PANACEA FAMILY HEALTH

5308 SE Rhone St, Portland OR 97206

Tel: 971-244-4694 • Fax: 971-244-9494

Name: Date of Birth: Age:

Address: City: State/Zip:

Phone Number: Home Alternate:

Occupation: Hours/week

If retired, when did you retire?

Email: SS# (billing purposes)

Emergency Contact Name: Relationship

Emergency contact Phone Numbers:

Name of and address of Person Responsible for payment of services if other than above:

How did you find our Clinic?

Are you ready and willing to make life style changes that will impact your over-all health?

Are you currently receiving medical care? From whom?

Have you ever seen a Holistic Health care provider? Who?

Welcome to Panacea Family Health Clinic. In order to provide you with the best health care and assist you with other details of our clinic we have provided the information on the following pages. We appreciate your assistance in completing the intake paper work.

**INSURANCE:** Panacea Family Health Clinic (PFH) will help you with your insurance billing. This is a service we provide for you, yet is a clinic expense. Please understand that we have a primary relationship with you, and not your insurance company. If you are planning on using your insurance coverage to pay for your services at PFH you must provide us with the **Insurance Paper Work** form. *This will allow you to understand your benefits and make the most of your insurance.* We expect that you will arrive at the clinic with all three pages complete. If you have been unable to complete the Insurance Paper Work we will kindly require you to pay for our services at your appointment. We accept credit and debit cards. For your convenience we will provide a super bill for you to turn in for reimbursement. Our office policy requires that the patient determine their personal insurance coverage. We have provided a detailed questionnaire to assist you with this task.

**CANCELLATION POLICY**: 24 hours notice is necessary for cancelled appointments. This allows space for acute and walk-in appointments. We reserve the right to bill for missed appointment.

**PHONE CALLS**:Established patients can contact the clinic or Dr. Paravicini at any time for questions and concerns. The first 10 minutes are free, for a maximum of 4 free calls a year. Other arrangements are possible depending on the family’s needs.

**SCENT POLICY**: Many individuals visiting our office are extremely sensitive to odors, chemicals and other products. Because of this, we ask that you please refrain from wearing any cologne, perfume, aftershave, deodorant, cream or any other scented products (i.e.: fabric softener/bounce) when you come to our clinic.

**WHAT TO EXPECT ON YOUR FIRST VISIT:** Naturopathic medicine takes time to search and understand the causes and reasons underlying your illness or symptoms. We do not just provide you with symptomatic relief. Because of this, please be prepared to take the time necessary for us to go over your detailed history, to review body systems, and to come up with an individualized treatment plan for you.

*If you do not understand your treatment plan or are having problems implementing the recommendations,* we encourage you to call us, so that we can help you appropriately.

**AUTHORIZATION TO RELEASE INFORMATION:** I have read and I accept this policy for my testing and/or treatment with PFH. In obtaining payment for services, I authorize my healthcare provider to furnish information from my medical records to any company that may be responsible for payment for all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim.

I have read the above information and fully understand my obligations and relationship with Panacea Family Health Clinic.

Print Name of Patient

Print Name of Signor Relationship to patient

Signature Date

Please list the concerns you have that you would like to discuss with the doctor

|  |  |  |  |
| --- | --- | --- | --- |
| Concern/Discussion  **Example** headaches | Date of Onset  June 2007 | Frequency (if applicable)  4 x per week | Severity  moderate |

3.

4.

5.

Please list how you have addressed your concerns:

1. 4.
2. 5.
3. 6.

**HOSPITALIZATIONS / SURGERIES:**

INCIDENT DATE INCIDENT DATE

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Mark All **Special Studies** You Have Had in the last five years: N=Normal, Abn=Abnormal

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | N/Ab | Date |  | N/Ab | Date |  | N/Ab | Date |
| Mammogram |  |  | Psych |  |  | MRI |  |  |
| Pap |  |  | Reading/Writing |  |  | CT Scan |  |  |
| Colon/Sigmoid |  |  | Speech/Language |  |  | X-Ray |  |  |
| Prostate |  |  | Hearing Test |  |  | Endoscopy |  |  |
| DEXA/bone |  |  |  |  |  |  |  |  |

Please bring copies of **most recent laboratory results** to your appointment.

