Clinic Of Natural Health
www.clinicofnaturalhealth.com
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NEW PATIENT CHILD AND TEEN INTAKE FORM

Please take the time to complete these forms. They will help us help you. The first section focuses on your health and personal history. The next section describes our treatments, fees and policies. The last section contains a federally required privacy statement and arbitration info.

Thank you, we look forward to working with you!

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ Cell: _____

Where can we leave personal, private messages at? _____

Age: _____ Date of Birth: _____ Gender identification: _____

Who do you live with (be specific): Adults _____ Children _____

Other Relatives _____ Pets _____ Other _____

School name, address: _____

Grade/level in school: _____

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, where and when did you last receive medical or health care and why?_____

_____.

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____

Context of Care

1. Why did you choose to come to this clinic?

2. What do you know about our approach?

3. What **three** expectations do you have from **this** visit to our clinic?

4. What **long term** expectations do you have from working with our clinic?

5. What expectations do you have of me personally as your health care provider?

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

   0 1 2 3 4 5 6 7 8 9 10

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

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

9. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

10. Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

11. What do you love to do?

CHILDHOOD ILLNESSES

Birth city and state: _____ Birth weight: _____

Any issues during your mother's delivery of you? _____

Have you had any of the following illnesses (please circle):

Rheumatic fever	Scarlet fever	Chicken pox	Diptheria
German Measles	Measles	Mumps	

VACCINATION HISTORY

What vaccinations have you had (circle those that apply to you)?

Hepatitis A and/or B	DTaP	MMR
Hib (Haemophilus	Pneumococcal	Varicella
Influenzae type B)	Rotavirus	Meningococcal
Polio	Influenza	HPV

HOSPITAL VISITS, SURGERIES, IMAGING

What hospitalizations, surgeries, x-rays, MRI's, CAT scans, EKG's or other tests have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to any foods, herbs, drugs, environmental or chemical substances, or anything else?

List them here: _____

Do you have any known contagious diseases at this time? Yes / No If yes, what? _____

CURRENT MEDICATIONS

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking, along with the dosage:

1) _____ 3)_____

2) _____ 4) _____

FAMILY HISTORY

Do you or any member of your family have a history of any of the following?

(please circle and list who the family member is):

Cancer	Kidney disease	Diabetes	Heart disease
Asthma	Hay fever	Hives	Tuberculosis
Epilepsy	Stroke	Anemia	Arthritis
Glaucoma	Mental Illness	High Blood Pressure	

What is your family heritage? _____

Any other relevant family history? _____

GENERAL INFO

Height: _____ Weight: _____ Weight one year ago: _____

Maximum weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies: _____

Exercise: Y / N If yes, what kind and how often: _____

Watch TV: Y /N If so, how many hours? _____ Read: Y / N If so, how many hours? _____

Do you have a spiritual or religious practice? Y / N If so, what kind? _____

FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now N=no/never had
P= problem in the past S=sometimes a problem now

GENERAL

Do you sleep well?	Y N P S
Average 6-8 hours?	Y N P S
Awake rested?	Y N P S
Have a supportive relationship?	Y N P S
Have a history of abuse?	Y N P S
Experienced a major trauma?	Y N P S
Use recreational drugs?	Y N P S
Treated for drug dependence?	Y N P S
Use alcoholic beverages?	Y N P S
Use tobacco?	Y N P S
If in the past, how many years?	_____
How many packs per day?	_____
Do you enjoy your work?	Y N P S
Take vacations?	Y N P S
Spend time outside?	Y N P S
Eat three meals a day?	Y N P S
Do you go on diets often?	Y N P S
Do you eat out often?	Y N P S
Do you drink coffee?	Y N P S
Drink black/green tea?	Y N P S
Drink soda?	Y N P S
Do you eat refined sugar?	Y N P S
Do you add salt to your food?	Y N P S

NEUROLOGIC

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

ENDOCRINE

Hypothyroid?	Y N P S
Hypoglycemia?	Y N P S
Excessive thirst?	Y N P S
Fatigue?	Y N P S
Heat or cold intolerance?	Y N P S

ENDOCRINE CONT.

