Welcome to Natural Health Works!

We would like to take this opportunity to welcome you to our clinic and thank you for trusting our team with your healthcare. We look forward to providing you with personalized, comprehensive care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our providers and office staff work closely together to provide you with excellent care.

It is our mission to provide you with compassionate and personalized care in the path toward helping you feel better. Our providers take the time to listen and thoroughly understand your health concerns in order to provide you with the best, most individualized treatment plan. In order to provide this level of care, our office visits are typically an hour long for the initial intake.

At Natural Health Works, we offer a variety of services which include: Naturopathic Medicine and Primary care, Regenerative Medicine (Stem Cell/PRP), and Acupuncture. Our providers are also skilled in providing conventional and specialty laboratory evaluations and assessments, nutritional IV therapy, manual therapies, spinal manipulation, and referrals for excellent care coordination. In addition, we offer a comprehensive medicinary stocked with professional nutritional and herbal supplements, hand prepared botanical tinctures, and homeopathic remedies.

Your completed intake paperwork helps our providers get to know you and your medical history. We know this is a lengthy form but we rely on its accuracy and completeness to provide you with the best possible care and a successful first visit. If you have any questions about our clinic or with completing the forms please contact us at info@naturalhw.com or by phone at (503) 722-7776.

Wishing you the best,

The Natural Health Works Team

Demographics

HOW DID YOU HEAR ABOUT US?

We're so glad you're here, thank you for trusting us with the care of your health and wellness.

☐ Friend/Family Member ☐ Healthcare Provider ☐ Email
☐ Newspaper ☐ Facebook ☐ Other: _____

PERSONAL INFORMATION

_____/___/___
First Name Last Name M.I. Gender DOB

*If Patient is a Minor, Name of Responsible Party: _____/___/___
DOB

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Relationship ☐ Other

_____
Address City State Zip

(_____)_____(_____)_____
Mobile Phone Home Phone Email Address

Preferred Method of Contact: ☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Disabled ☐ N/A

_____(_____)_____
Employer Work Phone Number

_____(_____)_____
Emergency Contact Person Relationship Phone Number

_____(_____)_____
Primary Care Physician Phone Number

Is your visit related to a Motor Vehicle Accident? ☐ Yes ☐ No
Is your visit related to a Worker's Compensation? ☐ Yes ☐ No

Medical History

_____/___/___

First Name Last Name DOB

What is the purpose of your visit? _____

What is your primary goal for treatment? _____

Please describe your symptoms. _____

_____

Are your symptoms getting worse, staying the same, or coming and going? _____

_____

Is there anything that makes the symptoms worse? _____

Is there anything that makes the symptoms better? _____

Are there any other concerns you have that need to be addressed? _____

_____

_____

Have you had any diagnostic studies in the past 12 months? Please check all that apply.

