Sacred Root Medicine
AN INTEGRATIVE HEALTHCARE PRACTICE

611 Main St., Suite A
Edmonds, WA 98020

# Naturopathic New Patient Form

Patient Name: _____Date of Birth:___/___/___Age:_____Gender:___

Address:_____

City:_____State:_____Zip:_____

Primary Phone _____-_____ Email:_____

Marital Status:_____

Emergency Contact:_____
*Name* *Phone* *Relationship*

Are you currently receiving healthcare? yes ☐ no ☐

_____
*Physician & Office Name* *Phone*

**Context of Care:**

Please list your most important health problems (in order of importance)

1._____ 2._____ 3._____

Have you received treatment for these concerning problems? yes ☐ no ☐

If yes, what modalities? _____

What *three* specific expectations do you have for your visit today?

1._____

2._____

3._____

Please describe your goals for treatment._____

_____

Please describe your current state of health._____

_____

What is your level of commitment to address the underlying causes of any of your symptoms that relate to your lifestyle. *Rate from 0-10, 10 being most fully committed.* 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

**General**

Height:_____ Weight: _____ One year ago? _____ Ideal Weight? _____

Do you have an exercise routine? yes ☐ no ☐

What type of exercise do you do? _____ How often? _____

History of trauma? yes ☐ no ☐ History of abuse? yes ☐ no ☐

Occupation:_____ City:_____

Do you enjoy your work? yes ☐ no ☐ why/why not? _____

Hrs of sleep per night:_____ Bed time:_____ Do you wake refreshed? yes ☐ no ☐

**Diet, Lifestyle, Habits**

What is the current level of stress in your life? *Rate from 0-10, 10 being severe stress.*

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What things have you found to help in the relieving of your stress?_____

_____

Spiritual Practice? yes ☐ no ☐ what?_____

Do you eat three meals per day? yes ☐ no ☐ If no, how many? _____

Please describe your typical daily meals.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you use any of the following? (*please check)*

Alcohol ☐ Tobacco ☐ Coffee ☐ Caffeine ☐ Recreational drugs ☐ Soda ☐

Do you have any cravings? Please specify and describe frequency._____

_____

Do you have any allergies to the following? *(please check)*

Medications ☐ Foods ☐ Seasonal ☐ Animals ☐ Environmental/Chemical ☐

If you checked any, please explain._____

_____

**Current Medications:**

Please list all current prescription medications, over-the-counter medications, vitamins, herbs and nutritional supplements. Include frequency and dosages. Attach a separate sheet if necessary.

Prescription & Over-the-counter medications:_____

_____

_____

Vitamins & Nutritional Supplements:_____

_____

_____

**Patient Medical History:**

Please check all that apply:

Broken or Fractured Bones ☐ Major Illnesses ☐ Operations & Hospitalizations ☐

If checked, please provide the date, diagnosis, location of injury and/or surgery._____

_____

_____

_____

**Personal & Family History**

Check any conditions listed below that you currently have or have had in the past. If there is a family history of any of the conditions listed, please underline and specify.

| | | |
|---|---|---|
| ☐ Appendicitis | ☐ Cancer *(type)*_____ | ☐ Hepatitis *type)*_____ |
| ☐ Asthma | ☐ Autoimmune Disorder | ☐ Blood Clots |
| ☐ Bronchitis | ☐ Diabetes | ☐ Migraines |
| ☐ Emphysema | ☐ Digestive problems | ☐ HIV/AIDS |
| ☐ Pneumonia | ☐ Addiction | ☐ Paralysis |
| ☐ Tuberculosis | ☐ Epilepsy | ☐ Colitis/Enteritis |
| ☐ Heart Disease | ☐ Multiple Sclerosis | ☐ Thyroid Problems |
| ☐ High Cholesterol | ☐ Mumps | ☐ Blood Clots |
| ☐ Hypertension | ☐ Scarlet Fever | ☐ Syphilis |
| ☐ Stroke | ☐ High Fever | ☐ Polio |
| ☐ Pace Maker | ☐ Bleeding Disorder | ☐ Mental Illness |
| ☐ Arteriosclerosis | ☐ Intestinal Parasites | ☐ Allergies |