**FAMILY GENETICS/**Family medical history: Please list if your mother (M), father (F), sister (S), brother (B), aunt (A), uncle (U), grandmother (GM) or grandfather (GF) have had/have any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Arthritis | Allergies/Hay fever | Eczema | Diabetes | Hypertension |
| Mental illness | Drug abuse | Alcohol use | History of abuse | Bleeding disorder |
| Parkinson’s | MS | Thyroid | Lyme |  |
| Cancer (please list type and age of diagnosis | | | | |

Do you come from Scandinavian, Irish, Scottish, Welsh, Japanese, Italian, Jewish, Native American, or Northern Asian ancestry which might put you at risk for genetic diseases? Circle the appropriate ancestry.

**PERSONAL MEDICAL HISTORY** (circle any history of these health issues)

**IMMUNIZATIONS** I received all the immunizations: Y / N. If not, mark those received:

MMR (Measles,Mumps Rubeola) Bacterial Meningitis Chicken pox

DTap (Tetanus, Diphteria, Pertussis) Hep B Polio

Hib (Infuenza) Flu (how often) Other:

Some people are not vaccinated or still get childhood illnesses. Circle those you had, if any: Chicken pox, Fifth disease/Hand-Foot-Mouth, Mumps, Scarlett fever, Measles, Whooping cough.

**CURRENT OR PAST DIAGNOSIS:** Circle all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies / hay fever | Diabetes | Menstrual dysfunction | Congestive heart failure |
| Asthma | Ulcer | Genito-urinary disorder disorder | Congenital heart disease |
| Shortness of breath | Gastro-intestinal | Kidney disease | Claudication |
| Fatigue | Anemia | Sexual dysfunction | Arrhythmia |
| Bronchitis/emphysema | Thyroid disease | Sex. transmitted disease | Stroke / TIA’s |
| Dizziness / fainting | Anxiety | Liver disease | Hyperlipidemia |
| Orthopnea | Mental disorder | Rheumatic fever | Heart attack |
| Gout | Depression | Lyme | Heart murmur |
| Arthritis | MS | Scarlet fever | High blood pressure |
| Cancer | Parkinson | Tuberculosis | Epilepsy / seizure |
|  |  |  |  |

**ALLERGIES:** Please list known allergies to drugs, foods, environmental exposure & your symptoms:

3.

4.

**SUPPLEMENT LOG**: List all vitamins, minerals and other nutritional supplements (bring these to first visit)

|  |  |  |  |
| --- | --- | --- | --- |
| Supplement Name | Dosage | Supplement Name | Dosage |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**MEDICATION LOG:** What medications are you taking now, including non-prescription drugs?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication Name | Date started | Dated Stopped | Dosage | # per day |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**BODY SYSTEMS CHECK** – Circle your current problems:

Sleep – Problems falling asleep / Freq. waking / Early waking / Wake un-refreshed / Sleepy / Night sweats

Head – Headaches / Migraines / Panic attacks / Scalp Issues / Hair loss

Eyes – Blurred vision / Itchiness / Spots / Dryness / Glaucoma / Photosensitivity

Ears – Hearing difficulty / Infections / Itchy ears / Sound sensitivity / Wax build up

Sinuses – Sinusitis / Congestion / Dripping / Phlegm / Allergies

Lungs/Heart/Circulation – Breathing difficulty / Infections / Palpitations / Chest pain/Angina / Arrhythmias / Blood pressure / Swelling / Edema

Digestion - Abdominal pain / Gas/flatulence / Gastric reflux / Difficulty swallowing / Nausea / Change in apetite / Change in weight / Food Cravings:

Bow How often do you pass stools? Times per day

Stools tend to be: Loose / Formed / Constipated / Alternating / Blood / Discolored stools

Muscle & Joints – Pain / Inflammation / Back/neck/shoulder aches / Lack of mobility / Muscle weakness

Nerves – Pain / Burning / Numbness / Tingling / Sensitivity

Bladder **-** Pain / Frequent night visits to toilet / Infections / Stress incontinence

Skin – Eczema / Psoriasis / Rash / Itchiness / Dryness / Spots / Athlete’s foot / Moles / Weak nails

Other:

**DENTAL HISTORY**:

Do you get regular dental care? Current no. of dental amalgams

How long since the first one was placed Total number that have been removed:

When removed? Removed (a) by a regular dentist or (b) by a holistic mercury-free dentist?

