PATIENT LAST NAME

_____

Nutura Clinic
8375 SW Beaverton Hillsdale Hwy Ste 100
Portland, OR 97225
Phone: 503-469-9818
Fax: 503-379-0967
www.nuturaclinic.com

Patient Intake Form

PATIENT INFORMATION:

Last Name _____ First _____ MI__ DOB __/__/__ Address _____ Age: _

City _____ State _____ Zip _____ Home # _____

Email Address _____ **OK to leave voicemail? Y | N** | Cell # _____

Sex: M | F | Gender ID: M | F | Non-Binary | Preferred Pronouns: _____ (he/she/they)

Circle: Live Alone | Single | Partnership | Engaged | Married | Separated | Divorced | Widowed | # of children: _____

Occupation _____ Hours per week _____ Enjoy job? **Y | N** | Spirituality important? **Y | N**

Partner's Name: _____ Phone #: _____

I. IN CASE OF EMERGENCY:

Person to contact: _____ Relationship to patient: _____

Home # _____ Cell # _____ Work # _____

II. BILLING & PRIOR CARE: *Verification of benefit does not guarantee payment from your insurance. You will be responsible for payment in the event insurance deems service(s) not payable under your plan.*

How do you intend to pay? Circle: Medical Ins | Cash/Self-Pay | Other: _____

Primary Ins: _____ ID #: _____ Group #: _____ Ph #: _____

Subscriber's Name:_____ DOB ___/___/___

Second Ins: _____ ID #: _____ Group #: _____ Ph #: _____

Subscriber's Name:_____ DOB ___/___/___

Do you have a Primary Care Provider? **Y | N** | PCP name & clinic: _____

Were you referred by another provider? **Y | N** | Provider name & clinic: _____

Visit today is related to: a motor vehicle collision | work accident/injury | wellness | establishing PCP | none of these

Circle any you've seen in the past: Naturopathic Physician | Acupuncturist | Chiropractor | Physical Therapist | None

Providers you see now: Therapist/Counselor | Psychiatrist | PT | Chiropractor | MD | DO | Dentist/Orthodontist | Other

Pharmacy: _____ Address: _____ Phone: _____

Do you have lab, imaging, health test, or treatment records from the past year or that apply to your conditions? **Y | N**

Records you have (or can bring): hard copies/paper | electronic only | I will sign record request release form for you.

How did you hear about Nutura Clinic? _____

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Health Questionnaire

CURRENT HEALTH CONCERNS:

Please describe below your most important health concerns and indicate how long you've had these issues.
We try to address as much as possible in your first appointment but please list the most important to address first.

_____

_____

_____

Immediate family member has same concern(s): **Y | N** | I've had concern(s) in the past: **Y | N** | When? _____

Treatments Tried:_____

Treatment Goal:_____

Today I feel: hopeful | discouraged | worried | excited | lost | indifferent | like I just need answers | ready for a change

PLEASE LIST ALL YOUR MEDICATIONS: PRESCRIPTION, OVER THE COUNTER, VITAMINS OR OTHER SUPPLEMENTS.
Initial here if you take NO medications and NO supplements: _____

Medication or Supplement Name ex: Magnesium Citrate	**For what condition?** ex: digestion	**Dose** ex: 200 mg cap 2x daily	**For how long?** ex: 2 years

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PLEASE LIST YOUR ALLERGIES, THE REACTION, AND SEVERITY. INITIAL HERE IF NO KNOWN DRUG ALLERGIES _____

Allergy (foods, drugs, environment, chemicals) ex: Penicillin	**Reaction** ex: throat swelling	**Severity** ex: severe/fatal	**For how long?** ex: childhood

EVENT HISTORY: PLEASE LIST ANY HOSPITALIZATIONS, SERIOUS INJURIES, SERIOUS ILLNESSES, OR SURGERIES.

Event: hospitalization, injury, illness, surgery ex: Knee replacement	**Year**	**Event: hospitalization, injury, illness, surgery** ex: Car crash	**Year**

HISTORY OF YOUR ONGOING OR PAST CONDITIONS: Mark any of the following conditions that apply to YOU:

- O AIDS
- O alcoholism
- O anemia
- O anorexia
- O appendicitis
- O osteoarthritis
- O autoimmune disease
- O bleeding disorder
- O bronchitis
- O bulimia
- O cancer
- O car accident(s)
- O cataracts
- O chemical dependency
- O chemical exposure
- O COPD
- O glaucoma
- O dementia
- O diabetes
- O eczema
- O gout
- O heart attack
- O heart disease
- O HIV positive
- O hernia
- O herpes
- O long Covid
- O measles
- O migraines
- O mold exposure
- O mononucleosis
- O multiple sclerosis
- O mumps
- O pacemaker
- O pneumonia
- O polio
- O prostate problem
- O rheumatic fever
- O rheumatoid arthritis
- O psychiatric care
- O second hand smoke
- O sexually transmitted infection
- O sleep apnea
- O snoring
- O stressful lifestyle
- O stroke
- O suicide attempt
- O teeth grinding
- O thyroid problem
- O tonsillitis
- O tuberculosis
- O typhoid fever
- O stomach ulcers
- O **NONE OF THESE**

