Welcome

Thank you for trusting Nature Cures Clinic with your health care. We take our commitment to you very seriously, and we look forward to working with you to enhance your health and well-being, both now and in the future.

We value your time, and realize that office visits may be an interruption in an otherwise very busy schedule for you. For this reason, we've taken steps to assure that your time in the clinic is as focused and efficient as it can be. Please note the following:

1) Enclosed you will find an extensive **New Patient Intake Form**; this form is our first introduction to you and your history. Your detailed and thoughtful responses will help us to use our time in the clinic more effectively.

2) If a **New Patient appointment is missed without 24 hours** notice we will ask that upon making a second New Patient appointment that you **provide us with a payment of $100 prior to your appointment**, which will be credited to your account and will be applied to your first visit. If you miss that second New Patient appointment without 24 hours notice, the $100 will be applied to a New Patient missed appointment fee.

3) If you have health insurance, Nature Cures Clinic will gladly assist with insurance billing. You must provide your insurance information **at the beginning of your scheduled visit.** Please bring your insurance card and the *How do I Check My Insurance Benefits* form (**filled out completely**) that was provided to you prior to your appointment, to the office with you at the time of your visit. **Please see the statement below regarding our Payment Policy.**

We look forward to seeing you in our clinic. Our goal is always to provide you with health care that exceeds your expectations.

Sincerely,

Nature Cures Clinic

Required Benefits Form for All Patients Using Insurance

Patient Name___________________________ Insurance ID#______________________

Nature Cures Clinic is happy to bill your insurance for your visit; however, **it is the patient's responsibility** to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-9 when calling to find out benefits and eligibility.

First***, Call the number*** on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions. Online benefits and insurance handbooks will not give the same information as a live representative.

1. When did my *coverage begin and when is it valid thru*?
Beginning Date of Coverage_________ Ending Date of Coverage____________

Does my insurance plan follow a **Fiscal** or **Calenda**r year schedule? ___________

2. Do I need *a referral from my primary care physician* (PCP) for alternative services?
___Yes ___No

3. Is the doctor I want to see (Dr. Greg Nigh, Dr. Greg Eckel, Dr. Rose Paisley, Dr. Erika Siegel, Dr. Hilary Costello, Dr. Arthur/Andy Swanson) ***In-Network*** *or* ***a preferred provider*** with my insurance?
___Yes ___No

4. What are my ***benefits*** for the following services? ******Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.*

<u>Specialties/Procedures:</u>

Naturopathic: % Covered_______ ;Co-pay/ Co-Insurance______; Year Max_____

Acupuncture: % Covered_______ ;Co-pay/ Co-Insurance______; Year Max______

Physical Therapy: % Covered_____; Co-pay/ Co-Insurance_____; Year Max_____

Chiropractic: % Covered_______ ;Co-pay/ Co-Insurance______; Year Max _____

Labs/Imaging % Covered_______ when billed to an In-Network Lab.

B12Injections: (CPT- 96372) Amount or % Covered______

5. Is there a Co-pay per **visit** or per **specialty**? Please circle which one.

6. What is my ***deductible for the year*** and has any or all of it been met?

Deductible $_______ Amount of Deductible met so far $________ Date____

Are any of the specialties listed above **subject to this deductible**? **____Yes ____No**

If so, **which specialties**? ____

8. Is My **Annual Gynecological Exam Covered by a Naturopathic Physician? ______**
If so, what is the coverage?____

9. What was the ***name of the representative*** I spoke with**________________ Date_____**

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!
*Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.

Consent Form

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent To Treatment

Naturopathic, chiropractic, and Chinese medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

____

Print Name Signature of Patient Date

Agreement to Payment Policy of Nature Cures Clinic

By signing below, I understand that full payment for all services and products I receive from Nature Cures Clinic and its practitioners is required at the time of service, except that portion billed to my insurance company. Further, I understand that Nature Cures Clinic may submit my bill to my insurance carrier, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.

____ Signature of Patient

Consent Regarding Use of Information – Please initial if you consent to the statement below, or leave blank if you do not consent.

______ Some physicians at Nature Cures Clinic use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow Nature Cures Clinic and its physicians to correspond with you via email in spite of these potential risks.