Hyperthyroid?	Y N P S
Diabetes?	Y N P S
Excessive hunger?	Y N P S
Seasonal depression?	Y N P S
Difficulty exercising?	Y N P S

IMMUNE

Reactions to immunizations?	Y N P S
Chronically swollen glands?	Y N P S
Slow wound healing?	Y N P S
Chronic fatigue syndrome?	Y N P S
Chronic infections?	Y N P S
Night sweats?	Y N P S

EARS

Impaired hearing?	Y N P S
Ringing in ears?	Y N P S
Dizziness?	Y N P S
Ear aches?	Y N P S

EYES

Impaired vision?	Y N P S
Cataracts?	Y N P S
Glaucoma?	Y N P S
Spots in vision?	Y N P S
Color blindness?	Y N P S
Tearing or dryness?	Y N P S
Eye pain or strain?	Y N P S

HEAD

Headaches?	Y N P S
Migraines?	Y N P S
Head injury?	Y N P S
Jaw or TMJ problems?	Y N P S

NOSE AND SINUS

Frequent colds?	Y N P S
Stuffiness?	Y N P S
Sinus problems?	Y N P S
Nose bleeds?	Y N P S

NOSE AND SINUS CONT.

Hayfever?	Y N P S
Loss of smell?	Y N P S

NECK

Lumps in neck?	Y N P S
Goiter?	Y N P S
Difficulty swallowing?	Y N P S
Pain or stiffness in neck?	Y N P S

MOUTH AND THROAT

Frequent sore throat?	Y N P S
Copious saliva?	Y N P S
Sore tongue or lips?	Y N P S
Hoarseness?	Y N P S
Jaw clicks?	Y N P S
Teeth grinding?	Y N P S
Gum problems?	Y N P S
Dental cavities?	Y N P S

SKIN

Rashes?	Y N P S
Acne/boils?	Y N P S
Change in skin color?	Y N P S
Lumps or bumps on skin?	Y N P S
Eczema or hives?	Y N P S
Itching?	Y N P S
Perpetual hair loss?	Y N P S

RESPIRATORY

Cough?	Y N P S
Sputum?	Y N P S
Asthma?	Y N P S
Wheezing?	Y N P S
Bronchitis?	Y N P S
Coughing up blood?	Y N P S
Shortness of breath?	Y N P S
Shortness of breath when lying down?	Y N P S
Pain in breathing?	Y N P S
Emphysema?	Y N P S
Tuberculosis?	Y N P S

GASTROINTESTINAL

Trouble swallowing?	Y N P S
Change in thirst?	Y N P S

GASTROINTESTINAL CONT.

Change in appetite?	Y N P S
Nausea/vomiting?	Y N P S
Ulcer?	Y N P S
Jaundice?	Y N P S
Gall bladder disease?	Y N P S
Liver disease?	Y N P S
Hemorrhoids?	Y N P S
Pancreatitis?	Y N P S
Heartburn?	Y N P S
Abdominal pain or cramps?	Y N P S
Belching or passing gas?	Y N P S
Constipation?	Y N P S
Bowel movements: how often? _____	
Is this a change?_____	
Black stools?	Y N P S
Blood in stools?	Y N P S

MENTAL/EMOTIONAL

Treated for emotional issues?	Y N P S
Depression?	Y N P S
Anxiety or nervousness?	Y N P S
Poor concentration?	Y N P S
Do you have mood swings?	Y N P S
Considered suicide?	Y N P S
Attempted suicide?	Y N P S
Tension?	Y N P S
Memory problems?	Y N P S

URINARY

Increased frequency of urination?	Y N P S
Inability to hold urine?	Y N P S
Pain in urination?	Y N P S
Frequency at night?	Y N P S
Frequent UTI's?	Y N P S
Kidney stones?	Y N P S

MUSCULOSKELETAL

Joint pain or stiffness?	Y N P S
Arthritis?	Y N P S
Broken bones?	Y N P S
Weakness?	Y N P S
Muscle spasms or cramps?	Y N P S
Sciatica?	Y N P S

