Tualatin Clinic address:
8555 SW Tualatin Road
Suite B
Tualatin, OR 97062

Scappoose Clinic address:
51669 SW Columbia River Hwy
Suite 130
Scappoose, OR 97056

Mailing address:
PO Box 909
Tualatin, OR 97062
Fax: (503)691-9018

Phone: (503) 691-0901 www.TrueHealthMedicine.com

PERSONAL INFORMATION

Name: ____ Date: ________________

Address: ____

City/State/Zip: ____

Telephone# (home): ________________ (cell): ________________ (work): ________________

Is there any reason we cannot send mail with our clinic name and return address on the envelope to your home? Y N

Is there any reason we cannot leave a voicemail message for you on any of your phone numbers? Y N

Email address: ____

Age: ______ Date of Birth: ________________ Gender: ____________________________

Please circle: Married Separated Divorced Widowed Single Partnership

Live with: Spouse Parents Children Friends Alone Other:__________________

Occupation: ____ Hours per week: _____

Employer: ____ Phone: ________________

How did you hear about our clinic? ____

Has any other family member already been a patient at the clinic? ____________________________

INSURANCE

Insurance Co: ____

Primary Insured Name: ___________________________________Phone: ________________

Primary Insured Address: ____

Policy/ID Number: _____________________________ Group Number: _____________________

Is your insurance through (circle one): Employer Cover Oregon Other: ________________

Do you have Secondary Insurance? Y N Please bring in all applicable insurance cards to every visit..

EMERGENCY CONTACT

Emergency Contact: ____

Relationship: ______________________________________ Phone: ________________

HEALTHCARE PROVIDERS

Are you currently established with a primary care provider (PCP)? If yes, please provide their contact information. Please list any other healthcare providers you would like us to coordinate care with.

____

____

____

True Health Medicine, PC
PO Box 909 Tualatin, OR 97062
503-691-0901

Patient Name:____________________________
Patient DOB: ____________________________

CHIEF COMPLAINT

What is your reason for coming in today? ____________________________

What are your most important health problems or concerns?

____

____

____

GENERAL INFORMATION

Height: __________ Weight: __________ Weight 1 year ago:__________
Maximum weight: __________ When:__________
When during the day is your energy the best? __________ Worst? __________

MEDICATIONS & SUPPLEMENTS

Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are taking. Please include brand and dosage as possible.

1)____________________ 5)____________________

2)____________________ 6)____________________

3)____________________ 7)____________________

4)____________________ 8)____________________

ALLERGIES Are you sensitive or allergic to…

Any drugs? ____________________________

Any foods? ____________________________

Any environmental or chemicals? ____________________________

PAST MEDICAL HISTORY

Please list any relevant or recent hospitalizations, surgeries, x-rays, CT scans, MRIs, EEG or EKG.

____________________ Year: ____________________ Year:

____________________ Year: ____________________ Year:

____________________ Year: ____________________ Year:

____________________ Year: ____________________ Year:

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

Cancer	Kidney Disease	Tuberculosis	Asthma/Hayfever/Hives
Diabetes	Epilepsy	Stroke	Osteoporosis
Heart Disease	Arthritis	Anemia	Metal Sensitivity
High Blood Pressure	Glaucoma	Mental Illness	

Please describe pertinent family history in more detail below:

____

____

True Health Medicine, PC
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Patient Name:______________________________
Patient DOB: ______________________________

TYPICAL FOOD INTAKE

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

Drinks: ______________________________

ON THIS AND FOLLOWING PAGES, PLEASE INDICATE AS FOLLOWS:

Y = Yes or Current Condition **N =** No or Never Had **P =** Significant Problem in the Past

LIFESTYLE

Interests and Hobbies: ______________________________

Do you exercise? Y N If yes, what kind? __________________ How often? ________

Sleep well?	Y N	Enjoy your work?	Y N
Average 6-8 hours?	Y N	Take vacations?	Y N
Awake refreshed?	Y N	Spent time outside?	Y N
Supportive relationship?	Y N	Watch television?	Y N
History of abuse?	Y N	How many hours/day?	_____
Major trauma?	Y N P	Read?	Y N
Use recreational drugs?	Y N P	How many hours/day?	_____
Been treated for drug dependence?	Y N P	Do you eat 3 meals/day?	Y N
Use alcoholic beverages?	Y N P	Do you go on diets often?	Y N
Treated for alcoholism?	Y N P	Drink coffee?	Y N P
Use tobacco?	Y N P	Drink green/black tea?	Y N P
Smoked previously?	Y N	Drink cola/other sodas?	Y N P
How many years?	________	Eat refined sugar?	Y N P
How many packs per day?	________	Add salt to food?	Y N P