______ Nature Cures Clinic is engaging in research into the efficacy of the therapies used by physicians practicing here. To gather sufficient data it is necessary to collect information about conditions treated, therapies used and outcomes observed from patient charts. In this process, no information that could be used to specifically identify individuals is ever used; only general demographic information is attached to the clinical data. By initialing this line, you are consenting to allow Nature Cures Clinic to include this anonymous data from your chart to conduct research to be published in the appropriate medical literature.

______ Some physicians at Nature Cures Clinic have an interest in writing about alternative medicine and health care for the general public, either as fiction or nonfiction. By initializing this line, you are consenting to allow your medical history and care in our clinic to be used as an example or case history in such writing, with the understanding that all identifying information would be altered.

Consent for Purposes of Treatment, Payment and Healthcare Operations for Patients of Nature Cures Clinic, LLC.

I consent to the use or disclosure of my protected health information by Nature Cures Clinic, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Nature Cures Clinic, LLC. I understand that diagnosis or treatment of me by my physician(s) at Nature Cures Clinic, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Nature Cures Clinic, LLC is not required to agree to the restrictions that I may request. However, if Nature Cures Clinic, LLC agrees to a restriction that I request, the restriction is binding on Nature Cures Clinic, LLC and my physician(s) at Nature Cures Clinic, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Nature Cures Clinic, LLC or Nature Cures Clinic, LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Nature Cures Clinic, LLC uses Quality Medical Billing Service as its insurance billing service; I understand this and do hereby give my consent to have my insurance information processed by this company.

I understand I have a right to review Nature Cures Clinic, LLC's Notice of Privacy Practices prior to signing this document. The Nature Cures Clinic, LLC 's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Nature Cures Clinic, LLC. This Notice of Privacy Practices also describes my rights and Nature Cures Clinic, LLC's duties with respect to my protected health information.

Nature Cures Clinic, LLC 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.

____ ____________________

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative’s Authority

Nature Cures Clinic Policies

Name:_____________________________

Please read carefully and initial by each policy. If you do not initial all policies we will be unable to treat you.

____ Cancellations and Missed Appointments

If you are unable to make your scheduled appointment, please call the clinic at least 24 hours in advance of your scheduled time. You will be charged a $50 missed appointment fee if you miss a scheduled appointment or fail to cancel at least 24 hours in advance. If you miss your first appointment without giving 24 hours notice, you will be asked to put down a deposit of $100 to reschedule; this deposit will apply towards your first visit.

____ Product Returns

We are unable to give refunds or credits on any supplements, opened or unopened. We cannot re-sell supplements that have left the office; we cannot guarantee that these items were protected from conditions that might affect their quality or integrity.

____ Payment Agreement

If you are not billing insurance then you are responsible for your balance at the time of your visit. You will receive the time of service (TOS) discount on these visits.

In addition, all supplements, labs (except for Quest Labs), and uninsured procedures (explained by your doctor) require payment at the time of service.

If you would like us to bill your insurance, then you are responsible for your co-pay or co-insurance at the time of service. If your insurance has a deductible, you must pay the full amount at the time of service until the deductible is met. We will bill towards this deductible if you wish, or you may choose to receive the time of service discount and submit the claims yourself (we will provide the necessary forms).

Your insurance might pay only a portion of the charge for your treatment; you are responsible to pay for any balance on your account. We will bill you for the remainder once we have received the payment and explanation of benefits from your insurance.

____ Insurance Agreement

If you would like us to bill your insurance then you are responsible for determining the extent of your coverage prior to your first appointment. Nature Cures provides a "How to check your benefits" form, which guides patients through calling their insurance company to determine their coverage. This form must be filled out completely. Our clinic is happy to assist with this if you are unable to determine benefits on your own; however, you must call the clinic at least 24 hours prior to your appointment in order for us to help you. **If you do not check your benefits, we will not bill your insurance**.

____ Cell Phones

Nature Cures Clinic is a Cell Phone Free Zone. Please silence your cell phones and step outside the clinic door to place or take any calls. Thank you for your cooperation.