☐ EKG ☐ CT Scan ☐ X-Ray ☐ MRI ☐ Mammogram

☐ EEG ☐ Colonoscopy ☐ DEXA Bone Scan ☐ Other: _____

Please list all medications and supplements you are currently taking. _____

_____

_____

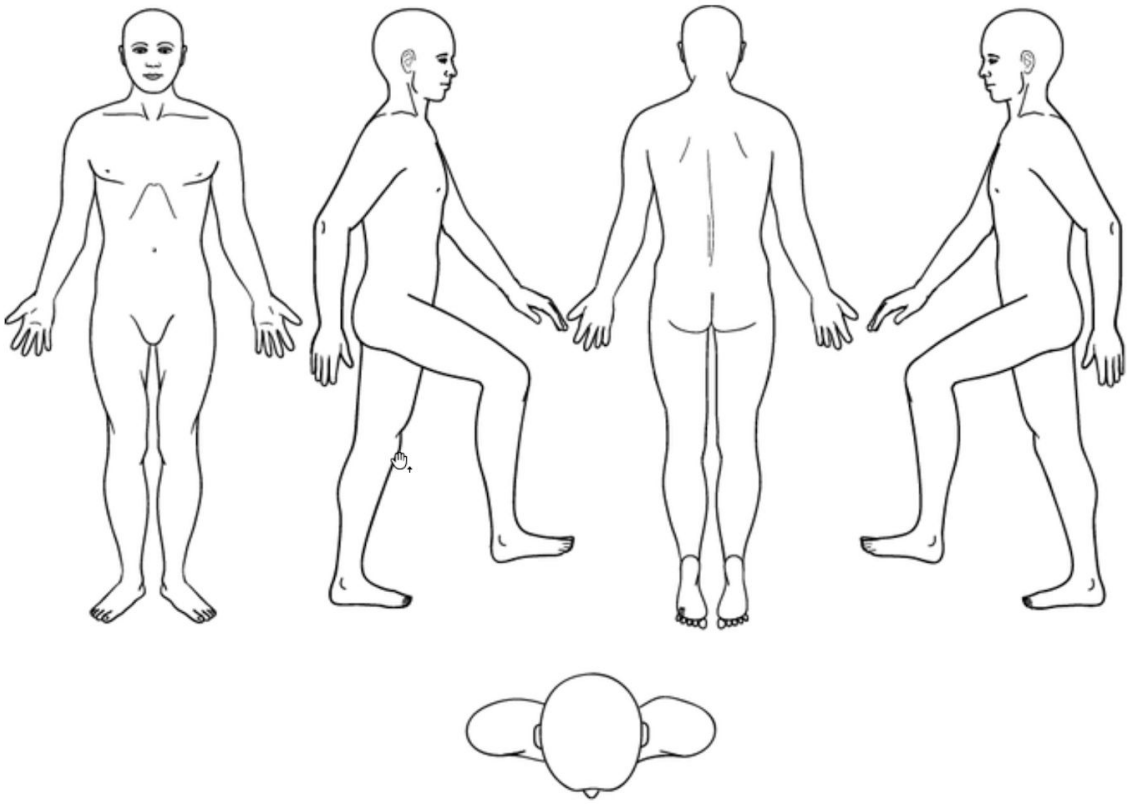
_____

_____

Please rate your pain on a scale from 1 - 10 (10 being the worst possible): _____

Please mark the location of the pain on the diagram below to indicate where on your body you feel:

xxx Pain *** Stabbing /// Numbness or Tingling
ooo Aching +++ Burning ^^^ Surgeries



Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, approximate dates: _____

Hospitalization/Surgeries:

Year	Hospital	Reason for Hospitalization and Outcome

Family History:

	Age	State of Health	Age of Death	Cause of Death
Mother				
Father				

Review of Systems: Mark any that have occurred in the LAST MONTH

General:
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Sleep loss
- ☐ Weight loss
- ☐ Weight gain
- ☐ Excessive tiredness
- ☐ Excessive thirst
- ☐ Nervousness
- ☐ Sweats

Respiratory:
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep apnea

Gastrointestinal:
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Stomach pain
- ☐ Vomiting

Head/Eyes/Ears/Nose/Throat:
- ☐ Sinus pain
- ☐ Change in vision
- ☐ Blurred vision
- ☐ Bleeding gums
- ☐ Allergies (seasonal)
- ☐ Ear pain
- ☐ Hoarseness
- ☐ Ear or Nasal discharge
- ☐ Difficulty swallowing
- ☐ Sore throat
- ☐ Nasal congestion
- ☐ Hearing loss
- ☐ Tooth pain

Genito-urinary:
- ☐ Blood in urine
- ☐ Lack of bladder control
- ☐ Frequent urination
- ☐ Painful urination

Skin:
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ New/changes in moles

Mental Health:
- ☐ Sense of hopelessness
- ☐ Difficulty organizing thought
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Changes in behavior
- ☐ Difficulty sleeping
- ☐ Difficulty concentrating

Cardiac:
- ☐ Chest Pain
- ☐ Abnormal Heart Rhythm
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Fainting

