ORIGINS
NATURAL HEALTH
& MIDWIFERY

PATIENT REGISTRATION FORM

Today's Date

PATIENT INFORMATION

Name:	Date of Birth:	Age:
Gender: ☐ M ☐ F	Marital Status:	
Address:	Phone (hm):	
City/State/Zip:	Phone (cell):	
Email:	May we leave messages at these numbers? ☐H ☐C	

Preferred method of communication: ☐Email ☐ Home phone ☐ Cell phone

Emergency Contact: Phone:

Their relationship to you:

For Minors Only: Name of Mother: Name of Father:

HOW DID YOU HEAR ABOUT US?

☐Family/Friend ☐ Insurance ☐Physician Referral

☐Internet: Specify ☐Other:

BILLING FORMATION

Is patient covered by insurance? ☐Yes ☐No	If No, Name of Person Responsible for Bill:
Primary Insurance: (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)	*Address and Phone Number of Responsible Party (if different from above)

Subscriber's Name Employer: Occupation: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

Secondary Insurance: Subscriber's Name Employer: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

☐ By checking this box, I am verifying that the above is true to the best of my knowledge.

Date: _____

119 Cedar Avenue | Snohomish, WA 98290
P: (360) 863-3223 | F: (888) 875-1198 | www.originsnaturalhealthandmidwifery.com

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119 Cedar Ave, Snohomish, WA 98290 *Phone: 360-863-3223* *Fax: 888-875-1198*

Consent for Treatment

I, the undersigned, hereby authorize the physicians listed above to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures, which may include but is not limited to venipuncture, PAP smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, immunization, psychological counseling, and balancing of work and social activities.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.

Herbs/Medicines: prescribing various therapeutic substances including plants, minerals, animal materials, and some pharmaceuticals, and non-drug contraceptive devices. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms.

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.

Homeopathic Remedies: use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Minor office procedures: Dressing wounds, ear cleansing, care of superficial lacerations.

Electromagnetic and Thermal Therapies: The use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, infrared and ultraviolet therapies, and hydrotherapy.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Discomfort, pain, minor bruising, infection, blistering, loss of consciousness or deep tissue injury from, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, temporary discoloration of the skin, temporary dizziness and lightheadedness, and aggravation of pre-existing symptoms.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution, 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 the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself or my representative or if it is required or permitted by applicable law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of her ability.

_____	_____
Patient's Name (Print)	Guardian's Name (Print)
_____	_____
Patient's Signature	Guardian's Signature
_____	_____ _____
Date	Relationship to Patient Date

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Acknowledgement of Receipt:

Financial Policy

The following outlines our financial policy. Please review carefully and sign/date it.

- Payment is due at time of service. The provider may arrange this differently under certain circumstances. Acceptable forms of payment include cash, check, Visa, & MasterCard. Insurance is also accepted. Payment for services are paid to the appropriate billing provider (not CAIM).
- Patients who pay out of pocket for their visit will ONLY be given a 20% discount if they pay at time of service.
- Nutritional supplements must be paid for at the time of purchase, regardless of insurance.
- Please give us 24 hours' notice if you can't make your appointment. Failure to give 24 hours advance notice for appointment cancellations may result in a fee. Patients will now be billed **$50.00 for appointments that are cancelled with less than 24 hours' notice**. Special circumstances may waive this fee. The front desk will now remind patients of this policy when they call for appointment reminder.
- Patients may be responsible for charges incurred by using the practitioner's pager, cell phone, or text service outside of normal business hours (Monday-Friday: 9am-6pm). This fee will be $40 per page, cell phone call, or text. We encourage all patients to call the front desk with immediate concerns during normal business hours.
- Patients are responsible for all bank charges and fees resulting from a returned check.
- Accounts more than 60 days overdue will incur financing charges of 1% per month on any outstanding balance.
- There may be an associated form fee at physician's discretion of $25. Forms include but aren't limited to letters of medical necessity.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance as a courtesy for which we are contracted providers, as long as you provide us with your current and correct information.

I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize my provider or my insurance company to release any information required to process my claims. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I also acknowledge that certain services may not be covered by my benefit plan, or deemed medically unnecessary, and agree to pay for any Non-Covered Service, such as phone or email consultations and outside labs. This authorization shall remain valid until revoked by me in writing.

Payment Issues: If financial problems arise, please contact our office ASAP. Installment or payment arrangements can be implemented. Balance will become due immediately if you break rules of the plan.

I have carefully read the Financial Policy. I understand and agree to the terms therein.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Print Patient Name Date of Birth

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Acknowledgement of Receipt:

Notice of Privacy Practices:

- I have been offered a copy of the Notice of Privacy Practices for the Practitioner that I am seeing. For future reference, I may access a copy at the front desk or on the website.

