Patient Information
Sellwood Family Medicine LLC
1567 SE Tacoma Street, Portland, OR, 97202 PH: 503.233.8113

Today's Date: ___/____/____

PATIENT'S INFORMATION

Legal Name: _____ DOB: _____
Last First M.I.

Preferred first name: (Nickname, Chosen name, etc): _____

Home Address: _____
Street Address Apt # City State Zip code

Email: _____Home Phone: _____ Cell Phone: _____
(For our use only)

Sex assigned at birth: ☐ Male ☐ Female ☐ Other(specify): _____
Gender Identity: ☐ Male ☐ Female ☐ Other(specify): _____
Preferred pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other(specify): _____

Insurance Company Name: _____

ID #: _____ Group #: _____ Do you have secondary insurance? ☐ Yes ☐ No

Employment Status: ☐ Full time ☐ Part time ☐ Not employed ☐ Retired ☐ Seasonal ☐ Student
Employer: _____ Address: _____

Primary Care (PCP) Information:
☐ I wish to establish Primary Care with Sellwood Family Medicine
☐ I already have a PCP and am seeking adjunctive care at Sellwood Family Medicine
My Primary Care Physician (PCP) is: _____
At (Clinic Name): _____
☐ I do not have a PCP and do not wish to establish Primary Care at this time

Emergency Contact:
Name: _____ Relationship: _____
Home phone: _____ Cell phone: _____Work phone: _____

How did you hear about our clinic?
☐ Referred by: _____ ☐ Internet search ☐ Other: _____

FINANCIAL POLICY

Thank you for choosing Sellwood Family Medicine. We are committed to providing you with the best possible medical care at the lowest possible cost. Prompt payment allows us to control costs, which ultimately keeps our fees to a minimum. The following is a statement of our financial policy that we require you to read and sign prior to your first treatment:

Payment and Insurance: Payment in full is due at the time of service. We accept credit cards, cash and checks. Our practice participates with most insurance carriers and, as a courtesy to patients, we will file claims directly with their insurance company.
At the time of service, we require payment for any non-covered services, standard co-pay, and coinsurance. Patients are responsible for knowing the scope of their current policy benefits, limits and out of pocket expenses.

Not all insurance carriers or products cover Naturopathic Medicine. **It is the patient's responsibility to verify that the insurance plan they are on covers naturopathic physicians *before every visit*.** If you do not have naturopathic coverage at the time of service, you are responsible for payment in full at the time of service.

Patients are responsible for obtaining the necessary referral, if required by their insurance plan. In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service.

If there is a change of insurance, it is the patient's responsibility to inform our office and provide a copy of the new card at the time of service. If the patient fails to inform our staff of an insurance change, they will be responsible for payment for the visit if the timely filing period for the correct insurance has expired.

We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Please be aware that few insurance companies will cover all medical costs. Any service not covered by your insurance plan is your responsibility and must be paid in full at the time of service.

Returned checks are subject to an additional $25.00 fee. In addition, outstanding balances referred to outside collection services will also incur a fee for that service.

Cancellation of appointment: Unless we are notified at least 24 hours in advance, our policy is to charge $50.00 for missed appointments.

Our practice believes that a good doctor-patient relationship is based upon effective communications. If you have any questions, please feel welcome to contact us at 503-233-8113.

By signing below I agree that I have read and understand this policy.

GUARANTOR (person who is financially responsible for the account):

Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

What are the concerns for which you are seeking care? (Primary concern first):

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

For what concern did you last receive health or medical care? _____

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking on a regular basis?

Medication/Herb/Supplement	Dose & Frequency	Reason for Taking

Circle each that you currently use:

Laxatives
Pain Relievers
Antacids
Cortisone
Antibiotics
Heart/Blood Medication
Allergy Medication Thyroid Medication
Sleeping Pills
Anti-Depressants
Birth Control Hormones
Appetite Suppressant

Personal & Family History

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters, or children. Specify which relatives.

☐ Anemia _____
☐ Alzheimer's_____
☐ Arthritis _____
☐ Asthma _____
☐ Cancer _____
☐ Diabetes _____
☐ Epilepsy _____
☐ Heart disease _____
☐ Hypertension_____
☐ Kidney Disease_____
☐ Mental illness _____
☐ Multiple sclerosis _____
☐ Parkinson's_____
☐ Stroke _____
☐ Other _____

Hospitalizations, MVAs, Surgery, X-Rays and Special Studies
What hospitalizations, surgeries, x-rays, or special studies have you had?
_____ Year : _____ _____ Year : _____
_____ Year : _____ _____ Year : _____

Allergies
Are you hypersensitive or allergic to foods, drugs, or environmental substances? If so, please list allergen and reaction. _____
_____

General
Weight ____ lbs. Weight 1 year ago ____ lbs. Max Weight ____ lbs. Height _____

Lifestyle
Exercise and hobbies: _____
_____

Average hours of sleep: _____

Supportive relationships: ☐ Yes ☐ No

Wake feeling well-rested: ☐ Yes ☐ No

Religious/spiritual practice: ☐ Yes ☐ No

Drink coffee: ☐ Yes ☐ No

Drink cola/soda: ☐ Yes ☐ No

Tobacco use: ☐ Currently ☐ In the past ☐ Cigarettes ☐ Chew ☐ Other: _____
How many years? _____ How many packs per day? _____

Marijuana use: ☐ Currently ☐ In the past

Other Recreational drug use: ☐ Currently ☐ In the past Specify: _____

Alcohol use: ☐ Currently ☐ In the past
per week _____ Specify Beer/Wine/Hard alcohol: _____

