Holly Christy, ND, LAc

Element 7

PATIENT REGISTRATION

Please fill out completely

First Name: MI: Last:

Street Address: E-mail:

City: State: Zip:

SSN: Gender: ( )M ( )F Home ph: ( )

Employer: Work ph: ( )

Date of Birth: - - Age: Alt ph: ( )

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependant ( )Partnered ( )Other

Responsible Party: Phone: ( )

Address: City, ST, ZIP:

In emergency contact: Phone: ( )

Referred By:

PRIMARY INSURANCE

Insurance Company Name: Phone: ( )

Claims Address: City, ST, ZIP:

Subscriber's Name: Date of Birth: - - SSN:

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

Subscribers Address: City, ST, ZIP:

I.D. # **as shown on card**: Group #:

Employer of insured: Phone: ( )

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? ( )Y ( )N Work related? ( )Y ( )N Auto accident? ( )Y ( )N State:______

Insurance Company Name: Phone: ( )

Claims Address: City, ST, ZIP:

Subscriber's Name: Date of Birth: - - SSN:

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

Subscribers Address: City, ST, ZIP:

I.D./ Claim # **as shown on card**: Policy #:

Employer if applicable: Effective / Injury Date: - -

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assesed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Eagle Harbor Healing Arts accepts most insurance carriers. It's always a good idea to call your insurance carrier to make sure you are covered for naturopathic medicine and acupuncture prior to your first visit. If your plan requires you to pay a copay, most insurance companies require one copay for each service. For example, if you receive both naturopathic medicine and acupuncture services, you will have to pay 2 copays. This is required by the insurance companies, and we are not legally allowed to waive the second copay. If you wish only to receive one service, please specify that while scheduling your appointment.

Signature Date

Health History

Name (first, middle. Last):	
Main concern or reason(s) for seeing doctor:	
Medications (dose and frequency):	Supplements (herbs, vitamins, homeopathics):

Past History

Major Illnesses (please give names and dates):	Previous hospitalizations, surgeries, traumas:

Well Being

Goals for Health:
What practices or activities do you use to sustain your health and well being? (religious, spiritual, what inspires you?)
Who do you turn to for support?
What causes stress for you?
Who lives in your home?
Allergies?

Your Health Care Team

Primary Care Provider (Contact Information):	Preferred Pharmacy (Contact Information):
Additional Providers (massage, chiropractic, etc.):	Do you have a living will or advanced directives?

Health History Continued

Family History

	Present Health or Cause of Death		Present Health or Cause of Death
Father		Brothers	
Mother		Sisters	
Spouse		Children	

Check (✓) the illnesses that have occurred in your immediate family:

- ☐ High blood pressure ☐ Cancer ☐ Bleeding tendency ☐ Depression ☐ Tuberculosis
- ☐ Heart disease ☐ Stroke ☐ Kidney disease ☐ Allergies ☐ Diabetes
- ☐ Substance Abuse ☐ Headaches ☐ Asthma ☐ Other:

____

Certification

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I , or my minor child, ever have a change in health.

