PATIENT HEALTH HISTORY

Patient's Name: ____
First Middle Last

Natural medicine healthcare is possible only when the physician completely understands the patient's physical, mental, and emotional conditions. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. Please write legibly and answer all questions thoroughly. Please mark anything you may have a question about.

Address: ____

City: ___________________________________ State: ________________________ Zip code: ____________

Telephone numbers: Home ___________________________ Work/Cell ______________________________

Patients will be emailed appointment reminders via our electronic health records(EHR). If you do not have an email address please write your preferred # for appointment reminders and other messages:
(______) ______-________ **Email (needed for our EHR): _______________________**

SS #: _________________________ Drivers license #: ___________________ Birth Date: ________________

Age: ___________ Gender (circle one): M F Other Children: ________________________

Occupation: ____ Hours per week: ______________________

Employer: _______________________________ Employer address: __________________________________

Relationship status: ❑Single ❑Married ❑Partnership

Emergency Contact: ____

Relationship: ______________________________ Telephone Number: _________________________________

If someone other than patient is responsible for payment, please complete the following:

Name of responsible party: _____________________________________ SS#: ____________________________

Relationship to patient: _______________________________________ Phone #: ________________________

Employer & address: ____
____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Lake Oswego Health Center, PC to release information necessary to secure payment. Payments are due in full at the time of service unless we are billing insurance. If there is a balance, there is a 6% admin fee for accounts past 30 days. There is a $40 cancellation fee for appointments that are canceled or changed within 24 hours. After 1 cancellation, there is a full appointment charge. Benefits quoted by insurance is still not a guarantee of payment. Please see our form to check your own benefits for further information. Patients are responsible for all fees that are not covered.

Signature: ____ **Date:** _____________________________

Are you currently receiving health care? ❑Y ❑N
If yes, please list your current providers: ____

If no, when and where did you last receive medical care? ____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: ____

____

How did you hear about our clinic? ____

May we thank the person who referred you? ____

SELF & FAMILY HISTORY

Please list past hospitalizations or surgeries: ____

____

Please list any recent lab work with any abnormal results: ____

What diagnostic imaging studies have you had? ❑ Bone density scan ❑ Mammogram
❑ Electrocardiogram ❑ Electroencephalogram ❑ X-rays ❑ CT scan ❑ MRI
❑ Ultrasound ❑ Colonoscopy/Sigmoidoscopy ❑ Other

Medications and/or Supplements

Do you take or use any of the following?

❑ Pain relievers (aspirin, ibuprofen) ❑ Sleeping Pills ❑ Tranquilizers
❑ Diet pills, appetite suppressants ❑ Antibiotics ❑ Laxatives
❑ Cortisone (cream or pills) ❑ Thyroid medication ❑ Antacids

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking with dosages and brand names, if possible: (Please add how long you have been on this med)

1. ____________________________________ 2. ____________________________________
3. ____________________________________ 4. ____________________________________
5. ____________________________________ 6. ____________________________________
7. ____________________________________ 8. ____________________________________

General

Height: ________________ Weight: ______________lbs. Weight one year ago: ___________lbs.
Maximum weight: __________lbs. When? __________ Are you happy with your current wt? ❑Y ❑N
Energy Level:

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

At what time of day is your energy the best? ___________________ Worst? ______________________

Is there any condition (physical, mental, emotional) from which you feel that you have not fully recovered?

____

Family History

Do you have a family history of any of the following (please circle)?

Alcoholism/addiction Cataracts Goiter Mental Illness

Allergies	Celiacs	Hayfever/hives	Skin conditions
Anemia	Depression	Headaches/Migraines	Stroke
Arthritis	Diabetes	Heart Disease	Suicide
Asthma	Liver Disease	Heart Murmur	Thyroid Problems
Autoimmune	Epilepsy	High Blood Pressure	Tuberculosis
Cancer,type?	Gall Bladder Disease	Kidney Disease	Other ____________

Is your father living? Yes; his age ____ No; age at time of death _____ Cause of death ____________

Is your mother living? Yes; her age ____ No: age at time of death _____ Cause of death ____________

Do you have siblings? If so, how is their health? ____

Childhood Illnesses

Any major health concerns (i.e. Polio, Rhuematic Fever, etc.) ______________________________________

Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diptheria	Polio
Measles/Mumps/Rubella (MMR)	Tetanus
Pertussis	Other ____

REVIEW OF SYSTEMS (self)

Please circle. Y= Yes, present condition P=Problem in the past N=No, never had the condition

Let the Doctor know if you have any questions.

