Seattle Naturopathic and Acupuncture Center

Dr. Diane Lee, ND, L.Ac

Health History Questionnaire

By completely filling out this form, you will help us help you. All answers will be *absolutely confidential*.
If you have any questions, please don't hesitate to ask. Thank you!

Name: ____ Today's Date: _____________ DOB: __________________

Age: __________ Sex: M / F Primary phone: Cell / Home / Work _____________________________________

Address: ____

City: ____ State: _______________ Zip: _______________________

Email address: __________________________________ Occupation: ____

Parents' names *(if patient is a minor)*: _________________________________ _________________________________

Who referred you to our clinic? ____

Name(s) of other healthcare provider(s)

Medical: ____ Naturopathic: ____

Chiropractic: ____ Other: ____

Primary Health Concerns

Why are you coming to our clinic today?

When did your problem(s) begin? Be specific.

Patient Medical History

Please circle and date.

Allergies (drugs, chemicals, foods)	High blood pressure	Seizures
Cancer	Hepatitis	Significant trauma *(auto accidents, falls, etc.)*
Diabetes	Rheumatic Fever	Venereal Diseases
Heart Disease	Surgeries	Other major illness(es)

Family Medical History

Please indicate family member, and if on (F)ather or (M)other's side of family.

Allergies	Cancer	High blood pressure	Seizures
Asthma	Diabetes	Heart Disease	Stroke

Occupational stress
(chemical, physical, psychological)

Describe your weekly exercise

Current medicines
List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.

Known allergies

Diet

Are you or have you ever been on a restricted diet? Y / N
If so, what kind?

Please describe your average daily diet.
Morning:

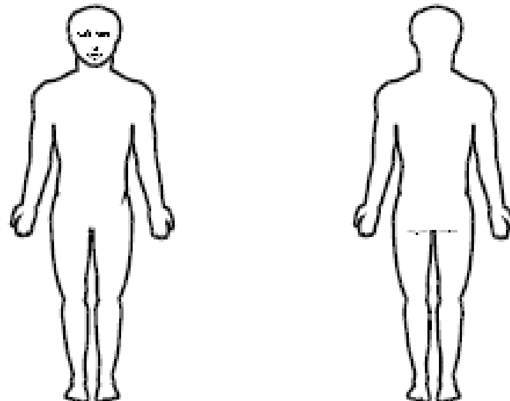
Afternoon:

Evening:

How many packs of cigarettes do you smoke each week?

How many servings of the following do you drink per week? Coffee ______ Soda ______ Tea ______ Alcohol ______

Please indicate painful or distressed areas on the diagram to the right.



Please check if the following symptoms are a current or recurring problem.

General

Poor appetite	Night sweats	Weight gain
Poor sleep	Sweat easily	Weight loss
Fatigue	Change in appetite	Chills
Cravings	Bleed or bruise easily	Fevers
Sudden energy drop (if so, when?)	Strong thirst	Peculiar tastes or smells

Other?

Skin and Hair

Rashes	Change in hair or skin texture	Recent moles
Itching	Loss of hair	Ulcerations
Eczema	Dandruff	Pimples

Other hair or skin problems?

Head, Eyes, Ears, Nose, and Throat

Using glasses	Earaches	Sinus problems
Color blindness	Poor hearing	Nose bleeds
Night blindness	Ringing in ears	Headaches
Eye strain	Mercury tooth fillings	Concussions
Eye pain	Tooth pain	Jaw clicks or pain
Blurry vision	Recurrent sore throats	Facial pain
Cataracts	Sores on lips or tongue	Neck pain

Other?

Cardiovascular

High blood pressure	Fainting	Cold hands or feet
Low blood pressure	Chest pain	Swelling of hands
Irregular heartbeat	Varicose veins	Swelling of feet
Dizziness	Blood clots	Other

Respiratory Asthma

Difficulty breathing	Bronchitis	Coughing blood
Cough	Pneumonia	Pain with deep breathing
Production of phlegm (if so, what color?)		Other

Gastrointestinal

Indigestion	Abdominal pain or cramps	Rectal pain
Gas	Nausea	Hemorrhoids
Bad breath	Vomiting	Blood in stool
Constipation	Chronic laxative use	Diarrhea

Other?

Genito-Urinary

Frequent urination	Unable to hold urine	Kidney stones
Urgency to urinate	Decrease in flow	Impotency
Pain upon urination	Distinctive or odd color urine	Sores on genitals
Blood in urine	Waking to urinate	Other

Gynecology and Pregnancy

Unusual menses	Irregular periods	Clots
Heavy	Painful periods	Vaginal sores
Light	Breast tenderness	Vaginal discharge

Changes in body or emotions prior to menstruation:

Do you practice birth control? Y / N
If yes, what type and for how long?