Do you have a spiritual practice? Y N If yes, what? ______________________________

REVIEW OF SYSTEMS

Mental/Emotional

Mood swings	Y N P	Anxiety/Nervousness	Y N P
Poor concentration	Y N P	Depression	Y N P
Memory problems	Y N P	Treatment for emotional problems	Y N P
Tension	Y N P	Considered/attempted suicide	Y N P

Immune

Frequent colds/infections	Y N P	Reaction to vaccination	Y N P
Slow wound healing	Y N P	Chronic fatigue syndrome	Y N P
Swollen glands	Y N P		

Endocrine

Low thyroid/hypothyroid	Y N P	Excessive thirst	Y N P
Low blood sugar/hypoglycemia	Y N P	Excessive hunger	Y N P
Diabetes	Y N P	Heat or cold intolerance	Y N P
Fatigue	Y N P	Seasonal depression	Y N P

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Patient Name:______________________________________
Patient DOB: ______________________________________

Neurologic

Muscle weakness	Y N P	Vertigo or dizziness	Y N P
Numbness or tingling	Y N P	Loss of balance	Y N P
Easily stressed	Y N P	Seizures	Y N P
Paralysis	Y N P		

Skin

Rashes	Y N P	Acne or boils	Y N P
Eczema	Y N P	Color change	Y N P
Hives	Y N P	Lumps	Y N P
Itching	Y N P	Night sweats	Y N P
Hair loss	Y N P	Suspicious mole	Y N P

Head

Headache	Y N P	Head injury	Y N P
Migraine	Y N P	Concussion	Y N P

Eyes

Impaired vision	Y N P	Eye pain/strain	Y N P
Blurriness	Y N P	Tearing or dryness	Y N P
Color blindness	Y N P	Cataracts	Y N P
Double vision	Y N P	Glaucoma	Y N P
Spots in eyes	Y N P	Use glasses or contacts	Y N P

Ears

Impaired hearing	Y N P	Ringing	Y N P
Earaches	Y N P	Dizziness	Y N P

Nose and Sinuses

Stuffiness	Y N P	Nosebleeds	Y N P
Sinus problems	Y N P	Loss of smell	Y N P
Hayfever	Y N P		

Mouth and Throat

Copious saliva	Y N P	Sore tongue or lips	Y N P
Dry mouth	Y N P	Frequent sore throat	Y N P
Teeth grinding	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicking or TMJ	Y N P
Do you have any silver fillings or other metal implants? How many? ___________________	Y N	Gum problems or periodontal disease	Y N P

If other than fillings, please describe: ____

Neck

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

Respiratory

Cough	Y N P	Bronchitis	Y N P
Coughing or spitting up mucus	Y N P	Pneumonia	Y N P
Coughing or spitting up blood	Y N P	Pleurisy	Y N P
Asthma	Y N P	Emphysema	Y N P
Wheezing	Y N P	Tuberculosis	Y N P
Difficulty breathing	Y N P	Shortness of breath at night	Y N P
Pain on breathing	Y N P	Shortness of breath lying down	Y N P
Shortness of breath	Y N P		

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Patient Name:__________________________________
Patient DOB: __________________________________

Blood/Peripheral Vascular

Easy bruising or bleeding	Y N P	Anemia	Y N P
Deep leg pain	Y N P	Colds hands and feet	Y N P
Varicose veins	Y N P	Thrombophlebitis	Y N P

Cardiovascular

Heart disease	Y N P	Angina	Y N P
High/Low Blood Pressure	Y N P	Murmur	Y N P
Blood clot	Y N P	Fainting	Y N P
Phlebitis	Y N P	Palpitations/Fluttering	Y N P
Rheumatic Fever	Y N P	Chest pain	Y N P
Swelling in ankles	Y N P		