Head

		Head injury	Y P N	Jaw/TMJ Problems	Y P N
Headaches	Y P N	Migraines	Y P N		

Ears

Ringing	Y P N	Excess Wax	Y P N	Earaches	Y P N
Impaired Hearing	Y P N				

Neck

Lumps	Y P N	Swollen Glands	Y P N	Pain or Stiffness	Y P N
Goiter	Y P N				

Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, Hives	Y P N
Lumps	Y P N	Acne, Boils	Y P N	Color Changes	Y P N
Itching	Y P N	Loss of Hair	Y P N	Night Sweats	Y P N

Musculoskeletal

Joint pain/stiffness	Y P N	Muscle Spasms	Y P N	Weakness	Y P N
Arthritis	Y P N	Broken Bones	Y P N	Sciatica	Y P N
Osteoporosis	Y P N	Muscle Pain	Y P N		

Eyes

		Recent Vision Changes	Y P N	Last Eye Exam Date ________	
Blurred Vision	Y P N	Cataracts	Y P N	Glasses/Contacts	Y P N
Eye Pain/Strain	Y P N	Glaucoma	Y P N	Tearing/Dryness	Y P N
Spots in Eyes	Y P N	Color Blind	Y P N	Double Vision	Y P N

Nose/Sinuses

Stuffiness	Y P N	Loss of Smell	Y P N	Sinus Problems	Y P N
Hayfever	Y P N	Nose Bleeds	Y P N	Frequent Colds	Y P N

Mouth/Throat

Hoarseness	Y P N	Gum Problems	Y P N	Freq. Sore Throat	Y P N
Jaw Clicks	Y P N	Dental Cavities	Y P N	Sore Lips/Tongue	Y P N
Teeth Grinding	Y P N	Dry Mouth	Y P N	Change in Thirst	Y P N

Respiratory

		Shortness of Breath	Y P N	Asthma/wheezing	Y P N
Tuberculosis	Y P N	Spitting up Blood	Y P N	Emphysema	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty Breathing	Y P N
Pneumonia	Y P N	Pain with Breathing	Y P N		

Cardiovascular

		Deep Leg Pain	Y P N	Poor Circulation	Y P N
Chest Pain	Y P N	Blood Clots	Y P N	Varicose Veins	Y P N
Murmur	Y P N	Rheumatic Fever	Y P N	Easy Bruising	Y P N
Ankle Swelling	Y P N	Valve Problems	Y P N	Palpitations	Y P N
High Cholesterol	Y P N	High/Low Blood Pressure	Y P N		

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Changes in Appetite	Y P N
Ulcers	Y P N	Black Stool	Y P N	Liver Disease	Y P N
Jaundice	Y P N	Hemorrhoids	Y P N	Gall Bladder Disease	Y P N
Heartburn	Y P N	Abdominal Pain	Y P N	Blood in Stool	Y P N
Trouble Swallowing	Y P N	Belching	Y P N	Passing Gas	Y P N

How many bowel movements per day? ___________

Urinary

Incontinence	Y P N	Frequent Infections	Y P N	Painful Urination	Y P N
Kidney stones	Y P N	Frequency	Y P N	Urgency	Y P N

Wake to urinate? If so, how often __________

Blood/Peripheral Vascular

Anemia	Y P N	Cold Hands/Feet	Y P N	Thrombophlebitis	Y P N
Leg Pain	Y P N	Easy Bruising	Y P N	Varicose Veins	Y P N

Neurological

Fainting	Y P N	Loss of Memory	Y P N	Seizures	Y P N
		Paralysis	Y P N	Numbness/Tingling	Y P N

Mental/Emotional

		Substance Abuse	Y P N	Nervousness	Y P N
Mood Swings	Y P N	Easting Disorder	Y P N	Tension/Stressed	Y P N
Anxiety	Y P N	Depression	Y P N	Thoughts of Suicide	Y P N

Endocrine

Hypothyroid	Y P N	Excessive Thirst	Y P N	Cold Intolerance	Y P N
Hyperthyroid	Y P N	Excessive Hunger	Y P N	Heat Intolerance	Y P N

Reproductive

		Hernias	Y P N	Sexual Difficulty	Y P N
Sex with	M F	Discharge or Sores	Y P N	Sexually active?	Y P N

Infection (i.e. herpes, etc) Y P N Date of last STD/STI testing? __________

Type of birth control (if applicable) ___________________________

MALE Reproductive

Testicular Masses	Y P N	Prostate Issues	Y P N	Testicular Pain	Y P N
Impotence	Y P N	Premature Ejaculation	Y P N	Date of last physical exam? ___________	

FEMALE Reproductive

Age of first menses _________________________ Age of last menses (if menopausal) __________________

Length of cycle _____________________________ Duration of menses _______________________________

Any gynecological procedures (i.e. hysterectomy full or partial, LEEP, colposcopy, ablation, etc)

____

Date of last annual exam? ___________________ Any previous abnormal paps? ❑Y ❑N

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	PMS	Y P N	Bleeding between cycles	Y P N
Fibroid/polyps	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Hormone Therapy	Y P N	Breast lump(s)	Y P N	Trouble Conceiving	Y P N
Nipple discharge	Y P N	Do self breast exams	Y P N	Fibrocystic breast	Y P N

# of pregnancies _____ # of live births_____ # of miscarriages _____ # of terminations_____

Is there anything else you would like us know in order to serve you better?