Have you ever been treated for alcoholism/addiction? ☐ Yes ☐ No Specify:_____

Review of Systems

Please indicate symptoms that you have had *in the past 6 months*

Mental/Emotional/Neuro.
- ☐ Treated for depression
- ☐ Seizures
- ☐ Mood swings
- ☐ Muscle weakness
- ☐ Considered/attempted suicide
- ☐ Loss of memory
- ☐ Poor concentration
- ☐ Vertigo/dizziness
- ☐ Depression
- ☐ Paralysis
- ☐ Anxiety or nervousness
- ☐ Numbness or tingling
- ☐ Memory problems

Endocrine
- ☐ Hair loss
- ☐ Brittle nails
- ☐ Excessive thirst
- ☐ General fatigue
- ☐ Fatigue after meals
- ☐ Heat/cold intolerance
- ☐ Seasonal depression

Cardiovascular
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Rheumatic fever
- ☐ Ankle swelling
- ☐ Night sweats
- ☐ Angina/chest pain
- ☐ Heart murmurs
- ☐ Fainting
- ☐ Heart palpitations/fluttering

Peripheral Vascular
- ☐ Easy bleeding/bruising
- ☐ Varicose veins
- ☐ Anemia
- ☐ Cold hands/feet

Immune
- ☐ Chronic fatigue syndrome
- ☐ Swollen glands
- ☐ Reaction to vaccines
- ☐ Ongoing infections
- ☐ Slow wound healing
- ☐ Frequent colds/flu
- ☐ Vaccine reactions

Musculoskeletal
- ☐ Joint pain or stiffness
- ☐ Broken bones
- ☐ Muscle spasms or cramps
- ☐ Arthritis
- ☐ Weakness
- ☐ Sciatica

Head
- ☐ Ear pain
- ☐ Ear itching
- ☐ Ringing in ears
- ☐ Impaired hearing
- ☐ Stuffiness/congestion
- ☐ Sinus pain
- ☐ Nose bleeds
- ☐ Headaches
- ☐ Hay fever
- ☐ Loss of smell
- ☐ Head injury
- ☐ Vision changes
- ☐ Eye pain/strain
- ☐ Glaucoma
- ☐ Eye dryness

Mouth & Throat
- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Teeth grinding
- ☐ Gum disease
- ☐ Dental cavities
- ☐ Dry mouth
- ☐ Jaw pain/clicking
- ☐ Mouth ulcers

Neck
- ☐ Lumps
- ☐ Pain/stiffness
- ☐ Goiter

Respiratory
- ☐ Cough
- ☐ Blood in cough/saliva
- ☐ Asthma
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pain on breathing
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Difficulty breathing

Breast
- ☐ Pain/tenderness
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Skin changes

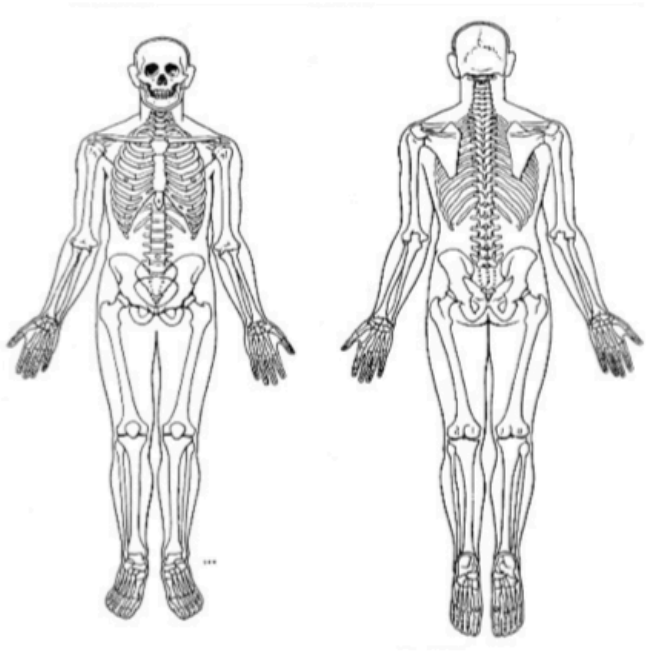
Intestinal
- ☐ Troubling swallowing
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Burning pain/reflux
- ☐ Jaundice
- ☐ Liver/Gallbladder disease
- ☐ Hemorrhoids
- ☐ Heartburn
- ☐ Abdominal pain/cramps
- ☐ Excessive belching/gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stools
- ☐ Blood in stools

continued on next page →

Genitourinary
- ☐ Pain with urination
- ☐ Frequent infections
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Frequent urinations
- ☐ Sexually active
- ☐ Pain during intercourse
- ☐ Vaginal/Penile discharge
- ☐ Sores on genitalia
- ☐ Sexual difficulties
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Testicular masses/pain
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Genital herpes
- ☐ HPV/genital warts
- ☐ Syphilis
- ☐ Condom use

Menstruation & Pregnancy:

Age at first period _____
Age of last period _____
Length of bleeding ___ days
Length of cycle ___ days
Date of last Pap _____
PMS symptoms _____
_____
Birth control method _____
_____
# of pregnancies _____
# of miscarriages _____
# of abortions _____
# of live births _____



On the diagram to the left, please circle any areas in which you are experiencing pain. Please describe that pain below.

_____

_____

_____

_____

_____

_____

_____

_____