Gastrointestinal

Trouble swallowing	Y N P	Heartburn	Y N P
Change in thirst	Y N P	Abdominal pain/cramps	Y N P
Change in appetite	Y N P	Belching or passing gas	Y N P
Nausea/Vomiting	Y N P	Constipation	Y N P
Ulcer	Y N P	Diarrhea	Y N P
Jaundice (yellow skin/eyes)	Y N P	Bowel movements – how often? ______/_______	
Gall bladder disease or removal	Y N P	Is this a recent change?	Y N
Liver disease	Y N P	Black stools	Y N P
Hemorrhoids	Y N P	Blood in stool	Y N P

Urinary

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

Musculoskeletal

Joint pain or stiffness	Y N P	Arthritis	Y N P
Broken bones	Y N P	Weakness	Y N P
Surgical (metal) implants/replacement joints	Y N	Sciatica	Y N P
Please describe: ________________________		Muscle spasms or cramps	Y N P

Female Reproduction

Age of first menses: ________________________		Date of last annual exam/PAP: __________________	
First day of last menses:________________________		Abnormal PAP	Y N P
Age of last menses: ________________________		Cervical Dysplasia	Y N P
Length of cycle:________________________ days		Are you sexually active?	Y N P
Duration of menses (bleeding): ______________ days		Sexual orientation: ________________________	
Painful menses	Y N P	Birth control? Type: ________________________	
Heavy or excessive flow	Y N P	Any problems with this method?	Y N
PMS	Y N P	Sexual difficulties	Y N P
If yes, what symptoms: ________________________		Pain during intercourse	Y N P
__________________________________		Difficulty conceiving	Y N P
Are cycles regular?	Y N	Number of pregnancies:	_______
Bleeding/spotting between cycles	Y N P	Number of live births:	_______
Clotting	Y N P	Number of miscarriages:	_______
Menopausal symptoms	Y N	Number of abortions:	_______
If yes, what symptoms: ________________________		Chlamydia	Y N P
Breast pain/tenderness	Y N P	Gonorrhea	Y N P
Do you do breast self-exams?	Y N P	Condyloma	Y N P
Nipple discharge	Y N P	Herpes	Y N P
Skin changes	Y N P	Syphilis	Y N P
Concerning lumps	Y N P	Other STI: ________________________	Y N P

Patient Name:________________________________
Patient DOB: ________________________________

Male Reproduction

Hernia	Y N P	Prostate disease	Y N P
Testicular Pain	Y N P	Discharge or sores	Y N P
Testicular Mass	Y N P	Chlamydia	Y N P
Are you sexually active?	Y N P	Gonorrhea	Y N P
Sexual orientation: ____________________		Condyloma	Y N P
Erectile dysfunction	Y N P	Herpes	Y N P
Premature ejaculation	Y N P	Syphilis	Y N P
Birth control? Type: ____________________		Other STI: ____________________	Y N P
Any problems with this method?	Y N	Have you ever had a prostate exam?	Y N P

Consents and Acknowledgements

Please note that your signature at the bottom of the next page constitutes your agreement that you have read, consent and acknowledge all of the information provided. If you have questions about any of these materials, please call the clinic to discuss them with our staff prior to your initial visit. Further, please note that agreeing to abide by all of our clinic policies is required of all patients. Changes made to this document by patients are not binding and your signature indicates your agreement with all policies regardless of notes or edits made on this policy.

Information Accuracy

All of the information provided in my demographics form, health history and insurance verification form is complete and accurate to the best of my knowledge and ability. I will inform my provider of any changes in my health, pregnancy status, medications, allergies, insurance or demographics in a timely manner.

Acknowledgement of HIPAA Notice of Privacy Practices

I hereby acknowledge that I have reviewed the Notice of Privacy Practices and/or have received a copy of the same. I have been made aware that should I have any questions or concerns regarding Notice of Privacy Practices, the Compliance/Privacy Officer for True Health Medicine, PC will meet with me personally to address them. I understand that the Notice is also posted online for my review at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it (copying fees may apply).