___________ Number of pregnancies
___________ Number of births
___________ Number of miscarriages
___________ Number of abortions

___________ Age of first menses
___________ Duration of menses
___________ Days between menses
___________ Start date of last menses
___________ Date of last PAP exam

Musculoskeletal

Neck pain	Back pain	Shoulder pain
Knee pain	Foot/ankle pain	Hip pain
Hand/wrist pain	Muscle pain	Muscle weakness
Other joint or bone problems:		

Neuro-psychological

Loss of balance	Depression	Concussion
Quick temper/irritability	Susceptible to stress	Seizures
Poor memory	Dizziness	Areas of numbness
Anxiety	Lack of coordination	Other

Have you ever been treated for emotional problems? Y / N

Have you ever considered or attempted suicide? Y / N

Any other neurological or psychological problems? Y / N

Please describe any other problems you would like to discuss:

CONTEXT OF CARE

1. Why did you choose to come to this clinic?
2. What <u>three</u> expectations do you have for <u>this visit</u> to our clinic?
3. What long-term expectations do you have for working with this clinic?
4. What expectations do you have for me personally as your physician?
5. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please rate 1-10, 10 being 100% committed)
6. What behaviors or lifestyle habits do you currently engage in regularly that believe <u>support</u> your health? (Please list.)
7. What behaviors or lifestyle habits do you currently engage in regularly that you believe <u>are detrimental</u> to your health? (Please list.)
8. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?
9. Who do you know who will sincerely and consistently support you with the beneficial lifestyle changes you will be making?
10. What do you LOVE to do?

Dr. Diane Lee, ND
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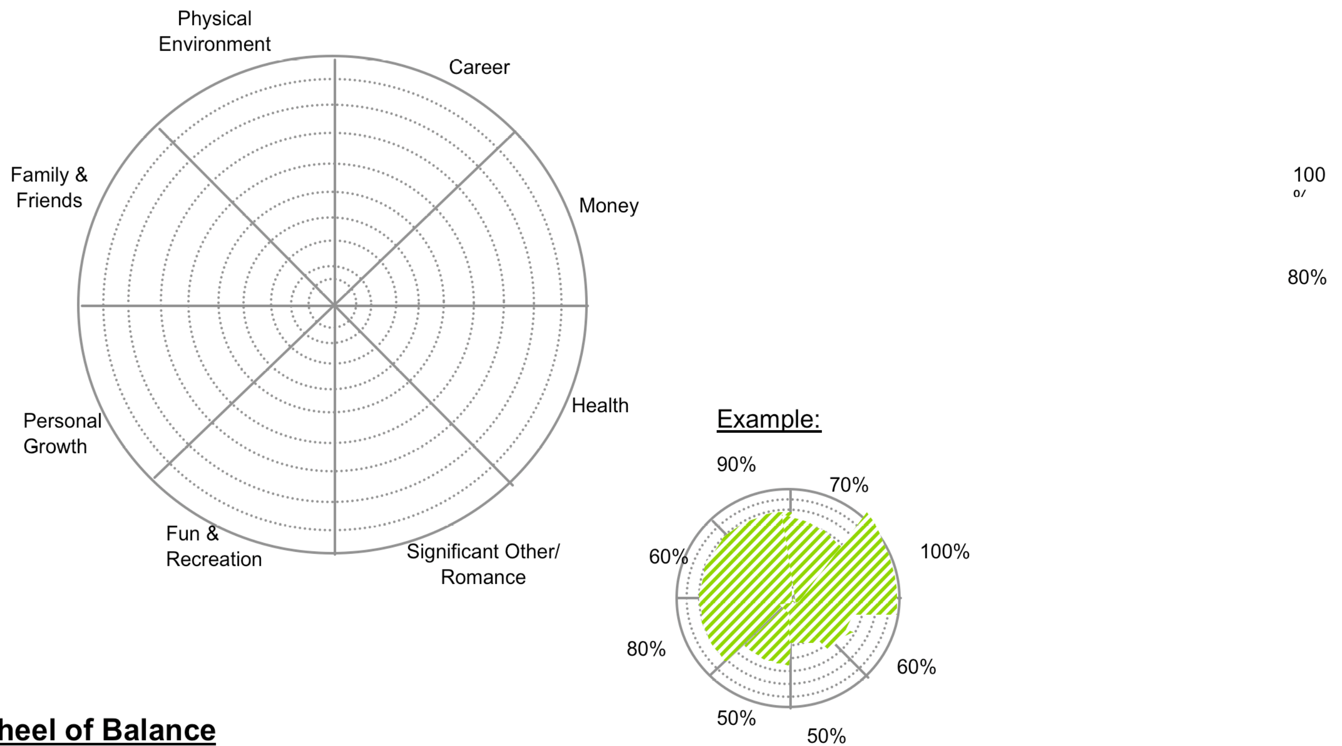
Wheel of Balance



Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

CONSENT FOR TREATMENT

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to discontinue participation in these procedures at any time with written notice. Knowing this, I voluntarily consent to the below procedures, realizing that no guarantees have been given to me by Dr. Diane Lee. Further, I will hold Dr. Lee harmless and will not ask for indemnity for any of the side effects that may be caused. I hereby acknowledge that I will be held financially responsible for services rendered.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record with written request and that obtaining a copy of my records may require a fee.

I hereby authorize Dr. Diane Lee to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **General Diagnostic Procedures** including, but not limited to, venipuncture, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments
- **Psychological Counseling, Lifestyle Counseling, Exercise Prescriptions**
- **Herbs/Natural Medicines** – prescribing of various therapeutic substances, including plants, minerals, and animal materials. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
- **Dietary Advice and Therapeutic Nutrition** – use of foods, diet plans, or nutritional supplements for treatment, which may include intramuscular vitamin injections
- **Soft Tissue and Osseous Manipulation** – use of massage, neuro-muscular techniques, muscle energy stretching, or visceral manipulation, as well as manipulations of the extremities and spine, including traction and craniosacral therapy
- **Thermal Therapies** including the use of cupping, moxa, and hydrotherapies
- **Acupuncture** including the insertion of sterilized needles at specific points on the body
- **Cupping –** a technique using glass cups on the surface of the skin with a heat-created vacuum

Potential risks: While not common, the following can occur: Pain, discomfort, blistering, discoloration, infection, burns, loss of consciousness; deep tissue injury from needles insertions, topical procedures, heat, or frictional therapies; electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; aggravation of pre-existing symptoms

Potential benefits: Restoration of health and the body's maximal functional capacity; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to pregnancy.

I understand that the Washington State Law does not authorize naturopaths to treat me for any cancer or malignancy and that I am required to be under the care of a medical doctor or osteopathic physician while receiving care at Seattle Naturopathic and Acupuncture Center.

I recognize that Dr. Diane Lee and the staff at Seattle Naturopathic and Acupuncture Center have my safety and well-being in mind and that they expect to have respectful conversation with me and expect the same in return.

TELEMEDICINE WAIVER

I hereby authorize Dr. Diane Lee to perform diagnosis, consultation, treatment, education, care management, and self-management via information and communication technologies including interactive audio, video, and transfer of medical data. The same laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand the information disclosed by me during my treatment is confidential.

I understand that I will not be seeing her in an office setting and that she will not be my primary care provider. I must maintain a primary care provider for physical examinations and other diagnostic and screening procedures. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment in recommending the treatments that they feel at the time, based on the facts known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Lee:

- my suspected diagnosis or condition
- the nature, purpose, and potential benefit of the proposed care
- the inherent risks, complications, potential hazards, or side effects o the treatment or procedure
- the probability or likelihood of success
- reasonable available alternative to the proposed treatment/procedure
- the possible consequences if treatment or advice is not following and/or nothing has been done

By signing this consent, **I agree to proceed with a telemedicine visit and certify I am physically in the state of Washington**. If I will not be in the state at the time of my appointment, it is my responsibility as the patient to reschedule the appointment to when I am back.

I consent to having my payment information on file as payment is required at time of service. I understand that my card will be charged the total amount for all services rendered including but not limited to telemedicine, lab work, herbs, and other such services. I am aware that I can provide written notice if I would like to refrain from keeping my payment information on file but will still be held financially responsible for any services rendered.

FINANCIAL AGREEMENT

I understand that Dr. Diane Lee is contracted with many insurance companies and if she is ***in network*** with my health plan, I am expected to pay any cost shares at the time of service. If the provider is ***out of network*** with my health plan, I am responsible for the full cost of care at the time of service. In addition, I agree to pay for services rendered by my provider, supplements and remedies, laboratory tests, or other costs or fees that are not covered by my insurance plan. Health insurance is a contract between me and my insurance company. Should I not go through insurance or do not have insurance, I am aware that I can request a Good Faith Estimate.