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Dear New Patient:

a. Please **read** and **fill in** all of the information that pertains to you.

b. On pages 2 through 11, under each category, **check all** symptoms that you experience either *acutely or chronically*. Use the column on the left side of the page. The columns to the right of the page will be used by your physician at re-exam.

c. **Add** and **total** all of the boxes you checked.

d. **Date** today's day.

	TEST	DATE	TEST RESULTS
☐	Physical	_______	______________________________
☐	Cholesterol	_______	______________________________
☐	Prostate	_______	______________________________
☐	Mammography	_______	______________________________
☐	Pap Smear	_______	______________________________
☐	Blood (which test?)	_______	______________________________
☐	HIV/STD	_______	______________________________
☐	Other	_______	______________________________

Please indicate if you have (or have been tested for) any of the following:			
☐ Diabetes	☐ Allergies	☐ Rheumatic Fever	☐ Vein Condition
☐ Heart Disease	☐ CVA (stroke)	☐ Thyroid Disorder	☐ Tuberculosis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Chicken Pox
☐ High Blood Pressure	☐ Gonnorhea	☐ Bleeding Tendency	☐ Polio
☐ Syphilis	☐ Measles	☐ Nervous Disorder	☐ Migraines
☐ Meningitis	☐ HIV	☐ Monoucleosis	☐ Other Liver Illnesses
☐ Epilepsy	☐ High Fever	☐ Multiple Sclerosis	☐ Other Heart Illnesses
☐ Paralysis	☐ Cancer	☐ Jaundice	☐ Other Kidney Illnesses
☐ Glaucoma	☐ Mumps	☐ Hepatitis	☐ Other Lung Illnesses

IMMUNIZATIONS?

____

____

____

____

SURGERIES?

____

____

____

____

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

1. Pain:

On the figures below, please mark clearly any areas of pain and indicate any scars.

	What makes the pain better?
☐	Soft Preassure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Rest
☐	Other

	What makes the pain worse?
☐	Soft Pressure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Other

R

L

2. Describe your pain:

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other:______________________

☐ ***Total Boxes Checked:***

Date:____________

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐ Total	☐ Total	☐ Total	☐ Total	☐ Total	☐ Total
Date:______	Date:______	Date:______	Date:______	Date:______	Date:______

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

3. *Kidney Function:*
(Overall Temperature)

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Cold Hands	☐	☐	☐	☐	☐	☐
☐ Cold Fingers	☐	☐	☐	☐	☐	☐
☐ Cold Toes	☐	☐	☐	☐	☐	☐
☐ Cold Feet	☐	☐	☐	☐	☐	☐
☐ Sweaty Hands	☐	☐	☐	☐	☐	☐
☐ Sweaty Feet	☐	☐	☐	☐	☐	☐
☐ Hot Body Temperature Sensation	☐	☐	☐	☐	☐	☐
☐ Cold Body Temperature Sensation	☐	☐	☐	☐	☐	☐
☐ Afternoon Flushes	☐	☐	☐	☐	☐	☐
☐ Night Sweats	☐	☐	☐	☐	☐	☐
☐ Heat in the hands, feet & chest	☐	☐	☐	☐	☐	☐
☐ Hot flashes any time of the day	☐	☐	☐	☐	☐	☐
☐ Thirsty	☐	☐	☐	☐	☐	☐
☐ Perspire easily	☐	☐	☐	☐	☐	☐
☐ Lack of perspiration	☐	☐	☐	☐	☐	☐
☐ Do you take water to bed	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**

4. *Lung, Kidney Function:*
(Overall Energy)

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Shortness of Breath	☐	☐	☐	☐	☐	☐
☐ Difficulty keeping eyes open (daytime)	☐	☐	☐	☐	☐	☐
☐ General Weakness	☐	☐	☐	☐	☐	☐
☐ Easily catch colds	☐	☐	☐	☐	☐	☐
☐ Low Energy	☐	☐	☐	☐	☐	☐
☐ Feel worse after exercise	☐	☐	☐	☐	☐	☐
☐ Chronic (daily) fatigue & malaise	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**

Nature Cures Clinic *~ 1020 SW taylor St. Suite 330 ~ Portland, OR 97205 ~ 503-287-4970*

