Health from the Heart

Helping Adults, Children, & Families, Naturally

NAME: _____ **AGE:** _____ **SEX:** _____ **DATE:** _____

E-MAIL ADDRESS: _____

MARITAL STATUS:

MARRIED SEPARATED DIVORCED WIDOWED SINGLE PARTNERSHIP

WHO CAN I THANK FOR REFERRING YOU? _____

WHEN AND WHERE DID YOU RECEIVE YOUR LAST HEALTH CARE, AND WHY ?

_____

_____

PLEASE LIST YOUR HEALTH CONCERNS, IN ORDER OF IMPORTANCE TO YOU:

1._____
2._____
3._____

FAMILY HISTORY

	Person Affected (i.e. Mother, Sister, etc.)
Alzheimer's	
Asthma	
Autoimmune Disease	
Cancer	
Diabetes	
Epilepsy	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Kidney Disease	
Mental Illness	
Neurological Illness	
Osteopenia or Osteoporosis	
Stroke	
Thyroid Disease	
Other	

CHILDHOOD ILLNESSES (Circle All That Apply)

Diaper Rash **Ear Infections** **Eczema** **High Fevers (> 102F)**

Measles **Mono** **Mumps** **Rheumatic Fever**

Rubella **Strep Infections**

IMMUNIZATIONS

Were you immunized as a child? Yes No
Have you received immunizations as an adult? Yes No
Any bad reactions to immunizations? Yes No

ALLERGIES (Include item and your reaction to it)

Drugs: _____

Foods:_____

_____

Environmental: _____

_____

Have you ever been given allergy shots? When?
_____

CURRENT MEDICATIONS (Include Dosage if Known)

Prescription Medications:
_____
_____
_____

Supplements:
_____
_____
_____

PAST MEDICAL HISTORY

Have you ever been hospitalized? Yes No
If yes, when and why?_____

_____

_____

MEDICAL HISTORY (Describe all that apply)

SKIN

ACNE	
BOILS	
COLOR CHANGES	
ECZEMA	
HIVES	
MOLES	
PSORIASIS	
WARTS	
OTHER	

HEAD

HAIR LOSS	
HEAD INJURY	
HEADACHES	
MIGRAINES	
OTHER	

EYES

EYE PAIN	
CATARACTS	
DOUBLE VISION	
DRYNESS	
GLASSES/CONTACTS	
GLAUCOMA	
REDNESS	
TEARING	
OTHER	

EARS

DISCHARGE	
DIZZINESS	
IMPAIRED HEARING	
INFECTIONS	
RINGING	
TRAUMA TO EAR	
OTHER	

NOSE AND SINUSES

FREQUENT COLDS	
NOSE BLEEDS	
HAYFEVER	
RUNNY NOSE	
SINUS PAIN OR INFECTIONS	
STUFFINESS	
OTHER	

MOUTH AND THROAT

BLEEDING GUMS	
CANKER SORES	
CAVITIES	
COLD SORES	
DENTURES	
DIFFICULTY SWALLOWING	
HOARSENESS	
ROOT CANALS	
SORE THROATS	
SORE TONGUE	
OTHER	

NECK

ENLARGED LYMPH NODES	
GOITER	
PAIN/STIFFNESS	
THYROID ISSUES	
TRAUMA TO NECK	
OTHER	

RESPIRATORY

ASTHMA	
BRONCHITIS	
COUGH	
EMPHYSEMA	
PLEURISY	
PNEUMONIA	
SHORTNESS OF BREATH	
SPITTING BLOOD	
WHEEZING	
OTHER	

CARDIOVASCULAR

ANGINA	
CHEST PAIN	
DIZZY STANDING	
HIGH BLOOD PRESSURE	
HIGH CHOLESTEROL	
HEART DISEASE	
IRREGULAR BEATS	
LEG PAIN WITH WALKING	
HEART MURMURS	
RHEUMATIC FEVER	
SWOLLEN ANKLES	
OTHER	

GASTROINTESTINAL

BELCHING OR GAS	
BLOOD IN STOOL	
CHANGE IN APPETITE	
CHANGE IN THIRST	
CONSTIPATION	
DIARRHEA	
HEARTBURN	
GALL BLADDER DISEASE	
HEMORRHOIDS	
MUCUS IN STOOL	
ULCERS	
VOMITING BLOOD	
HOW OFTEN DO YOU HAVE STOOLS?	
OTHER	

NEUROLOGICAL

DIZZINESS/VERTIGO	
FAINTING	
LOSS OF BALANCE	
NUMBNESS/TINGLING	
PARALYSIS	
SEIZURES	
LIMB WEAKNESS	
OTHER	

ENDOCRINE/BLOOD

ANEMIA	
EASY BRUISING	
EASY BLEEDING	
EXCESSIVE HUNGER	
HEAT OR COLD INTOLERANCE	
HYPO OR HYPER THYROID	
WEIGHT – CURRENT	
OTHER	