Men Only:
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Penile discharge
- ☐ Sore on penis
- ☐ Lump in testicles

Women Only:
- ☐ New breast lump(s)
- ☐ Breast Implant(s)
- ☐ Frequent yeast infections
- ☐ Vaginal dryness
- ☐ Breast discharge
- ☐ No menstrual bleeding
- ☐ Post menstrual
- ☐ Breast pain
- ☐ Pelvis Pain

Last Pap Smear: _____

Last menstrual period:_____

Length of last period: _____

Days between cycles: _____

Regular cycle? Yes No

Age of first period: _____

# of Pregnancies: _____

# of Deliveries: _____

SOCIAL HISTORY

Tobacco Use: ____Never used tobacco ____Former Smoker ____Current Smoker ____Other

If you chose "Other," please specify. _____

Did you have a drink containing alcohol in the past year? ____Yes ____No ____Active in AA

If you answered yes to the question above:
How often did you have a drink containing alcohol?

____Monthly or less ____2-4 times per month ____2-3 times a week ____4 or more times a week

How many drinks did you have on a typical day that you were drinking?

____1-2 drinks ____3-4 drinks ____5-6 drinks ____7-9 drinks ____more than 10 drinks

Have you ever used illegal drugs? ____Never ____Formerly ____Currently ____Active in NA

LIFESTYLE HISTORY

Do you feel you eat a healthy diet on a daily basis? ____Yes ____No

Do you follow a specific dietary lifestyle?
____Vegan ____Vegetarian ____Paleo ____Keto ____South Beach ____Mediterranean

____Atkins ____Intermittent Fasting ____No Specific Dietary Approach ____Other: _____

Have you ever had an eating disorder? ____Yes ____No

How much water do you consume daily? ____less than 64 ounces ____ more than 64 ounces

Do you consume less than 5 servings of fruits and vegetables per day? ____Yes ____No

Do you exercise? ____Yes ____No

If so, how many days per week? ____1-2 ____3-4 ____5-7

If so, how long do you spend exercising per session? ____15-30 min ____30-60 min ____>60 min

Are you tired or fatigued? ____Yes ____No

If so, for how long? _____

On a scale of 1-10, what is your daily energy level (10 being very energetic): _____

How many hours of sleep do you average each night? ____<5 ____6 ____7 ____8 ____>8

Do you have a lot of stress in your life currently? ____Yes ____No

On a scale of 1-10, what is your typical daily stress level (10 being very stressed): _____

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Natural Health Works and any associates, assistants, and other health care providers it may deem necessary, to treat my condition.I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Natural Health Works to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Natural Health Works' Notice of Privacy Practices, which is displayed for public inspection at its facility. This Notice describes how my protected health information may be used and disclosed.

I authorize Natural Health Works to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Natural Health Works to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Natural Health Works will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility.

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked.

I have read and understand the information above and accept the terms of this agreement.

_____

Print Name

_____ _____

Signature of Patient or Responsible Person Date

Authorization to Release Medical Records to Natural Health Works

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize _____
(Name, address & phone number of hospital/health care provider)

to release a copy of the medical information for:

Name:_____ D.O.B._____
(Patient Name)

To: Natural Health Works, 710 John Adams ST, Oregon City, OR 97045

Fax # 503-723-0789

The information will be used on my behalf for the following purpose(s):_____

_____.

By initialing the spaces below, I specifically authorize the release of the following medical records*, if such records exist:

___All hospital records (including nursing records and progress notes)

___Transcribed hospital reports

___Medical records needed for continuity of care

___Most recent five year history

___Emergency and urgent care records

___Diagnostic imaging reports

___Clinician office chart notes

___Dental records

___Laboratory reports

___Pathology reports

___Billing statements

___Other:_____

__Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

*The following items must be initialed to be included in other documents.