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Date:____________

5. Liver, Spleen, Heart Function:

Date:______	Date:______	Date:______	Date:______	Date:______	Date:______

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

- ☐ Dizziness
- ☐ See floating black spots

☐ ***Total Boxes Checked:***
Date:____________

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐ Total	☐ Total	☐ Total	☐ Total	☐ Total	☐ Total
Date:______	Date:______	Date:______	Date:______	Date:______	Date:______

6. Heart Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Coffee? How much per week?_______

☐ ***Total Boxes Checked:***
Date:____________

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐ Total	☐ Total	☐ Total	☐ Total	☐ Total	☐ Total
Date:______	Date:______	Date:______	Date:______	Date:______	Date:______

7. Spleen Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

- ☐ Low Appetite
- ☐ Abrupt Weight Gain
- ☐ Abrupt Weight Loss
- ☐ Abdominal Bloating
- ☐ Abdominal Gas

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

spleen function continued next page...

7. Spleen Function, continued…

	Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	Gurgling noise in Stomach	☐	☐	☐	☐	☐	☐
☐	Fatigue after eating	☐	☐	☐	☐	☐	☐
☐	Prolapsed Organs? Which?_________	☐	☐	☐	☐	☐	☐
☐	Bruise easily?	☐	☐	☐	☐	☐	☐
☐	Over-Thinking	☐	☐	☐	☐	☐	☐
☐	Worry	☐	☐	☐	☐	☐	☐
☐	***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
	Date:____________	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**

8. Lung Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	Nasal Discharge (color___________)	☐	☐	☐	☐	☐	☐
☐	Cough	☐	☐	☐	☐	☐	☐
☐	Nose Bleeds	☐	☐	☐	☐	☐	☐
☐	Sinus Congestion	☐	☐	☐	☐	☐	☐
☐	Dry Mouth	☐	☐	☐	☐	☐	☐
☐	Dry Throat	☐	☐	☐	☐	☐	☐
☐	Dry Nose	☐	☐	☐	☐	☐	☐
☐	Dry Skin	☐	☐	☐	☐	☐	☐
☐	Allergies (what?_________________)	☐	☐	☐	☐	☐	☐
☐	Alternating Chills/Fever	☐	☐	☐	☐	☐	☐
☐	Sneezing	☐	☐	☐	☐	☐	☐
☐	Headache (location______________)	☐	☐	☐	☐	☐	☐
☐	Overall achy feeling in body	☐	☐	☐	☐	☐	☐
☐	Stiff Neck	☐	☐	☐	☐	☐	☐
☐	Stiff Shoulders	☐	☐	☐	☐	☐	☐
☐	Sore Throat	☐	☐	☐	☐	☐	☐
☐	Difficulty breathing	☐	☐	☐	☐	☐	☐
☐	Smoke cigarettes (# per day_______)	☐	☐	☐	☐	☐	☐
☐	Sadness	☐	☐	☐	☐	☐	☐
☐	Melancholy	☐	☐	☐	☐	☐	☐
☐	***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**

Nature Cures Clinic ~ *1020 SW taylor St. Suite 330 ~ Portland, OR 97205 ~ 503-287-4970*

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Date:____________

Date:______ Date:______ Date:______ Date:______ Date:______ Date:______

9. Spleen, Stomach, Small/Large Intestine Function

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Loose Stools	☐	☐	☐	☐	☐	☐
☐ Constipated	☐	☐	☐	☐	☐	☐
☐ Incomplete Stools	☐	☐	☐	☐	☐	☐
☐ Diarrhea	☐	☐	☐	☐	☐	☐
☐ Blood in Stools	☐	☐	☐	☐	☐	☐
☐ Mucous in Stools	☐	☐	☐	☐	☐	☐
☐ Undigested food in the Stools	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**

10. Stomach Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Burning sensation after eating	☐	☐	☐	☐	☐	☐
☐ Large appetite	☐	☐	☐	☐	☐	☐
☐ Bad Breath	☐	☐	☐	☐	☐	☐
☐ Canker Sores (mouth)	☐	☐	☐	☐	☐	☐
☐ Bleeding, swollen or painful gums	☐	☐	☐	☐	☐	☐
☐ Heartburn	☐	☐	☐	☐	☐	☐
☐ Acid Regurgitation	☐	☐	☐	☐	☐	☐
☐ Ulcer (diagnosed?)	☐	☐	☐	☐	☐	☐
☐ Belching	☐	☐	☐	☐	☐	☐
☐ Hiccoughs	☐	☐	☐	☐	☐	☐
☐ Stomach Pain	☐	☐	☐	☐	☐	☐
☐ Vomiting	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

