa, or Mastercard.

**Cancellation policy:** **It is my responsibility to provide 24 hours notice by phone to cancel or change appointments, unless I have an emergency. I understand that I am responsible for paying the full amount for the missed appointment. This cancellation fee cannot be billed to my insurance, and is entirely my responsibility.**

**Medicinary/pharmacy items:** I understand that it is my full responsibility to pay for any medicines or pharmacy items that I choose to purchase at the time of the visit or at the time of pick up. I understand that items purchased **cannot be returned or refunded** unless the item is expired or defective. If I have an adverse reaction to, or simply cannot tolerate, a particular medicine recommended or prescribed to me, it is my responsibility to notify my provider(s) as soon as possible, so that the treatment can be re-evaluated.

**Minors (patients under the age of 18):** The minor patient's parent(s) or legal guardian(s) is/are fully responsible for payments of fees for services, costs of supplements and medicines, cost of laboratory tests, or other fees out of pocket at the time of the visit. All minors must be accompanied by their parent(s) or legal guardian(s) during the full office visit or appointment, unless otherwise agreed upon by the provider(s), the patient(s), and their parents/guardians.

**I have read, and agree to, the above financial policies.**

Patient Signature (or signature of parent or legal guardian)

\_\_\_\_\_ Today's Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Alive & Well Healing Arts, PC  
Daivati Bharadvaj, ND  
Naturopathic Physician  
9900 SW Wilshire Suite 190 D, Portland OR 97225  
503-297-3825 ext 5

## HIPAA PATIENT CONSENT FORM

Effective September 1<sup>st</sup>, 2003

I, \_\_\_\_\_, consent to the use or disclosure of my protected health information by Daivati Bharadvaj, ND, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Alive & Well Healing Arts PC dba Daivati Bharadvaj, ND. I understand that diagnosis or treatment of me by Daivati Bharadvaj, ND, may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the health care operations of the practice. Daivati Bharadvaj, ND is not required to agree to the restrictions that I may request, however, if Daivati Bharadvaj, ND agrees to a restriction that I request, that restriction is binding.

“Protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Daivati Bharadvaj, ND’s Notice of Privacy Practices prior to signing this document. Daivati Bharadvaj, ND’s Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Alive & Well Healing Arts PC dba Daivati Bharadvaj, ND. The Notice of Privacy Practices also describes my rights and the duties of Daivati Bharadvaj, ND with respect to my protected health information.

Alive & Well Healing Arts PC dba Daivati Bharadvaj, ND reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the HIPAA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my time of my next appointment.

Daivati Bharadvaj, ND reserves the right to leave a message on the patient’s home answering machine/recorder or private cell phone. As the patient, I consent to this right.

I understand that if I, the patient, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.

\_\_\_\_\_  
Signature of Patient or Personal Representative  
(print)

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative  
Authority

\_\_\_\_\_  
Date



**DIRECTIONS TO: JADE RIVER HEALING ARTS CENTER**  
**9900 SW Wilshire Street, Suite 190, Portland, OR 97225**

**Phone: 503-297-3825 •  Parking on the WEST end of building.**

**Building Note:** The numbering of suites in our office building is inconsistent. Our office, Suite 190, is located at the EAST end of the building, near the soda machine in the EAST lobby.

**Highway 26 West-Bound (from Portland)**

- Take Exit 69B--Cedar Hills/Barnes Rd.  
(same exit as for St. Vincent's Hospital & Oregon College of Art & Crafts).
- At end of the off ramp turn LEFT on Baltic Rd (proceed through underpass).
- Turn RIGHT at the traffic light (sign to Cedar Hills points to RIGHT).
- Turn LEFT just before the Cedar Hills Mall (signage will point you to 217 South).
- Turn LEFT at the stop sign on Wilshire, and proceed over 217 (to the east).
- Take your first RIGHT into the parking lot for the Sunset Office Building.
- There is also a small parking lot on the EAST end of the building, and under shade trees along Wilshire Street.

**Highway 26 East-Bound (from Beaverton & Hillsboro)**

- Take Exit 69B--Cedar Hills/Barnes Road
- Follow the clover-leaf exit which curves to the RIGHT. At the light (Baltic Road), continue STRAIGHT (NOT to your right).
- Turn LEFT just before the Cedar Hills Mall (signage will point you to 217 South).
- Turn LEFT at the stop sign on Wilshire, and proceed over 217 (to the east).
- Take your first RIGHT into the parking lot for the Sunset Office Building.
- There is also a small parking lot on the EAST end of the building, and under shade trees along Wilshire Street.

**Highway 217 North-bound**

- Once past the Walker Road Exit, get in the FAR RIGHT LANE
- You will see signs to Portland & Cedar Hills and Hwy 26 East.
- Freeway curves to the RIGHT & to Hwy 26 EAST: STAY RIGHT.
- Just into the curve, you will see an exit "CEDAR HILLS" to your RIGHT.
- Be sure to SLOW DOWN, as this is a "quick" exit.
- The exit curves further to the RIGHT, and you arrive at SW WILSHIRE ST.
- Turn to your RIGHT (West-bound on Wilshire).
- Continue about 200 feet, and on your LEFT you will see a red sign for the SUNSET OFFICE BUILDING.
- Turn LEFT into our parking lot, at the WEST end of the building.

- There is also a small parking lot on the EAST end of the building, and under shade trees along Wilshire Street.

**From MAX Light Rail**

- Get on the BLUE LINE to/from Hillsboro.
- Get off at the Sunset Transit Center (first stop WEST of Zoo/Tunnel stop).
- Go up stairs or elevator to main level, and turn LEFT (or South, as you come up from the tracks level), and
- Cross over Highway 26 on the pedestrian bridge.
- Proceed LEFT from the bridge steps (road curves here towards your LEFT).
- At the Stop sign (intersection of Parkway, Marlow & Butner) proceed STRAIGHT along Marlow Avenue.
- You are walking along the WEST side of the Cedar Hills Mall and the Big Lots Store. At the next intersection,
- Turn LEFT on Wilshire Street (behind the shopping center).
- Continue STRAIGHT (East) along Wilshire, crossing over 217.
- Turn RIGHT in the first driveway at the Sunset Office Building, and enter the building. Our office is at the far end of the building (East end) near the soda machine.