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HEALTH HABITS: Please circle all that apply and list amounts | **Please initial here if in sober program:** _____

Substance Currently or in the Past	How much?	How often?	For how long?	Never
Alcohol: Y | N | Liquor | Beer | Wine	#_____ drinks	daily | weekly | occasionally		
Tobacco: smoke | chew | Y | N		daily | weekly | occasionally		
Vape: THC | Nicotine | Y | N		daily | weekly | occasionally		
Cannabis: smoke | edible | Y | N		daily | weekly | occasionally		
Recreational drugs Y | N		daily | weekly | occasionally		
Other Y | N | List:		daily | weekly | occasionally		

Height:_____ Current Weight:_____ Goal weight:_____ ○ **Decline weight**
Exercise: **Y | N** | Type: _____Frequency:_____
Recent Travel: **Y | N** | Location: _____ Vaccines: Up to date | Need update | None | Decline

KNOWN FAMILY HISTORY: Or, please initial here if adopted and history unknown to you: _____

Relation	Age	State of health	Health conditions OR cause of death Circle all that apply:
Father			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Mother			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Dad's Father			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Dad's Mother			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Mom's Father			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Mom's Mother			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Sibling			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Sibling			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____
Sibling			heart disease **|** stroke	heart attack **|** high blood pressure **|** arthritis **|** kidney disease **|** diabetes cancer & type:_____ **|** chemical dependency **|** other: _____

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GENERAL:
- O weakness
- O fatigue
- O fever or chills
- O major weight loss
- O major weight gain
- O sleeping problems
- O recently sick

SKIN:
- O rash
- O lumps
- O sores
- O itching
- O hives
- O dryness
- O nails soft or split
- O change in moles
- O sore that won't heal
- O hair loss
- O hair thinning

HEENT:
- O headache
- O head injury
- O dizziness/vertigo
- O fainting
- O vision loss
- O vision changes
- O vision: flashes
- O vision: halos
- O double vision
- O hearing loss
- O ringing ears
- O earaches
- O nasal congestion
- O runny nose
- O nosebleeds
- O sinus pain/swelling
- O dry mouth
- O hoarseness
- O throat pain
- O allergies

NECK:
- O lump(s)
- O swollen lymph nodes
- O pain
- O stiffness

HEART:
- O chest pain or discomfort
- O racing heart
- O irregular heartbeat
- O shortness of breath
- O lower leg swelling
- O easily winded

LUNGS:
- O cough
- O painful breathing
- O wheezing
- O phlegm

DIGESTION:
- O heartburn/reflux
- O bad taste in mouth
- O pain after eating
- O can't burp
- O nausea
- O vomiting
- O vomiting blood
- O belching often
- O indigestion
- O bowel changes
- O diarrhea
- O constipation
- O rectal bleeding
- O dark/tarry stools
- O abdominal pain
- O bloating
- O flatulence
- O hemorrhoids

URINARY:
- O increased urination
- O waking to urinate
- O urgency
- O burning or pain on urination
- O blood in urine
- O urinary infections
- O kidney stones
- O lack of bladder control
- O dribbling stream
- O change in urine smell

CIRCULATION:
- O leg cramps
- O varicose veins
- O cold hands/feet
- O bruising easily

MUSCLE/JOINTS:
- O muscle pain
- O joint pain
- O stiffness
- O neck ache
- O backache
- O circle: arm | elbow | wrist | hand | leg | hip | knee | foot
- O night pain

NERVES:
- O seizures
- O heaviness of both legs
- O shooting pain down arms or legs
- O paralysis
- O numbness or loss of sensation
- O tingling
- O tremors or other twitching

METABOLIC:
- O heat intolerance
- O cold intolerance
- O excessive sweating
- O night sweats
- O excessive thirst
- O excessive hunger
- O reduced appetite
- O increased urination
- O change in glove/shoe size

MENTAL HEALTH:
- O anxiety/panic
- O depression
- O memory changes
- O disordered eating
- O low sex drive
- O suicidal thoughts

M/F BREAST:
- O breast lump(s)
- O breast pain or discomfort
- O nipple discharge

FEMALE:
- O painful period
- O very heavy period
- O menopausal symptoms
- O postmenopausal bleeding
- O bleeding between periods
- O vaginal discharge
- O vaginal itching
- O vaginal sores
- O vaginal lumps
- O vaginal dryness
- O painful sex
- O missed/late period

MALE:
- O penile discharge
- O genital sores
- O genital pain
- O testicular lump(s)
- O erectile dysfunction
- O painful sex
- O difficulty urinating
- O split stream when urinating
- O early ejaculation
- O prostate issues

ESTABLISHED PATIENTS ONLY:
- O change to meds/supp
- O changes to allergies
- O hospital visit
- O accident | injury
- O **new** health concern

NOTHING ON THIS PAGE APPLIES TO ME IN PAST MONTH:
Initial _____

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_____

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FEMALE BODIED HEALTH:

Menstrual & sexual history:

First day of last menstrual period (date): _____ # of days bleeding: _____ Age periods started:_____
Cycle length (period to period): between 21-35 days | less than 21 days | more than 35 days | uncertain | I don't track
Breast cancer self-check? Y | N | Date of last Pap smear: _____ Abnormal Paps: Y | N | Date: _____
Sexually active: Y | N | men only | women only | men & women | 1 partner | more than 1 partner
Birth control method and for how long: _____ STI prevention method:_____
Date of last STI testing: _____ Any abnormal STI test results? Y | N | If yes, when? Date: _____

Mark all that apply:

- O Frequent yeast infections
- O Frequent urinary tract infections
- O Heavy periods
- O Painful periods
- O Irregular periods
- O Bleed between periods
- O Ovarian pain
- O Breast tenderness
- O Severe PMS
- O Can't lose weight
- O Infertility
- O Difficulty conceiving
- O Risky sexual behavior
- O History of sexual abuse
- O Feel unsafe in home or relationship

Pregnant: Y | N | **Breastfeeding:** Y | N | **Is it possible you are or could become pregnant?** Y | N
# of pregnancies, if any: ____ # of births, if any, with year(s):_____
# of miscarriages w/year(s): _____ # of elective abortions w/year(s): _____
Any complications with any of the above? Y | N | Describe:_____

Menopause: Y | N | If yes, when? Year: _____ **Hysterectomy?** Y | N | Complete | Partial | Date: _____
Date of last mammogram: _____ Abnormal mammogram? Y | N | Date:_____ Date of last DEXA: _____

MALE BODIED HEALTH:

Testicular cancer self-check? Y | N | Last PSA result: _____ Date: _____ History of high PSA: Y | N | Date: _____
Sexually active: Y | N | women only | men only | men & women | 1 partner | more than 1 partner
Birth control method and for how long: _____ STI prevention method: _____
Date of last STI testing: _____ Any abnormal STI test results? Y| N | If yes, when? Date: _____

Mark all that apply:

- O Frequent fungal infections like jock-itch
- O Can't gain muscle
- O Starting and stopping urine flow
- O Biker/cyclist/ equestrian
- O Penile injury
- O Testicular pain
- O Infertility
- O Risky sexual behavior
- O History of sexual abuse
- O Feel unsafe in home or relationship

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health status.

Signature of patient, parent, guardian, or health proxy **Date**

Printed name of patient, parent, guardian, or health proxy Relationship to patient

PATIENT LAST NAME

_____

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HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care.

It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. **Please check all that apply:**

- ○ **Please do not phone me at home. Use this alternate phone number:** _____
- ○ **Please do not phone me at work. Use this alternate phone number:** _____
- ○ **Please do not leave messages on my answering machine.**
- ○ **Please do not contact me by email.**
- ○ **Please send mail, including my bills, to this alternate address:**

  _____

  _____
- ○ **Other request (please describe):** _____

Signature of patient, parent, guardian, or health proxy **Date**

Printed name of patient, parent, guardian, or health proxy Relationship to patient

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STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing one of the healthcare providers at Nutura Clinic. We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following Financial Policy prior to your visit, and please ask if you have questions.

INSURANCE

Nutura Clinic's healthcare providers are contracted with many healthcare insurance, worker's compensation and motor vehicle accident plans. Nutura Clinic will bill them directly once we verify your coverage, if services at Nutura Clinic are not covered, you are responsible for any balance left after payment and/or denial.

CO-PAYMENTS AND DEDUCTIONS

If your policy has an office visit co-payment, you must agree to pay the co-payment at the time of your visit. Failure to do so will result in an additional $15.00 fee. Patients are responsible to know the terms of their insurance and whether services are covered.

PATIENTS WITHOUT INSURANCE

The full balance is due upon checkout.

ALTERNATIVE BENEFITS

Many of services we offer can be considered an alternative therapy that may or may not be covered by your insurance. We will verify your coverage before your scheduled appointment if the insurance information is provided 48 hours ahead of the appointment. It is your responsibility to pay full cash prices when your insurance status was not verified before your appointment. Even though our providers may be contracted with your insurance, there are provider specialties and services that can be excluded on insurance plans.

ADDITIONAL CHARGES AND FEES

For any check that is returned for non-sufficient funds, Nutura Clinic will charge an additional $35.00 to your account and we will not accept your personal checks in the future. You will be asked to remit the amount of the check plus the service charge in cash or with a credit card payment within 10 days. If your account has not cleared by then, we will refer it for collection action.

Patients that "no show" or do not cancel 24 hours prior to their appointment time may be assessed an appointment charge of $80. This charge is your responsibility.

When a child of divorced parents is seen, we will expect payment from whichever parent accompanies that child. We will not bill ex-spouses or the other parent.

If you are having financial difficulty, we will be happy to work with you. You may want to establish a payment plan. We ask that these payments are made as scheduled, each month and on time. We do monitor these accounts and non-payment may jeopardize your ability to be seen by our physicians.

Name of responsible party (if other than the patient): _____

Relationship to the patient: _____ Phone: _____

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 Nutura Clinic to release information necessary to secure payment.

Signature _____ **Print** _____ **Date** _____