Informed Consent for Treatment

I hereby authorize the physicians of True Health Medicine, PC, to perform procedures within their scope of practice as necessary to facilitate my diagnosis and treatment, including common diagnostic procedures e.g., venipuncture, UA, PAP smears, referrals for radiography or laboratory; minor office procedures; naturopathic physical medicine; medical use of nutrition; western botanical medicine; lifestyle counseling including recommendations for exercise, sleep, stress reduction and the use of patent or compounded prescription medicines. I recognize the potential risks of these procedures including allergic reactions to prescribed herbs, supplements or medicines; side effects of natural or pharmaceutical medicines; inconvenience of lifestyle changes; injury from injections, venipuncture or physical medicine. I recognize the potential benefits of treatment including restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression. I will be given a chance to ask questions prior to any new procedures and will consult my provider with any questions or concerns immediately. With this knowledge, I voluntarily consent to treatment realizing that no guarantees have been given to me by the naturopathic physician 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 further acknowledge that changes in my medication, condition or pregnancy status may affect the safety of treatment and agree to inform my doctor immediately upon such changes.

Email, Patient Fusion Portal and Communications

We do not recommend using direct email to contact your provider and instead recommend that patients utilize Patient Fusion's portal feature to establish secure communication with your providers if they have allowed this option. If this is not available, please call the office as your primary means of communication. Please note that messaging your provider through the portal is not recommended for urgent issues. For all urgent issues, we recommend calling the clinic during business hours. Our scheduling software does generate email to patients to confirm and remind you of your appointments and from

time to time to alert you that it is time to schedule. Please open and read all emails from the clinic to ensure that you receive any important information and to verify that your scheduled appointment times are correct.

Office Policies

The goal of our clinic is to provide a safe, serene and respectful environment for patients, staff and providers. To that end, please note the following:

- We do not offer childcare in our clinics. Please do not leave children unattended. For office visits where sensitive physical exams or physical medicine such as acupuncture or massage therapy are being performed, we recommend that you do not bring your children to the office.
- This office is a cell phone-free zone. Please take any calls before arriving at the office and silence all cell phones upon entering the clinic.
- Due to chemical and fragrance sensitivities, we request that patients, guests and visitors do not wearing perfume, aftershave, scented hand lotion, scented hair products, essential oils and/or similar products.
- Please respectfully comply with requests by staff and providers. We appreciate your participation in co-creating our healing environment.

Insurance Billing and Financial Policies

I hereby authorize the release of medical information necessary to process insurance claims for current and future claims without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information as required to process claims. **I understand that it it my responsibility to understand my insurance coverage and that I am financially responsible for all charges assigned to me or denied by my insurance company** or for all charges if we are not billing insurance. Additionally, please note the following:

- Motor vehicle accidents and workers compensation issues are billed differently. Please notify us immediately if you are being treated under one of these claims.
- Our clinic offers access to an on-call physician. Please note that these services are subject to charges which may not be covered by your insurance. Calling our on-call physician constitutes agreement to be charged for that service. The minimum fee for this is $50.
- Appointments that are not attended or rescheduled with less than 24 hours notice are subject to a missed appointment fee of $50. New patient appointments that are missed or rescheduled with less than 24 hour notice are subject to a missed appointment fee of $100. After repeated missed or rescheduled appointments (with less than 24 hour notice), patients may be required to pay a deposit to schedule future appointments. Missed appointment fees are not covered by insurance and are your responsibility.
- To provide the best possible naturopathic care, visits with our providers tend to be more detailed and longer than visits with other providers. Insurance company policies vary in coverage for prolonged visits. Please reference our Insurance Verification Form for more information. If your insurance does not cover prolonged visits, please discuss this with our staff for scheduling options.
- Returned checks are subject to a $35 fee. This fee is not covered by insurance and is your responsibility.
- Late balances are subject to a interest of up to 1.5% monthly (18% APR). Accounts more than 90 days in arrears are subject to collection. The key to avoiding this is communication. WE WILL WORK WITH YOU! Just talk to us.
- For uninsured patients or patients with insurance for whom we are out-of-network, payment in full is due at the time services are rendered. We may offer a discount to patients who pay in full at the time of service. Any visit that is not paid for in full will be billed at our regular undiscounted fee.

As stated above, your signature here implies your agreement to abide by all policies as outlined above.