____

____

____

Do you have any physical limitations? ____

List your top 3 goals for today?

____

____

____

Habits

Please write what you last had for breakfast, lunch, dinner, and snacks **in the last 24 hours**:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Fluids (type and guess amounts):
____

Do you have any dietary restrictions and why? ____
Please indicate the following:
Smoke: ❑Y ❑P ❑N If yes, amount:__________ Alcohol: ❑Y ❑N If yes, amount:__________
Caffeine (soda, coffee, tea, etc…): ❑Y ❑N If yes, amount:______________________________
TV: Hours per day ❑ 0-1 ❑ 1-3 ❑ 3-4 ❑ 4 +
Exercise: ❑Y ❑N If yes, amount and type:___________________________________
Any injuries that keep you from exercising more? ________________________________
Main Interests/Hobbies: ____
Do you have a spiritual practice: ❑Y ❑N
How many hours do you sleep? __________ Do you wake rested? ❑Y ❑N
Do you have any stress management practices? ❑Y ❑N
What do you do to relax? ____
Do you have a good support system (friends, family)? _________________________________
Exposed to chemicals/tobacco at home or at work? ❑Y ❑P ❑N If yes, list: ___________________
____

How motivated are you to make changes in your life to improve your health (10=most)?
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What changes are you willing to make to improve your health?
❑Lifestyle Changes ❑Take Supplements ❑Exercise ❑Nutrition changes
❑Smoking Cessation ❑Sleep Patterns ❑Counseling ❑Alcohol reduction/cessation
❑Recreational Hours/Hobbies

Please provide your insurance
ID# _________________________
Group # ____________________
Name of insurance: ____________________
Customer service number: _______________
Secondary insurance information: __________________

Please review and initial the following:

_____We provide a courtesy reminder call/email, however we require a **24 Hour Cancellation Notice.** Please inform our front desk of contact information changes. Please call at least 24 hours in advance if you need to cancel or reschedule so we may make that appointment available to other patients. **A cancellation fee of $40 will be charged if less than 24 hours notice is given**, **and a 48-hour notice for new patient visits**. **If more than 1 visit is missed, you may be charged the**

full office visit. Outstanding balances will accrue a 6% administration fee if not paid within 30 days.

______ LOHC & Colling Chiropractic, PC have same-day appointments reserved for urgent health issues. If you have an emergency health concern, please call 911. We will be notified and send visit notes on admittance to the hospital.

______LOHC & Colling Chiropractic, PC offer a **20% time of service discount for uninsured patients.** Charge varies based on the complexity of the visit. Payments must be paid in full at check out. **LOHC does not offer payment plans and all sales are final.**

______I authorize LOHC & or Colling Chiropractic, PC to bill my insurance for me. I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by LOHC & or Colling Chiropractic PC. As a courtesy we check your insurance benefits. However, this information given is **NOT** a guarantee of payment. Patients are required by law to know their coverage. We recommend that patients also call, confirm and document the reference number.

______ **For a prescription refill, please call your pharmacy.** They will fax a refill request to LOHC. You must have seen your physician within the last 3-6 months before refills can be approved—schedule an office visit if necessary. Please schedule an appointment with the prescribing doctor if you feel you are in need of a medication change. **Refill requests can take up to 24hrs.**

______In compliance with HIPAA, LOHC is unable to provide medical advice or information via email or phone. **Please schedule an office visit to review lab results, and if you have questions about new or existing symptoms.**

______Intramuscular nutrient injections are not covered by insurance. Associated fees will be charged at the time of the visit. Intravenous nutrient therapy is rarely covered and will be explained at your office visit in the event it is recommended for your care.

______A $30 dollar blood draw fee is due at the time of service when performed at LOHC. This is a handling fee separate from a co-pay. This applies to all blood draws.

______ Calls will be returned within 24 hrs, and emails within 48 hrs, M-F. Please direct email inquiries to **info@lakeoswegohealth.com.** If you do not hear back from us, please call the clinic. ______ There is a $10-$200 fee for printing YTD Ledgers, FMLA forms, physician letters, attorney letters and additional paperwork. Fee varies based on workload.

______ Initial ONLY if it is ok to leave private information on your voicemail and please include the appropriate number: (______)____________________

Please write below your current email and phone number for reminder calls.

Email: ______________________________ Phone: ______________________________

Thank you