LONDON**HEALTH**CENTER *2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 FAX (360) 384-2955*

Thank you for selecting London Health Center. To help us meet your health care needs please fill out this form completely in ink. If you have any questions or need assistance, we will be happy to help you.

Personal Information

Legal Name: _____

Wishes to be called: _____

Date: _____

Date of birth: _____

☐ Married ☐ Significant Other ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Address: _____

City, State, Zip: _____

Employer: _____ Occupation: _____

Referred by: _____ E-mail : _____

Contact Information:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ *Message Okay*? Yes No

In case of emergency, who should we contact? Name: _____

Relationship _____ Work # _____ Home # _____

Insurance Information *We will make a photocopy of your insurance card*

Primary Insurance _____ **Subscriber's Name** _____ **DOB** _____

Secondary Insurance _____ **Subscriber's Name** _____ **DOB** _____

First Choice or Great West insurance only: Subscriber's Social Security # _____

Authorization and Release

I hereby authorize the direct payment of medical benefits to London Health Center for services rendered. I understand that I am financially responsible for any balance not covered by my insurance, **including pager charges**. I hereby authorize London Health Center, Inc. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I understand that charts will be shared if I am seeing more than one provider at London Health Center and information may be discussed between providers in this clinic.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

X _____

Signature of patient or parent if minor Date

A photocopy or scanned copy of these assignments shall be as valid as the original.

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Health Questionnaire

Please fill out both sides of this form

Name:_____ Date of Birth: _____

REASON FOR VISIT: _____

GOALS FOR TODAY: _____

HAVE YOU EVER CONSULTED A NATUROPATHIC PHYSICIAN BEFORE? ☐ Yes ☐ No

FAMILY HISTORY

ADOPTED? ☐ YES ☐ NO If yes, please fill out information for biological relatives if known.

IF ANY IMMEDIATE FAMILY HAS HAD ANY OF THE FOLLOWING - PLEASE CIRCLE THE # AND INDICATE RELATIVE

1) ALCOHOLISM	7) CANCER (SPECIFY)	13) HEART DISEASE	
2) ALZHEIMER'S	8) CHOLESTEROL HIGH	14) HYPERTENSION	
3) ANEMIA	9) DIABETES	15) MENTAL ILLNESS	
4) ARTHRITIS	10) EPILEPSY	16) MIGRAINE	
5) ASTHMA	11) GLAUCOMA	17) OSTEOPOROSIS	
6) BLEEDS EASILY	12) HAYFEVER	18) THYROID	
OTHER:			

FATHER	Living? ☐ YES ☐ NO	Present health or cause of death:		
MOTHER	Living? ☐ YES ☐ NO	Present health or cause of death:		
SPOUSE	Living? ☐ YES ☐ NO	Present health or cause of death:		
BROTHERS	# Alive	Health:	# Deceased:	Cause of death:
SISTERS	# Alive:	Health:	# Deceased:	Cause of death:
CHILDREN	# Alive:	Health:	# Deceased:	Cause of death:

HOSPITAL ADMISSIONS (Not including pregnancies)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

HEALTH HABITS AND OCCUPATIONAL HAZARDS

HEALTH HABITS: Check (√) which substances you use/have used and describe how much you use.	Do you eat organic foods?	Are you sensitive to:	OCCUPATIONAL: Does your work exposes you to the following:
☐ Drugs_____Year quit:_____ ☐ Tobacco_____Year quit:_____ ☐ Alcohol_____ ☐ Caffeine_____ ☐ Soft drinks	☐ Always ☐ Often ☐ Sometimes ☐ Never	☐ Sugar ☐ Caffeine ☐ Chemicals ☐ Perfumes ☐ Medicines	☐ Stress ☐ Heavy Lifting ☐ Hazardous Substances ☐ Other: Occupation:_____
What foods (if any) do you exclude from your diet?			
Additional Comments:			

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MEDICATIONS

MEDICATIONS	DOSAGES	MEDICATIONS	DOSAGES
VITAMINS & SUPPLEMENTS	DOSAGES	VITAMINS & SUPPLEMENTS	DOSAGES

ALLERGIES TO MEDICATIONS please list medication and your reaction to that medication

☐ No Known Allergies

MEDICAL HISTORY Mark C for current problems and P for past problems

Check (√) symptoms you currently have or have had in the past six months.

GENERAL
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes/halos/other

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sores that will not heal

MEN ONLY
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal vague bleeding
- ☐ Breast lump or pain
- ☐ Breast discharge
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Menstrual flow irregular
- ☐ Miscarriages - #_____

Last Pap Smear_____
☐ Normal ☐ Abnormal

First day of last menstrual period_____

Last Mammogram_____
☐ Normal ☐ Abnormal

Check (√) conditions you have or have had in the past:

☐ AIDS	☐ Cataracts	☐ Heart Disease	☐ Measles	☐ Prostate Problem
☐ Appendicitis	☐ Chemical Dependency	☐ Hepatitis	☐ Migraine Headaches	☐ Rheumatic Fever
☐ Arthritis	☐ Chicken Pox	☐ Herpes	☐ Multiple Sclerosis	☐ Scarlet Fever
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Mumps	☐ Stroke
☐ Bleeding Disorder	☐ Emphysema	☐ HIV Positive	☐ Pacemaker	☐ Thyroid problems
☐ Breast Lump	☐ Epilepsy	☐ Kidney disease	☐ Pneumonia	☐ Tuberculosis
☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Polio	☐ Ulcers

Additional Comments:

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

X_____

Signature of patient or parent if minor Date