BLOOD

Anemia? Y N P S
Easy bleeding or bruising? Y N P S
Cold hands/feet? Y N P S
Deep leg pain? Y N P S
Thrombophlebitis? Y N P S
Varicose veins? Y N P S

FEMALE REPRODUCTIVE

Age of first menses: _____
Age of last menses (if menopausal):_____
Length of cycle: _____days
Duration of menses: _____days
Are your cycles regular? Y N P S
Painful menses? Y N P S
Heavy or excessive flow? Y N P S
PMS? Y N P S
PMS Symptoms: _____
Bleeding between cycles? Y N P S
Clotting? Y N P S
Endometriosis? Y N P S
Ovarian cysts? Y N P S
Vaginal odor? Y N P S
Vaginal discharge? Y N P S
Date of last pap smear: _____
Abnormal PAP? Y N P S
Cervical dysplasia? Y N P S
Are you sexually active? Y N P S
Sexual orientation: _____
Birth control? Y N P S
Type: _____

FEMALE REP. CONT.

Pain during intercourse? Y N P S
Gonorrhea? Y N P S
Herpes? Y N P S
Chlamydia? Y N P S
Genital warts? Y N P S
Syphilis? Y N P S
Difficulty conceiving? Y N P S
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____
Do you do self breast exams? Y N P S
Breast pain/tenderness? Y N P S
Breast lumps? Y N P S
Nipple discharge? Y N P S
Menopausal symptoms? Y N P S

MALE REPRODUCTIVE

Are you sexually active? Y N P S
Sexual orientation: _____
Birth control? Type: _____
Discharge or sores? Y N P S
Chlamydia? Y N P S
Gonorrhea? Y N P S
Genital warts? Y N P S
Herpes? Y N P S
Syphilis? Y N P S
Hernias? Y N P S
Testicular masses? Y N P S
Testicular pain? Y N P S
Prostate disease? Y N P S
Impotence? Y N P S
Premature ejaculation? Y N P S

TYPICAL FOOD INTAKE

Breakfast: _____ Coffee/Tea? _____

Lunch: _____ Snacks: _____

Dinner: _____ Drinks: _____

Anything else you feel I should know?

About the treatments you may receive

Dr. Yezman's intention is to meet each patient's needs, and address each person physically, spiritually, and mental-emotionally. She has acquired a set of skills to address many different health issues. These treatments and techniques include:

- Physical exam, including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments. One of more of these may be done to help evaluate your health issues further. Dr. Yezman has done numerous physical exams and will do her best to make sure you are as comfortable as possible.

- Evaluation of blood, urine, stool and saliva by means of labwork obtained from an outside source. If you have labwork you want examined, please bring it in with you or complete the "Records Release" form on the Services and Form page of the website.

- Soft tissue work such as muscle energy technique and strain- counterstrain. Dr. Yezman is experienced in soft tissue work and may use one of these techniques in combination with other methods. Most forms of bodywork stimulate circulation to the areas treated. This increases the body's need for water and food. Be sure to drink water and eat well on days you are treated.

- Dietary advice and therapeutic nutrition: including the use of foods, dietary plans, nutritional supplements and intra-muscular vitamin injections. Dr. Yezman has extensive experience with finding a person's own special balance in nutrition.

- Dr. Yezman carries an inventory of nutrient supplements, homeopathics, Western herbal medicines, and patented Chinese Medicine herbs. If any are recommended for you, Dr. Yezman will explain why it is beneficial and how to take them. Clear and detailed instructions will be given during the visit.

- Hydrotherapy: includes the use of hot and cold water to improve the circulation of blood and lymph, and may include the use of gentle, safe levels of electrical current. Depending on the type of current and how strong the stimulation is, this will alleviate pain, relax muscles, or decrease swelling.

- Acupuncture, including but not limited to needle insertion in body, ear or scalp, moxa, electrical stimulation, acupressure. Dr. Yezman is experienced in a wide range of techniques and completes them as gently and safely as possible.