11. Dampness trapped in the Body:

- [ ] Bodily sensation of heaviness
- [ ] Mental heaviness
- [ ] Mental sluggishness
- [ ] Mental fogginess
- [ ] Swollen hands
- [ ] Swollen feet
- [ ] Swollen joints
- [ ] Chest congestion
- [ ] Nausea
- [ ] Snoring

☐ ***Total Boxes Checked:***

Date:____________

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:______	**Date:**______	**Date:**______	**Date:**______	**Date:**______	**Date:**______

12. Liver Function (eyes):

- [ ] Itchy
- [ ] Bloodshot
- [ ] Hot
- [ ] Dry
- [ ] Watery
- [ ] Gritty
- [ ] Blurry Vision
- [ ] Decreased Night Vision
- [ ] Near-sighted
- [ ] Far-sighted

☐ ***Total Boxes Checked:***

Date:____________

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:______	**Date:**______	**Date:**______	**Date:**______	**Date:**______	**Date:**______

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

13. Liver, Gall Bladder Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Alternating Diarrhea & Constipation	☐	☐	☐	☐	☐	☐
☐ Chest Pain	☐	☐	☐	☐	☐	☐
☐ Tight sensation in the Chest	☐	☐	☐	☐	☐	☐
☐ Bitter taste in the mouth	☐	☐	☐	☐	☐	☐
☐ Anger easily	☐	☐	☐	☐	☐	☐
☐ Depression	☐	☐	☐	☐	☐	☐
☐ Frustration	☐	☐	☐	☐	☐	☐
☐ Irritability	☐	☐	☐	☐	☐	☐
☐ Skin Rashes	☐	☐	☐	☐	☐	☐
☐ Headache at the top of the Head	☐	☐	☐	☐	☐	☐
☐ Tingling Sensation	☐	☐	☐	☐	☐	☐
☐ Numbness	☐	☐	☐	☐	☐	☐
☐ Muscle twitching	☐	☐	☐	☐	☐	☐
☐ Muscle cramping	☐	☐	☐	☐	☐	☐
☐ Muscle Spasms	☐	☐	☐	☐	☐	☐
☐ Seizures	☐	☐	☐	☐	☐	☐
☐ Convulsions	☐	☐	☐	☐	☐	☐
☐ Lump in the throat	☐	☐	☐	☐	☐	☐
☐ Neck Tension	☐	☐	☐	☐	☐	☐
☐ Shoulder Tension	☐	☐	☐	☐	☐	☐
☐ Limited Range-of-Motion (Neck)	☐	☐	☐	☐	☐	☐
☐ Limited Range-of-Motion (Shoulder)	☐	☐	☐	☐	☐	☐
☐ How much Alcohol / day?__________	☐	☐	☐	☐	☐	☐
☐ Recreational drugs (which?__________)	☐	☐	☐	☐	☐	☐
☐ High-pitched Ringing in Ears	☐	☐	☐	☐	☐	☐
☐ Gall Stones (history or current)	☐	☐	☐	☐	☐	☐
☐ STD's (which?__________________)	☐	☐	☐	☐	☐	☐
☐ Unable to adapt to Stress	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:**______	**Date:**______	**Date:**______	**Date:**______	**Date:**______	**Date:**______

Nature Cures Clinic *~ 1020 SW taylor St. Suite 330 ~ Portland, OR 97205 ~ 503-287-4970*