___*HIV/AIDS related records

___*Mental health information

___*Generic testing information

___*Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:_____

___This authorization is limited to records regarding the following treatment:_____

___This authorization is limited to records from the following time period:_____

___This authorization is limited to a worker's compensation claim for injuries of:_____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____

(Date) (Signature of Patient)

_____ _____

(Date) (Signature of person authorized by law)

Notice of Privacy Practices
(Medical)

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any given form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** - means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payments** - means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** - include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of September 20, 2010 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The US Department of Health and Human Services
Office of Civil Rights
200 SW Independence Avenue
Washington, DC 20201
(202) 619-0257 or toll free: 1-877-696-6775

Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Natural Health Works' health care operations. The Notice of Privacy Practices also describes my rights and Natural Health Works' duties with respect to my protected health information. The Notice of Privacy Practices is available from your healthcare provider.

Natural Health Works reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____	_____
Print Name	Signature of Patient or Responsible Person	Date

Permission for Verbal Communications

_____/___/___

Print Name of Patient DOB

I permit Natural Health Works, their physicians, nurses, and other personnel to discuss health information, in person or by telephone, with the following people or organizations involved in my medical care.

This authorization is limited to discussions regarding the following medical condition:

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care)

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Release of information under this document is limited to verbal discussions with my health care providers. This document does not permit the release of any written health information to the individuals named above with the exception given to other health care providers needing information for continuation of care.

This authorization is valid for 1 year from signing or until: _____

I understand that I may revoke this permission at any time but I must notify Natural Health Works, who I wish to remove from the list and the date they need to be removed. This may be done in writing.

_____ _____

Signature of Patient or Responsible Person Date

Authorization for Patient Communication

I authorize Natural Health Works' staff to leave private detailed or confidential health information messages on my voicemail.

(_____)_____
Mobile Phone

(_____)_____
Home Phone

I authorize protected health information to be sent to my email*

_____
Email

*Please note: email communications are not encrypted and while efforts are made to ensure privacy, confidentiality cannot be guaranteed and patients are responsible for securing their part of the communication. The originating email address should not be used to send medical information or questions.

_____
Print Name

_____
Signature of Patient or Responsible Person

_____
Date

Please sign below if you would like to receive appointment reminders, monthly newsletters including updates about new services, treatment options and/or events at Natural Health Works.

_____
Signature of Patient

Financial Policy

Patient Responsibility

Patients are responsible for all charges resulting from treatment provided by Natural Health Works, PC. Payment for provided treatment is collected at the completion of your appointment.

There is a $25 return check fee.

Cancellation and Rescheduling Fees

We understand that life happens! If you need to cancel or reschedule your office visit, you must notify us as soon as possible, at least with 24 hours notice. If sufficient notice is not made, there is a $25 cancellation/rescheduling fee.

If you need to cancel/reschedule your procedure you must notify us with at least 2 business days. There will be a $50 cancellation/rescheduling fee for insufficient notice for procedures (PRP, Prolotherapy, Ozone, IV Therapy).

No Show Fees

You may be charged up to $50 for not showing for your scheduled procedure and $25 for not showing to your office visit. If you have a recurring pattern of no shows and/or late cancellations, you may be terminated as a patient with Natural Health Works, PC.

Past Due and Collection Accounts

We reserve the right to send accounts with balances that have been outstanding for over 90 days from the date of service to a collection agency. If you have a balance on your account for more than 90 days old, you will be referred to Solverity, to make payment arrangements. If any portion of your past due amount has been assigned to a collection agency, we will request that you pay one-half of that collection balance before your appointment is scheduled with our office.

If you have any questions or concerns, please do not hesitate to contact our billing office at 503-722-7776 between the hours of 9:00 a.m. - 4:00 p.m. Monday through Thursday.

The patient's signature (or signature of the patient's parent/legal guardian) acknowledges that you agree and understand the above information.

I have read the above Financial Policy and accept the terms of this agreement.

_____	_____	_____
Print Name	Signature of Patient or Responsible Person	Date