URINARY

INCREASED FREQUENCY	
INCREASED URGENCY	
INABILITY TO HOLD	
INFECTIONS – BLADDER	
INFECTIONS – KIDNEY	
KIDNEY STONES	
PAIN WITH URINATION	
URETHRAL DISCHARGE	
OTHER	

FEMALE REPRODUCTIVE SYSTEM

AGE MENSES BEGAN	
# OF DAYS OF PERIOD	
# OF DAYS BETWEEN PERIODS	
EXCESSIVE FLOW	
PMS	
SCANTY FLOW	
USING BIRTH CONTROL?	
USED ORAL CONTRACEPTION IN PAST?	
MENOPAUSAL SYMPTOMS	
VAGINAL DRYNESS?	
# OF PREGNANCIES	
# OF LIVE BIRTHS	
# OF MISCARRIAGES	
# OF ABORTIONS	
FERTILITY ISSUES	
DECREASED SEX DRIVE?	
ARE YOU SEXUALLY ACTIVE?	
SEXUAL PREFERENCE	
VENERAL DISEASE	
OTHER	

BREASTS

BREASTFEEDING – CURRENT	
BREASTFEEDING – PAST	
BREAST LUMPS	
BREAST PAIN	
HAVE YOU HAD A MAMMOGRAM?	
NIPPLE DISCHARGE	

MALE REPRODUCTIVE

DISCHARGE OR SORES	
HIGH PSA	
PROSTATE DISEASE	
PROSTATE PAIN	
TESTICULAR MASS	
TESTICULAR PAIN	
VENEREAL DISEASE	
ARE YOU SEXUALLY ACTIVE?	
SEXUAL PREFERENCE	
DECREASED SEX DRIVE?	
OTHER	

MUSCULOSKELETAL

ARTHRITIS	
BROKEN BONES	
GOUT	
JOINT PAIN/STIFFNESS	
JOINT SWELLING	
MUSCLE CRAMPS	
OSTEOPENIA OR OSTEOPOROSIS	
OTHER	

PERIPHERAL VASCULAR

COLD HANDS OR FEET	
DEEP LEG PAINS	
NUMB HANDS OR FEET	
RAYNAUD'S	
VARICOSE VEINS	
OTHER	

MENTAL/EMOTIONAL

ADHD	
ANXIETY	
BIPOLAR DISORDER	
DEPRESSION	
EXCESSIVE ANGER	
EXCESSIVE FEAR	
EXCESSIVE STRESS	
HALLUCINATIONS	
MOOD SWINGS	
PANIC ATTACKS	
SCHIZOPHRENIA	
OTHER	

HABITS

# OF HOURS YOU SLEEP	
DO YOU WAKE RESTED?	
SMOKE CIGARETTES?	
HOW MUCH ALCOHOL?	
RECREATIONAL DRUGS?	
TREATMENT FOR ALCOHOL OR DRUG DEPENDENCE?	

YOUR MAIN HOBBIES AND INTERESTS:

_____
_____
_____

EXERCISE HABITS AND FREQUENCY:

_____
_____
_____

DO YOU HAVE A RELIGIOUS/SPIRITUAL PRACTICE?

_____

ARE YOU SEEING A COUNSELOR?

_____

ARE YOU SEEING ANY OTHER HEALTHCARE PRACTITIONERS?

_____
_____

WHAT ARE YOU DOING TO SUPPORT YOUR HEALING AND GROWTH?

_____
_____
_____

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW TO HELP YOU WITH YOUR HEALING PROCESS?

_____
_____
_____
_____

THANK YOU!

Health from the Heart

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CONFIDENTIAL CONTACT INFORMATION

Date: _____ **Full Legal Name:** _____

Date of Birth: _____ **Preferred Name:** _____ _____

E-Mail Address: _____

Address _____

City :_____ **State:** _____ **Zip:** _____

Phone: (H)_____ **(C)** _____ **(W)**_____

Age: _____ **Gender: F__ M___**

Emergency Contact Name: _____
Relationship: _____
Phone: _____

COMMUNICATION

What is the best way to communicate with you between office visits? Email/ Home Ph/ Cell Ph/ Work Ph

Is there any place you do NOT want me to leave a message? _____

May I discuss your private medical information with you via email? Yes/ No

May I send you educational/promotional materials such as newsletters via email? Yes/ No

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature :_____**Date:** _____

Health from the Heart

Helping Adults, Children, & Families, Naturally

INFORMED CONSENT FOR PURPOSES OF HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Dr. Julie Glass and Health From The Heart originate and maintain health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care
3. A source of information for applying my diagnosis to my bill
4. A means by which a third-party payer can verify that services billed were actually provided
5. A tool to conduct routine health-care operations such as quality assessment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that I may revoke this consent in writing at any time, except to the extent that Dr. Glass has taken action relying on this consent.