Did your mother have amalgam fillings before your birth? Yes / No Not sure

No. of gold caps root canals \_ or other dental restorations

Do you have any current dental issues?

**TOXIC ENVIRONMENTAL EXPOSURES**:

Do you smoke? Yes / No Have you been exposed to second-hand smoke? Yes/No

How much do/did you smoke? When did you quit?

Do you live or did you live near any of the following for extended periods of time? Industrial zone, Polluting factory, Nuclear plant, Power plant, Golf course, Farms, Within 300 yards of highways or major thoroughfares, Mobile phone tower, High power generator, Crematorium, Other:

To your knowledge, have you ever been exposed to any other major environmental toxins? (Circle exposures): Dry cleaning, Moth balls, Fabric softener, Paint, Candles, Solvents, Other:

**SEXUAL AND REPRODUCTIVE HEALTH:** Note: If you feel ready to be open in this area, the purpose of the following is to enable us to better assist your health.

Married Single Divorced/Separated: Number of Children/Age:

Heterosexual Homosexual Bisexual Additional comment:

**Men:** (circle what applies) Prostate problems, Sexual impotence, Lack of libido, Genital discharge, Testicular pain, Vasectomy, Herpes, Other

**Women**: No. of births: No. of miscarriages: No. of abortions:

Use/On birth control (indicate type):

Menstruation has been (circle): Regular, Irregular, Absent. Length: every \_ \_days, for

Heavy/Light – PMS:

Menopause: Started age \_ Have you used hormones? Yes / No Symptoms?

Other (circle): Ovarian Cysts, Infertility, Pregnant now, Planning pregnancy, Caesarian, Hysterectomy, Herpes, Breast lump, PCOS, Endometriosis, Abnormal mammogram, Abnormal Paps, STD

**EXERCISE** Routine & Frequency:

**ENERGY**: Rate your energy from 1-10 (1=no energy; 10 the best energy): Overall:

Morning Noon Night Between meals Just after meals

Do you use Caffeine or other stimulants? What How Much?

**SLEEP:** Sleep \_\_\_\_\_ hours/day, between the hours of:

Check if you have difficulties: Falling asleep: Staying asleep: Going back to sleep:

**MIND / EMOTIONS / SPIRITUAL** **HEALTH**: Check current feelings:

Happiness Anxiousness Anger/frustration Fear

Depression Content Poor Concentration Loneliness

Brain Fog Joyfulness Racing Mind Grief/Sadness

Worry Poor Memory Hopeless Other

**STRESS:** Rate your current overall stress level (1 = very relaxed, 10 = very stressed)

Factors most contributing to your stress: Health Work Money Family Other

What best helps you deal with your stress? \_ \_\_

Medication use & history:

Alcohol Use \_ Marijuana Use Other drugs

Are you currently seeing a counselor/who?

Do you have an active spiritual practice? \_

Do you have a support network, please describe:

**Describe Your TYPICAL DIET**: - what did you eat in the past 2-3 days

Breakfast:

Lunch:

Dinner:

Snacks:

Deserts: (how often)

Fluids (include type and amount):

List Your History of Food allergies/Sensitivities:

Or foods you find difficult to digest:

**PATIENT CONSENT FORM**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
* Obtain Payment form third party payers
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Panacea Family Health Clinic of its Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Panacea Family health Clinic to obtain a current copy of this notice.

I understand that I may request in writing that PFH restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand PFH Clinic is not required to agree to my requested restrictions, but if PFH Clinic does agree then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that PFH Clinic has taken action relying on this consent.

Check all that apply to this consent:

□ Please do not phone me at home. Use this alternate phone number: \_ \_

□ Please do not phone me at work. Use this alternate phone number: \_

□ Please do not leave messages on my answering machine.

□ Please do not contact me by e-mail.

□ Please send me mail, including my bills, to this alternate address: \_ \_

□ Other request: (please describe)

Patient Name Signature Date