If you experience any symptoms after treatment to a degree that concerns you, you are encouraged to call and talk with Dr. Yezman, or be sure to mention it at your next visit.

Schedule

We respect your time and do not want you to wait too long in our waiting room. We are usually on time, and ready to see you at your scheduled appointment time. If we are going to be more than 10 minutes behind, we will try to reach you before your appointment to let you know. In return, we ask that you arrive a few minutes before your appointment so you are ready at your scheduled appointment time.

Dr. Yezman's schedule can fill up in advance. If you are on a treatment plan that requires repeated visits, we suggest that you schedule the treatments as far in advance as possible.

Missed appointments

If you have an appointment you cannot keep, please call us as soon as possible. We understand that schedules change and things come up. We will gladly reschedule your appointment. If you give us more than 48 hours notice, another patient will be happy to have your appointment slot. Our office staff and other patients will appreciate this advanced notice.

We understand that everyone makes mistakes and sometimes forgets an appointment. We do not want to charge you for missed appointments. We'd much rather see you! However, to safeguard our schedule against repeated no-shows, we charge $60 for a missed appointment. If a patient consistently cancels or misses appointments, we may ask that patient to seek out a different practitioner.

Fees and financial responsibilities

We understand the need for information and predictability in the cost of care, so we provide the fee schedule to each patient. We cannot guarantee a specific fee per visit, because each treatment session may vary in length, treatment and the services delivered. The goal of the treatment plan, along with each treatment session, is to best solve the health issues that have brought you here.

The first appointment consists of a very thorough and detailed Naturopathic medical intake. This includes a history, examination, review of lab work or other medical information and a treatment plan. The cost for this initial visit is $250, and is an one and a half hour appointment.

Follow up Naturopathic consultation appointments are $150.

New patient acupuncture only appointments are one hour long and include intake, examination, acupuncture and treatment plan. The cost for this is $150, and follow up appointments are $100.

Fee Schedule
New Patient Comprehensive Naturopathic intake: $250
Established patient Naturopathic consultation: $150
New patient acupuncture appointment: $150
Established patient acupuncture: $100
Vitamin injections: $35-75
Hydrotherapy treatment: $45
Hot/cold poulticd: $15
Local massage: $20
Complete certified physical exam: $175
Nutritional supplements: costs vary

Insurance Billing

Dr. Yezman is not in-network with any insurance plans, HMOs, or PPOs. You must have out-of-network benefits in order for your insurance to cover Dr. Yezman's treatments.

Nutrient supplements, homeopathics and herbs must be paid for by the patient.

No matter what type of insurance you are using, you are responsible for the fees for your treatment. If the insurance company denies payment, you are responsible for paying the fees in full. If the insurance company pays only part of the fees, you are responsible for paying the balance.

If you do not understand any of these policies, please ask and we will discuss them before you sign below.

With your signature, you indicate that you have read and understand the schedule, treatments, fees and financial policies.

Sign: _____ Date: _____

Parent, Guardian, or Responsible Party if patient under 18 years old:

Print Name: _____

Sign: _____ Date: _____

Consent to Examination and Treatment

Your safety and comfort are of the greatest importance to Dr. Yezman. Be assured that no technique will be performed or treatment delivered without your full consent and participation. To assure us that you consent to examination and treatment, we respectfully ask you to read these pages and sign at the bottom.

If you do not understand any of this information, or if you cannot agree to sign this page, please tell Dr. Yezman about your specific concerns.

1) Your treatment may consist of one or more of the following:
   - Physical exam, including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments. This can be used for school or employment evaluations, and will give us a general idea of your health.
   - Evaluation of blood, urine, stool and saliva by means of labwork obtained from an outside source.
   - Soft tissue work such as muscle energy technique and strain- counterstrain
   - Dietary advice and therapeutic nutrition, including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections
   - Botanical/ herbal medicines, and patented Chinese Medicine herbs, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, topical creams, pastes, plasters, washes or other forms
   - Homeopathic remedies (highly diluted quantities of naturally occurring substances)
   - Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
   - Counseling, including but not limited to visualization for improved lifestyle strategies
   - Acupuncture, including but not limited to needle insertion in body, ear or scalp, moxa, electrical stimulation, acupressure

2) As the patient, you are always allowed to decline treatment. No matter the issue.