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

14. Kidney, Urinary Bladder Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Frequent cavities, teeth problems	☐	☐	☐	☐	☐	☐
☐ Easily broken bones	☐	☐	☐	☐	☐	☐
☐ Sore knees	☐	☐	☐	☐	☐	☐
☐ Weak knees	☐	☐	☐	☐	☐	☐
☐ Cold sensation in the knees	☐	☐	☐	☐	☐	☐
☐ Low Back Pain	☐	☐	☐	☐	☐	☐
☐ Memory problems	☐	☐	☐	☐	☐	☐
☐ Excessive hair loss	☐	☐	☐	☐	☐	☐
☐ Low-pitched ringing in the ears	☐	☐	☐	☐	☐	☐
☐ Kidney Stones	☐	☐	☐	☐	☐	☐
☐ Bladder Infections	☐	☐	☐	☐	☐	☐
☐ Lack of bladder control	☐	☐	☐	☐	☐	☐
☐ Wake during the night 2 (or more) times to urinate?	☐	☐	☐	☐	☐	☐
☐ Fear	☐	☐	☐	☐	☐	☐
☐ Easily startled	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**

15. Libido:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Normal	☐	☐	☐	☐	☐	☐
☐ High	☐	☐	☐	☐	☐	☐
☐ Low	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

16. Urination (Bladder Function):

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Color (please check):	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Pale____; Dk Yellow____; Clear____	☐	☐	☐	☐	☐	☐
☐ Reddish	☐	☐	☐	☐	☐	☐
☐ Cloudy	☐	☐	☐	☐	☐	☐
☐ Scanty	☐	☐	☐	☐	☐	☐
☐ Profuse	☐	☐	☐	☐	☐	☐
☐ Strong Oder	☐	☐	☐	☐	☐	☐
☐ Burning	☐	☐	☐	☐	☐	☐
☐ Painful	☐	☐	☐	☐	☐	☐
☐ Discharge	☐	☐	☐	☐	☐	☐
☐ Difficult	☐	☐	☐	☐	☐	☐
☐ Urgent	☐	☐	☐	☐	☐	☐
☐ Frequent	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**	**Date:______**

WOMEN ONLY

☐ Yes	☐ No	Do you have a regular menstrual cycle?	________	Age of first menstruation
☐ Yes	☐ No	Are you pregnant?	________	Average number of days in flow
☐ Yes	☐ No	Do you have bleeding beetween periods?	________	Average number of days in entire cycle
☐ Yes	☐ No	Do you have a vaginal discharge?	________	Number of children
			________	Number of pregnancies
			________	Age of menopause (if applicable)

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (choose one): normal, pale, bright red, brown rust, dark purple, other	________	________	________	________	________	________	________
Amount of flow (choose one): normal, heavy, light	________	________	________	________	________	________	________
Pain/Cramps (choose one): dull, sharp, other	________	________	________	________	________	________	________
Vomiting (check if yes):	________	________	________	________	________	________	________

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Nausea (check if yes):	________	________	________	________	________	________	________

Women Only:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Nausea	☐	☐	☐	☐	☐	☐
☐ Vomiting	☐	☐	☐	☐	☐	☐
☐ Food cravings	☐	☐	☐	☐	☐	☐
☐ Water retention	☐	☐	☐	☐	☐	☐
☐ Breast swelling	☐	☐	☐	☐	☐	☐
☐ Breast tenderness	☐	☐	☐	☐	☐	☐
☐ Headaches	☐	☐	☐	☐	☐	☐
☐ Migraines	☐	☐	☐	☐	☐	☐
☐ Dull pain (where?__________)	☐	☐	☐	☐	☐	☐
☐ Sharp pain (where?___________)	☐	☐	☐	☐	☐	☐
☐ Depression	☐	☐	☐	☐	☐	☐
☐ Irritability	☐	☐	☐	☐	☐	☐
☐ Anxiety	☐	☐	☐	☐	☐	☐
☐ Other (explain_____________)	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**
Date:____________	**Date:**______	**Date:**______	**Date:**______	**Date:**______	**Date:**______	**Date:**______

Men Only:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
☐ Swollen testes	☐	☐	☐	☐	☐	☐
☐ Testicular pain	☐	☐	☐	☐	☐	☐
☐ Impotence	☐	☐	☐	☐	☐	☐
☐ Premature ejaculation	☐	☐	☐	☐	☐	☐
☐ Feeling of coldness or Numbnesss in external genitalia	☐	☐	☐	☐	☐	☐
☐ Other?	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked:***	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**	☐ **Total**

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Date:____________

Date:______ Date:______ Date:______ Date:______ Date:______ Date:______