I understand that any amounts quoted at the time of service are not a guarantee of coverage nor is it indicative of the entire amount they may be owed by me. Should my health plan deny coverage for any services, I am responsible for calling my health plan regarding any errors.

I am aware that Dr. Diane Lee is a dual licensed ***Naturopathic Doctor (N.D.)*** and ***Acupuncturist (L.Ac.)*** and that my insurance will be billed under the respective license based on the services rendered. I understand that some services will require both licenses be billed and may require two separate copays or cost shares from me. For example, if my needs fall under the scope of Naturopathic care during my Acupuncture appointment, two separate cost shares may be owed by me. Should any billing issues arise, it is my responsibility to call my health plan.

I understand that there are some services that might be considered experimental by my insurance plan and therefore get denied. If this is the case, I know that I will be held responsible for the full cost at the time of service.

PATIENT CANCELLATION AND NO-SHOW POLICY

I recognize that Dr. Diane Lee's time is valuable and for her to provide me with high-quality care, it is important to keep my scheduled appointment with her. I am aware that I can ask to be set up for appointment reminders either via text and/or email but it is still my responsibility to keep record of my appointments and arrive on time. If I need to cancel, I will contact the office **at least 48 hours in advance**. I am aware that any late cancellations/no-shows will be recorded in my chart and multiple offenses can affect my ability to make appointments.

If I arrive more than 10 minutes late, it is up to the discretion of the provider whether I am still able to be seen.

I understand that should I cancel late or do not show up, the following policy will be applied.

- **After One (1) late cancel/no show, I will be given a warning**
- **After Two (2) late cancel/no show, I will be charged $60 for a late cancellation and $100 for a no show.**
- **For any further late cancels/no show, my ability to see the provider may be terminated**

In the case of an emergency where I am not able to notify the office, I understand that each situation will be discussed when it happens and is up to the judgement of the provider and office staff.

NOTICE OF PRIVACY PRACTICES

I understand that I have access to a copy of the Privacy Practices at any time. I am aware that a detailed description of the Privacy Practices of this clinic is ready for my viewing at www.seattlenaturopahticcenter.com and that a physical copy is available upon request. I consent to the use of my personal health information for the purposes of treatment, payment, and clinic healthcare operations. If I am under 18 years of age, I understand that a parent or legal guardian/representative will need to sign for me. If I have any questions or concerns regarding the management of my healthcare information or would like to schedule an appointment, I will contact Seattle Naturopathic and Acupuncture Center staff.

By signing this form, I acknowledge I have reviewed the above Consent for In-Person and/or Telemedicine Treatment, Financial Agreement, Cancellation and No-Show Policy. Furthermore, I acknowledge that I have access to the Notice of Privacy Practice (available at www.seattlenaturopathiccenter.com or a physical copy upon request).

_________________________________ _________________________________ _______________________

Patient's Name (Print) Patient's Signature Date

_________________________________ _________________________________ _______________________

Legal Guardian/Representative (Print) Legal Guardian/Representative Signature Date

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Relationship/Representative's Agency

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, have insurance coverage with __________________ and assign directly to Seattle Naturopathic and Acupuncture Center all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Seattle Naturopathic and Acupuncture Center to release all information necessary to secure the payment benefits. I give permission to the Seattle Naturopathic and Acupuncture Center to release information to my other health care providers. I authorize the use of this signature on all my insurance submissions.

PERSONAL HEALTH INFORMATION DISCLOSURE

I would like to receive a reminder for future appointments via:

(Please Initial) ____Text ____Email ____Opt out of reminder

It is okay to leave a detailed voice message on the phone number I have provided on my intake paperwork.

(Please initial) ______Yes ______No

Please list any individual(s) with whom we may disclose information concerning your private health information:

Name: _____________________________________ Relationship to Patient: ________________

You have granted Seattle Naturopathic and Acupuncture Center permission to disclose your private health information to those listed above. This information includes and is not limited to information regarding appointments, current diagnoses, treatment plan, and financial matters.

By signing this form, I acknowledge I have reviewed the above Assignment of Insurance Benefits and Personal Health Information Disclosure Policies.

_____________________________ _____________________________ ____________________

Patient's Name (Print) Patient's Signature Date

_____________________________ _____________________________ ____________________

Legal Guardian/Representative (Print) Legal Guardian/Representative Signature Date

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Relationship/Representative's Agency