3) Your treatment may require you to change into a gown and/or shorts. These garments are designed to allow you to move freely and will allow Dr. Yezman to access your skin while preserving your comfort and modesty. Your comfort and relaxation are of the greatest importance, so please notify Dr. Yezman if you are cold or if you do not feel adequately covered.

4) Your treatment may require Dr. Yezman to contact areas all over your body. Let us know of any specific concerns you have. By signing below, you are indicating that you give Dr. Yezman permission to examine and treat any area that is necessary.

5) Your health issues will always be discussed and explained with you. While the risk of complications or side effects from any treatments is rare, at times they do occur. The

most common may include, but are not limited to, soreness, bruising, itching, burns, and temporary worsening of symptoms. By signing below, you are indicating that yo understand and accept these risks.

6) Dr. Yezman will recommend as part of your treatment plan specific exercises, nutritional supplements, homeopathics and/or herbs. You are responsible for following the instructions, and for following through with the recommendations made. Please ask Dr. Yezman any specific questions you have about your treatment plan.

7) After the initial interview and examination, Dr. Yezman will do her best to describe your condition and a plan for treatment. You are not obligated to receive treatment. If at any time during treatment you have concerns about the course of your care, the techniques being used, or if new symptoms arise, tell Dr. Yezman about your concerns or new symptoms. They may contain important information about your health and wellness.

By signing below, you indicate that you have read and understood the information on these pages, and you consent to examination and treatment.

I have fully read and understand the above statements above.

Sign: _____ Date: _____

Parent, Guardian, or Responsible Party if patient under 18 years old:

Print Patient's Name: _____

Sign: _____ Date: _____

We are required by federal law (HIPAA) to have your signature on this form. It describes how we can and cannot use your information.

I consent to the use or disclosure of my protected health information by Dr. Nicole Yezman for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I understand that diagnosis or treatment of me by Dr. Yezman may be conditioned upon my consent as evidenced by my signature on this document.

I understand 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 healthcare operations of the practice. Dr. Nicole Yezman is not required to agree to the restrictions that I may request. However, if dr. Yezman agrees to a restriction that I request, the restriction is binding on Dr. Yezman's office.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Yezman has taken action in reliance on this consent.

My "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 clearinghouse. This protected health information relates to my psat, present or future physical or mental health or condition and identifies me, or ther is a reasonable basis to believe the information may identify me.

Dr. Yezman uses Lottie Mackey for insurance billing services; I understand this and do hereby give my consent to have my insurance information processed by this company.

I understand I have a right to review Dr. Yezman's Notice of Privacy Practices prior to signing this document. Dr. Yezman's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Yezman's office. This Notice of Privacy Practices also describes my rights and Dr. Yezman's office's duties with respect to my protected health information.

Dr. Yezman's office 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 calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Sign: _____ Date: _____

Parent, Guardian, or Responsible Party if patient under 18 years old:

Print Patient's Name: _____

Sign: _____ Date: _____

Consent to Arbitration

When you come in for your initial visit, you will be asked to sign an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive from Dr. Nicole Yezman of the Clinic Of Natural Health, is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no on anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by Oregon and Michigan courts.

By signing this agreement you are changing the place where your claim will be presented, if ever there is one. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. This agreement generally helps to limit the legal costs for both patients and physicians, because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings. This arbitration agreement enables Dr. Yezman to provide you with more affordable healthcare.

Our goal, of course, is to provide you with quality medical care which fully meets your health care needs. We know that most problems begin with communication, this has been proven time and time again. Therefore, if you have any questions about your care, please ask, we are open to discuss and problem solve any concerns you may have.

I agree to the terms and conditions listed above.

Sign: _____ Date: _____

Parent, Guardian, or Responsible Party if patient under 18 years old:

Print Patient's Name: _____

Sign: _____ Date: _____