____

Print Patient Name

____ ______________________

Signature (Patient or Guardian) Date

REVIEW OF SYSTEMS

Name:	Date of Birth:
	Date:
Place a check in each box next to any symptoms you have experienced within the last 6 months.	
Constitutional Symptoms: ☐Weight Change ☐Fever/Chills ☐Weakness ☐Fatigue ☐Sweats/Night Sweats	
Eyes: Last eye exam ___________________________ ☐ Vision/Glasses ☐ Blurring ☐ Pain ☐ Discharge	
Ears, Nose, Mouth, Throat: ☐ Tinnitus ☐ Diminished Hearing ☐ Postnasal Drip ☐ Bleeding ☐ Obstruction ☐ Mouth Sores ☐Teeth ☐Hoarseness ☐ Taste	
Cardiovascular: ☐ Palpitations ☐ Chest Pain ☐ Shortness of breath ☐ Edema (ankle swelling) ☐ High Blood Pressure ☐ Leg pain while walking	
Respiratory: ☐ Difficulty Breathing ☐ Wheezing ☐ Cough ☐ Sputum ☐ Smoker: How much___________ How long __________ Brand ____________	
Gastrointestinal: ☐ Appetite ☐ Pain ☐ Indigestion ☐ Jaundice ☐ Hernia ☐ Blood in Stool (black or red in stool) ☐ Hemorrhoids ☐ Food Avoidance ☐ Gall Bladder problem ☐Constipation ☐Anal Discomfort ☐Painful Swallowing ☐Nausea/Vomiting/ Diarrhea	
Genitourinary: ☐Painful urination ☐Up at night to urinate ☐Blood in urine ☐Frequency ☐Urgency ☐Incontinence	
Musculoskeletal: ☐ Trauma ☐ Swelling ☐ Pain/arthritis	
Integumentary – (Skin and/or breast): ☐Itching ☐Rashes ☐Breast Masses ☐ Breast Pain ☐Nipple Discharge ☐ Hair/Nail changes	
Neurological: ☐ Fainting ☐ Convulsions ☐ Speech problem ☐ Weakness ☐ Numbness/Tingling ☐ Gait/Coordination problem ☐ Headaches/Migraines	
Psychiatric: ☐ Memory Loss ☐ Mood problem ☐ Irregular sleep ☐ Anxiety ☐ Depression ☐ Phobia ☐ Drug/Alcohol Abuse	
Endocrine: ☐ Goiter ☐ Tremor ☐ Hormone Therapy ☐ Heat/Cold Intolerance ☐ Blood sugar imbalance ☐ Diabetes ☐ Hypothyroidism	
Hematologic/Lymphatic: ☐ Anemia ☐ Bleeding Tendency ☐ Transfusion ☐ Lymphadenopathy	
Sexual History: Sexually Active ☐Yes ☐No ☐ Syphilis ☐ Gonorrhea ☐ Sores/Discharge ☐ Chlamydia ☐ Herpes ☐ Pain w/ intercourse ☐ Prostate problem ☐ Testicular Pain / Swelling ☐ Erectile Dysfunction	
Female Reproductive Hx: ☐ Last Menstrual Period______________ Cycle length (day 1 of period to day 1 the following month) ________________ Menses length _________________ ☐ Spotting ☐ Irregularity ☐ Dysmenorrhea (cramps) ☐ Menopausal symptoms G P SAB TOP	
Allergies: ☐ Sensitivity to drugs/vaccines ☐ Asthma ☐ Eczema ☐ Hives ☐ Hay Fever ☐ Food Sensitivities_________________________________	

	Screening Exams/Labs	Last Done:
Habits: ☐ Seatbelt/Helmet use ☐# of alcoholic drinks per week___________	**Screening Exams/Labs**	**Last Done:**
Diet: Detailed description of your diet (e.g. breakfast, lunch, dinner, snacks)	**Physical exam:**	
	Gynecological Exam:	
	Self Breast Exam/Mammogram:	
	Dental exam:	
	Bone Density (DEXA):	
	Colorectal screening (Colonoscopy):	
Water intake (how much per day):	**Stress ECG:**	
Other beverages :	**Labs: Glucose:** **Lipids:** **PSA:** **Other:**	
Exercise (how much and how often):		

Informed Consent For Treatment

I, the undersigned hereby authorize ELEMENT 7 WELLNESS, to perform the following specific procedures necessary to facilitate my diagnosis and treatment. Medical treatments and procedures not within license of scope practice will be referred out to an appropriate provider.

Common Diagnostic Procedures: e.g., venipuncture, pap smears, laboratory, diagnostic imaging.
Minor Office Procedures: e.g. dressing wound, ear cleaning.
Botanical Medicine: botanical substances may be prescribed as teas, granulations, alcohol-based tinctures, capsules, tablets, creams, plaster poultices, compresses or suppositories.
Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle Counseling and Hygiene: nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
Psychological Counseling
Contraception Counseling: oral birth control pills, IUDs, diaphragms, etc.
Acupuncture: insertion of special sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
Cupping: a technique to relieve symptoms with cups made of glass, to put on the skin with a vacuum created by heat.
Moxa: an indirect warming technique on an acupuncture point using an herbal stick of moxa to relieve symptoms.
Tuina: an ancient massage used to treat a wide variety of common disharmonies.
Legend substances: pharmaceutical agents approved for prescription by naturopathic physicians.
Intravenous nutrition/chelation: introduction of vitamins, minerals and/or chelating agents for the promotion of detoxification and/or general health.

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

Potential risks: discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of the skin, an aggravation of symptoms existing prior to treatment, allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from needle insertion, injections, venipuncture or other procedures.

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

With this knowledge, I voluntarily consent to the above procedures, realizing that ELEMENT 7 WELLNESS has given no guarantees to me, regarding cure or improvement of my condition. I hereby release ELEMENT 7 WELLNESS, from any and all liability, which may occur in connection with the above-mentioned procedures except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. Any cancellation must be within 24 hours prior to the scheduled appointment to avoid charges for the visit.

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 my representative or myself, or unless required by law. I understand that I may look at my medical records and request a copy of it by paying the appropriate fee. I understand that my practitioner will answer any questions I have.

____ ______________________
Signature of Patient or Guardian Date

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Print Name of Patient