Signature: ____ Date: ___________________

If signed by someone other than patient, please indicate relationship:

____

True Health Medicine, PC
PO Box 909 Tualatin, OR 97062
503-691-0901

Patient Name:____________________________________

Patient DOB: ____________________________________

Consent for Massage Therapy

I hereby request and consent to the performance of massage therapy by the licensed massage therapist(s) employed by True Health Medicine, PC. I am aware that massage therapists do not diagnose illness or disease, perform spinal manipulations nor prescribe medical treatment. The goals of massage therapy are to reduce muscular tension, spasm or pain, increase circulation and reduce stress, though no guarantee of benefit is implied. I will keep my massage therapist aware of all health conditions due to potential contraindications for massage and absolve my practitioner for liability due to my not relaying pertinent information about my health or condition. I agree to communicate clearly with my practitioner if the treatment needs to be modified due to physical or other discomfort up to and including discontinuing the treatment, which I may request at any time. Privacy will be assured, but I agree to dress down only according to my comfort level and as required for my treatment. I understand that sexual advances or sexually suggestive remarks will result in immediate termination of the treatment and may result in being denied services in future.

Signature: ____ Date: ________________

Consent for Acupuncture

I hereby voluntarily consent to receive acupuncture and acupuncture treatment for my present and future health conditions. The procedure, risks, alternatives and aftercare for Acupuncture treatment have been explained to my satisfaction. I understand and accept the risks of acupuncture include bruising, bleeding, a mild aching, soreness, numbness or tingling at the site, dizziness, fainting and a temporary exacerbation of symptoms, including the extremely rare risks of acupuncture (extremely low incidence when treatment performed by a licensed acupuncturist) include infection, nerve damage, organ puncture and spontaneous miscarriage. I understand that this document describes the major risks or treatment and that providers are not able to anticipate and explain all possible complications. I understand the possible risks and complications involved that have been listed here. I also understand that I agree to notify my provider of any bleeding disorders, drug therapies or recreational drug use, pregnancy/breast-feeding status, any symptoms that develop during or after treatment and any additional questions that may arise during treatment. I consent to receive treatment that involves the above procedures. I understand that results are not guaranteed. I understand that I have the right to refuse or discontinue treatment at any time. I understand that this refusal may affect the expected results.

Signature: ____ Date: ________________

True Health Medicine, PC
PO Box 909 Tualatin, OR 97062
503-691-0901

Patient Name:______________________________________
Patient DOB: _______________________________________

HEALTH INSURANCE VERIFICATION FORM

True Health Medicine bills insurance as a courtesy to our patients, however it is the patient's responsibility to be aware of coverage details. Patients are ultimately responsible for all charges resulting from all office visits and treatments received. This form will help you and us understand your insurance coverage. Please call member services for your insurance company and have the following information available for yourself and the primary insured party: name, date of birth, insurance ID and group ID.

Patient Name: ________________________________ Date of Birth: ______________________

Representative: ______________________________ Date: ____________________________

Reference Number for Call: ____

When did my coverage begin? _______________ When did my coverage end? ______________

Do I have a deductible? Y N How much? ____________ How much has been met? ________

Is my deductible based on: (Circle one) calendar year or fiscal year - If fiscal, start date: _________

Do I have coverage for:		Do I pay a copay or %? How much?	Do I have a maximum benefit? How much?
Naturopathic physician	Y N	_______________	_______________
Acupuncture	Y N	_______________	_______________
Massage	Y N	_______________	_______________

Is the doctor or clinic "in network" or "out of network"?	IN OUT
If out of network, do I have out of network benefits for naturopathic physician, acupuncture and massage?	Y N
Is a naturopathic doctor considered a primary care provider (PCP) on my plan?	Y N
Do I need a referral from a medical doctor or primary care provider (PCP) for naturopathic care, acupuncture or massage therapy?	Y N
Do I need prior authorization for naturopathic care, acupuncture or massage therapy?	Y N
Are claims for naturopathic, acupuncture or massage billed to American Specialty Health or Complementary Health Plans (CHP Group)? (Especially relevant to HealthNet and Kaiser)	Y N
Is CPT code 99354 a covered service and/or will it be applied to my deductible?	Y N
Can my naturopathic doctor perform my annual preventive wellness visit?	Y N

What laboratory is in-network with or preferred by my insurance?

____

Are there any limits placed on my naturopathic physician, such as ordering labs or imaging? Please list details below and on the back of this form. Y N