_____ _____
Signature of Patient or Responsible Party Date

Acknowledgement of Confidentiality:

- **Voicemail (please check one circle)**:

I hereby give permission for Origins Natural Health to leave the following on my voicemail:

- o Detailed medical information
- o Limited medical information (please specify with your provider)
- o Billing and appointment information

_____ _____
Signature of Patient or Guardian Date

- **Email (please check one circle)**:

I hereby give permission for Origins Natural Health to leave the following on my email:

- o Detailed medical information
- o Limited medical information (please specify with your provider)
- o Billing and appointment information

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Patient Name Date of Birth

HEALTH HISTORY QUESTIONNAIRE *For Women*

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	**Date**	**DOB**
PRIMARY CARE PHYSICIAN:	**Physician Phone #**:	
OTHER HEALTHCARE PRACTITIONERS: Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.:		
Name:	**Type of practice:**	**Phone number:**

Date of last physical exam:	**Date of last pap exam:**	**Date of last fasting blood labs:**

Please list your current health concerns in order of their importance to you

Concern:	Date of onset:
1.	
2.	
3.	
4.	
5.	

Previous medical diagnoses

Diagnosis:	Diagnosed by:	Date of diagnosis:
1.		
2.		
3.		
4.		
5.		

Traumas, Car Accidents, Injuries:

Surgeries and Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ..... ☐ Yes ☐ No

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MEDICATIONS

PRESCRIPTION & OTC MEDICATIONS	SUPPLEMENTS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

ALLERGIES

Drug Allergies	Reaction
1.	
2.	
3.	
Food Allergies	**Reaction**
1.	
2.	
3.	
Environmental Allergies	**Reaction**
1.	
2.	
3.	

CHILDHOOD MEDICAL HISTORY

Prenatal history: Any complications during your mother's pregnancy with you? ☐Yes ☐No
If so, describe:

Birth History: ☐Vaginal ☐Cesarean Section ☐Forceps/Vacuum ☐Other, describe:
Newborn problems: ☐Jaundice ☐Hospitalization ☐Other, describe:

Childhood Illnesses: How often did you get sick as a child? ☐Often ☐Not often
What kind of illnesses did you usually experience? (i.e. ear infections, sore throat, cough, allergies, asthma…)
How often did you take antibiotics? ☐Often ☐Not often
Other medications taken regularly as a child?

List Any Other Medical Problems You Had As A Child:

Home Environment as a child:

# of Siblings: Birth order: What adults lived with you?

Was your home safe? Did you have any traumas or losses as a child?

Did you grow up in the: ☐City ☐Suburbs ☐Rural area Exposure to smoke or use drugs regularly? ☐Yes ☐No

SOCIAL AND LIFESTYLE FACTORS

HABITS	Yes	No	Details
Current tobacco use	☐	☐	Packs per day:
Past tobacco use	☐	☐	Packs per day: When did you quit?
Alcohol consumption	☐	☐	Per day? Per week? Types:
Are you concerned about the amount you drink?			☐ No ☐ Yes
Have you ever had a problem with drinking in the past?			☐ No ☐ Yes
Recreational drug use	☐	☐	Types:
Ever been treated for drug/alcohol abuse?	☐	☐	When?
Seat belt use	☐	☐	
Caffeine use	☐	☐	Cups per day? Types:
Regular exercise?	☐	☐	How much? What type?

SOCIAL	Yes	No	
Happy with your relationship?	☐	☐	Length?
What is your predominant emotion?			
Do you feel well-supported socially?			
Are you religious or spiritual? Explain:			
Have you ever been emotionally, sexuually, or physically abused?			☐ Yes ☐ No
Do you have concerns about abuse/violence in your life right now?			☐ Yes ☐ No

HOME	Yes	No	
Is your home a sanctuary?	☐	☐	
Who lives with you?			
Do you have any pets?	☐	☐	What type and how many?
Does your home have lead paint?	☐	☐	
Is your home moldy/damp?	☐	☐	
Is your home safe?	☐	☐	
Is their a gun in your home?	☐	☐	If yes, is it locked away or kept safe?

OCCUPATION	Yes	No	
Type of work?			
How many hours per week?			How many days per week?
Do you take vacations?	☐	☐	
Do you enjoy your work?	☐	☐	

STRESS

Stress level: ☐ Low ☐ Medium ☐ High

Stress source: ☐ Money ☐ Job ☐ Family/Relationship ☐ Other:

What do you do to relieve stress?

SLEEP	Yes	No	
Problems falling asleep?	☐	☐	
Problems staying asleep?	☐	☐	
Do you wake up refreshed?	☐	☐	
How many hours of sleep do you normally get per night?			

