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:____

Social Security #: ____

Married   Significant Other   Single   Divorced   Widowed   Separated

Address:____

City, State, Zip:____

Employer: ______________________________ Occupation: ________________________

Referred by:____

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, Inc. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. 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 of these assignments shall be as valid as the original

Health Questionnaire   Please fill out both sides of this form

Name:_________________________________ Date of Birth: ___________________________

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

What foods (if any) do you exclude from your diet?

Additional Comments:

MEDICATIONS

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

ALLERGIES TO MEDICATIONS (please list)
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 year.

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