Patient (or Legal Guardian) Name:

Signature:

Relationship to patient:

Date:

Health from the Heart

Helping Adults, Children, & Families, Naturally

Thank you for choosing Health From The Heart, LLC to assist you with your healthcare needs. I am dedicated to helping you improve your health. Please fill out all of the papers in this package and bring them with you to your first appointment. Read this form carefully, and sign and date at the end.

- Our first appointment is the longest, since during this time I listen carefully to your health concerns, review your medical history, and we begin the process of creating an treatment plan individualized to your needs. Please set aside 1 ½ hours for this visit. If you are bringing your child in to be treated and he/she is not able to tolerate the full appointment length we will divide the session into as many pieces as is necessary to fulfill his/her needs. Allow 45 minutes for follow up appointments.

- Full payment is required at the time of service. I accept cash, check, visa, and master-card.

- I respect your time and make every effort to schedule appropriately. If you need to reschedule your appointment, please do so at least 48 hours in advance. If you do not reschedule or cancel your appointment with sufficient notice, you will be charged for the **entire appointment** and this fee is **not** billable to insurance.

- If you are faced with an emergency after hours, call my main number (503 522-6356), and you will receive the contact number for the physician on-call.

- If you would like to make a phone appointment, either between visits or in place of a face-to-face follow up visit, that is possible (unless I feel as if there is a medical reason that I need to see you in person). The price for any phone conversation that lasts over 10 minutes is $50 per 15 minutes, and is not billable to insurance.

- It is your responsibility to know your insurance benefits (see included form). If your insurance covers my services, I will bill them, and you will be responsible for your copay and any non-covered services at the time of your visit. Since I am a single practitioner, and strive to provide you with the best medical care at the most affordable price, I ask that you take responsibility for resolving any discrepancies with insurance that might arise. You are responsible for paying Health From The Heart, LLC the full amount while any insurance negotiation takes place. If insurance reimburses me for something you have paid,I will mail you a check.

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- If I prescribe supplements for you, assume you are to continue taking them (until I recommend otherwise). You can call me to pick up supplements in-between office visits, pick them up at your office visits, or order them from my on-line vendor. Please let me know if you are interested in ordering your supplements on-line.

- Your referrals are the life of my business, and I **thank you** for all of them! I also welcome and appreciate **written testimonials**.

Again, thank you for your trust. By signing below you acknowledge that you have read the above office policies and agree to abide by them.

Signed_____ Self/Parent/Legal Guardian

Date_____

INSURANCE BENEFITS VERIFICATION

(Please allow 1 hour for this form, and bring it completed to your first appointment)

If you would like me to bill your primary insurance carrier, please fill out this form. Bring it completed, as well as your insurance card, to your first appointment. I do not bill secondary insurance.

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PATIENT INFORMATION

Name _____

Address _____

Phone _____ Company _____

INSURED INFORMATION (IF DIFFERENT)

Name _____

Address _____

Phone _____ Company _____

Date of Birth _____ Relationship to Patient _____

INSURANCE COMPANY INFORMATION

Name _____

Phone _____

ID# _____ Group # _____

It is your responsibility to be aware of your benefits, including coverage, co-pay, deductible, and maximums. Please call the number listed on the back of your insurance card, and fill out the form below.

1. Name of Representative I am speaking with _____ Date _____
2. Beginning Date of Coverage _____ Ending Date _____
3. Does my insurance cover Naturopathic Doctors? Yes/ No

4. Is Dr. Julie Glass, ND a covered provider under my plan? Yes/ No

5. Do I need a referral from my primary care physician to see Dr. Julie Glass, ND? Yes/ No

6. What is my co-pay or % covered for Dr. Glass for:
    1. Office Visits _____
    2. Lab Work _____
    3. Diagnostic Imaging _____

7. What is my yearly maximum for naturopathic office visits? _____

8. What is my yearly maximum for naturopathic lab work/diagnostic imaging? _____

9. Do I have an annual deductible? Yes/ No Amt. of deductible met so far _____

10. Is my deductible based on calendar year? Other? _____

11. Is Providence a preferred lab? Yes/ No

12. Is Portland Adventist Hospital Lab a preferred lab? Yes/ No

13. Other preferred labs? _____

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Dr. Julie Glass/Health From The Heart. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Dr. Julie Glass/Health From The Heart. This authorization will be considered valid unless revoked by me in writing.

Signature _____ **Date** _____