SEXUAL AND REPRODUCTIVE HEALTH

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Menstrual History

Age of first period? _____

First day of your most recent period? _____

How long is your cycle, month to month? _____

Is your cycle length regular?..... ☐Yes ☐No

How many days do you bleed? _____

PMS? ..... ☐Yes ☐No

Describe:

Gynecologic Conditions

check if you have had any of the following

☐Recurrent Yeast Infection ☐Uterine fibroid
☐Recurrent Bacterial vaginosis ☐Ovarian Cyst
☐Itching, odor, discharge ☐Breast lump
☐PCOS ☐Fibrocystic breasts
☐Endometriosis ☐Nipple discharge
☐None of these ☐Pain with intercourse

Sexual History

Are you currently sexually active? ☐Yes ☐No With: ☐Men ☐Women ☐Both

Have you been sexually active with: ☐Men ☐Women ☐Both ☐Neither
☐Bisexual Men ☐Bisexual women ☐Prostitutes ☐IV drug users

Are you satisfied with your sex life? ☐Yes ☐No Do you practice safer sex? ☐Yes ☐No

Do you have need for birth control? ☐Yes ☐No Number of sexual partners this year:

STDs: ☐HIV ☐Herpes ☐HPV/Warts ☐Gonorrhea ☐Chlamydia ☐Syphilis ☐Hepatitis ☐Trichimonas

Contraceptive/Safe-sex practice History: *What birth control methods/safe-sex practices have you used? (Fertility awareness, condoms, sponge, cap, diaphragm, IUD, oral contraceptives, norplant, Depo-provera…)*

Type:	How long?	Any problems?	Current use?

Pregnancy History:

Date	Outcome (vaginal delivery, caesarean, miscarriage, abortion, etc)	Did you breastfeed?	How long?
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	

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FAMILY HEALTH HISTORY

Are you adopted? ..... ☐Yes ☐No

Mother:	☐Living ☐Deceased	Cause:	Age:
Father:	☐Living ☐Deceased	Cause:	Age:
Siblings:	Number living:	Number deceased:	Causes/Ages:
Children	Number living:	Number deceased:	Causes/Ages:

Has any family member (or you) been diagnosed with:	**YES**	**NO**	**Who? At what age?**	**Details**
Asthma	☐	☐		
Emphysema	☐	☐		
Severe allergies	☐	☐		
Thyroid problems	☐	☐		
Stroke	☐	☐		
Heart disease	☐	☐		
Heart attack	☐	☐		
Blood clots in lungs or legs	☐	☐		
High blood pressure	☐	☐		
High cholesterol	☐	☐		
Ulcers	☐	☐		
Kidney disease	☐	☐		
Gallbladder disease	☐	☐		
Osteoporosis	☐	☐		
Liver disease	☐	☐		
Colitis/Crohn's/Celiac	☐	☐		
HIV/AIDs	☐	☐		
Anemia	☐	☐		
Blood disorder	☐	☐		
Diabetes	☐	☐		
Alcohol or drug problems	☐	☐		
Eating disorders	☐	☐		
Cancer	☐	☐		
Mental illness/depression	☐	☐		
Alzheimer's disease	☐	☐		
Other:	☐	☐		

REVIEW OF SYSTEMS			
(Please check if you have had problems with the following)			
Now	**Past**	**Condition**	**Notes**
		1. General	
☐	☐	Weight loss/gain (circle)	
☐	☐	Poor memory/Brain fog	
☐	☐	Fatigue	Energy level (1 – 10)?
☐	☐	Decreased libido	
☐	☐	Too hot/cold (circle)	
☐	☐	Excessive sweating/Night sweats	
☐	☐	Frequent colds/flus	
		2. Skin	
☐	☐	Dryness	
☐	☐	Rashes/Itching/Eczema	
☐	☐	Hair or nail changes	
☐	☐	Easy bruising	
☐	☐	Acne	
		3. Head/Neck	
☐	☐	Headache/Migraines	
☐	☐	Ringing in ears	
☐	☐	Poor hearing	
☐	☐	Earaches	
☐	☐	Tooth/Gum problems	Number of mercury fillings?
☐	☐	Hoarseness	
☐	☐	Sore throat	
☐	☐	Poor vision	When was your last eye exam?
☐	☐	Light sensitivity	
☐	☐	Blurred/Double vision	
☐	☐	Dry eyes	
☐	☐	Poor night vision	
		4. Lungs	
☐	☐	Difficulty breathing	
☐	☐	Persistent cough	
☐	☐	Wheezing	
		5. Cardiovascular	
☐	☐	Heart palpitations	
☐	☐	Chest pain	
☐	☐	Irregular heartbeat	
☐	☐	Swelling in hands or feet	

Now	Past	Condition	Notes
		6. Gastrointestinal	
☐	☐	Change in appetite	
☐	☐	Nausea/Vomiting	
☐	☐	Abdominal pain	
☐	☐	Difficulty swallowing	
☐	☐	Indigestion/Reflux	
☐	☐	Gas/Bloating	
☐	☐	Constipation	
☐	☐	Diarrhea	
☐	☐	Blood/Mucus in stool	
		7. Genitourinary	
☐	☐	Pain with urination	
☐	☐	Urgency/Frequency	
☐	☐	Bladder incontinence	
☐	☐	Excessive thirst	
		8. Musculoskeletal	
☐	☐	Muscle pain	Where?
☐	☐	Joint pain	Where?
		9. Neurological	
☐	☐	Dizziness/Vertigo/Fainting	
☐	☐	Problems with speech/coordination	
☐	☐	Paralysis/Numbness	
☐	☐	Tremors	
		10. Psychological	
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Mood changes	

AND LAST OF ALL

Is there anything else I should know?

Thank you for taking the time to fill out this questionnaire. I look forward to working with you.

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