Immunizations: yes ☐ no ☐ which?_____

_____

Other relevant history. _____

_____

_____

_____

_____

_____

_____ _____

Patient Signature (or Guardian, if under age 18) Date

## Review of Systems

**Please Check the Following Symptoms If Present:**

### Endocrine
- ☐ Cold Hands/Fingers
- ☐ Cold Feet/Toes
- ☐ Sweaty Hands
- ☐ Sweaty Feet
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Night Sweats
- ☐ Hot flashes
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Easily Perspire
- ☐ Lack of Perspiration

### Respiratory/Cardiovascular
- ☐ Shortness of Breath
- ☐ Difficulty Inhalation
- ☐ Difficulty Exhalation
- ☐ Cough
- ☐ Asthma
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Clots

### Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Food in Stool
- ☐ Number of bowel movements per day?__

### General
- ☐ Anxiety
- ☐ Depression
- ☐ Restlessness
- ☐ Fatigue
- ☐ Tension/Stress

### Neurological
- ☐ Tingling
- ☐ Numbness
- ☐ Dizziness
- ☐ Headaches
- ☐ Memory Loss
- ☐ Tremors
- ☐ Fainting
- ☐ Seizures

### EENT
- ☐ Vision Changes
- ☐ Double Vision
- ☐ Painful Vision
- ☐ Blurry Vision
- ☐ Light Sensitivity
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Ringing in the Ears
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Sinus Congestion
- ☐ Allergies
- ☐ Sore Throat
- ☐ Swollen Lymph Nodes
- ☐ Mouth Sores/Ulcers

### Musculoskeletal
- ☐ Joint Pain
- ☐ Muscle Spasms
- ☐ Muscle Twitches
- ☐ Muscle Weakness

### Skin
- ☐ Dryness
- ☐ Rash
- ☐ Eczema
- ☐ Hives
- ☐ Color Changes
- ☐ Suspicious Lesions

### Genitourinary
- ☐ Painful Urination
- ☐ Urgency
- ☐ Frequency
- ☐ Blood in Urine

### Libido
- ☐ Normal
- ☐ High
- ☐ Low

### Reproductive
**MEN -**
- ☐ Swollen Testes
- ☐ Testicular Pain
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Erectile Difficulties
- ☐ Hernia

**WOMEN -**
- ☐ Mood Swings
- ☐ Food Cravings
- ☐ Water Retention
- ☐ Breast Swelling
- ☐ Breast Tenderness
- ☐ Frequent Headaches
- ☐ Migraines
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Pain with Intercourse
- ☐ Irregular Discharge

_____ Age of first menses

_____ Average # days in flow

_____ Average # days in entire cycle

_____ # of children

_____ # pregnancies

_____ Age of menopause

**yes** **no** Regular menses cycles?

**yes** **no** Bleeding between periods?

**yes** **no** Are you pregnant?
Date of last menses?_____

**yes** **no** Birth control use?
What type?_____

**yes** **no** Hx of STIs?
What type?_____

# HIPPA Notice of Privacy Practices

Please review the following information carefully. It discusses how your medical information may be used and disclosed and how you can gain access to this information.

This HIPPA Notice of Privacy Practices explains how we may use and disclose your Protected Health Information (PHI) to carry out treatment, for payment of healthcare operations, and for other purposes that are permitted or required by law.

**Uses and Disclosures of Protected Health Information**

***Treatment:***

We may use and disclose your PHI in order to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party to whom has already obtained your permission to have access to your PHI. For example, we would disclose your PHI to another practitioner with whom you have begun treatment, if requested. This would be done in order to ensure that the practitioner has the necessary information to manage your care accordingly.

***Payment:***

Your PHI will be used as needed to obtain payment for your healthcare related services. This may include certain activities that your health insurance plan may undertake before it approves or pays for healthcare services provided.

***Healthcare Operations:***

We may use or disclose, as needed, your PHI in order to support the activities of your healthcare providers practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign-in sheet at registration desk where you will be asked to sign in and indicate your healthcare provider. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

***Required by Law:***

We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. Public health issues such as communicable diseases, legal proceeding, law enforcement, coroners, funeral directors, organ donation, criminal activity, national security, workers compensation, abuse or neglect may require the use of your PHI. You will be notified, as required by the law, of any such uses or disclosures.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. You may revoke this authorization at any time, in writing, except to the extent that your healthcare provider or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Patient or Guardian signature Date