BASTYR UNIVERSITY

PERSONAL HEALTH HISTORY for YOUR CLINICAL TEAM

Patient:____Date of Birth:______________

Last Name First Name Middle Initial

What is the main reason, or goal, for your visit today? ____

____

Allergies: Do you have a severe allergy to any of the following? (**Please select all that apply)**

☐ Sulfa ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Latex ☐ Sulfites
☐ Cats ☐ Dogs ☐ Mold ☐ Dust ☐ Bees ☐ Pollen
☐ Wheat ☐ Shellfish ☐ Peanuts ☐ Eggs ☐ Milk ☐ Soy
☐ Other ____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking.

If you need additional space to list medications/supplements, please use page 6 or the back of page 7.

Name of Medication/Supplement	Dose	Frequency Taken

Medical Conditions: Do you currently have or have a history of the following? **(Please select all that apply)**

☐ Adrenal Disorder
☐ Anemia
☐ Anxiety
☐ Arthritis/Joint Disorder
☐ Asthma
☐ Cancer
☐ COPD
☐ Depression
☐ Diabetes Mellitus
☐ Digestive Problem
☐ Heart Disease
☐ Hyperlipidemia
☐ Hypertension
☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Liver Disease
☐ Stroke
☐ Thyroid Disease
☐ Other:

Surgeries / Hospitalizations: (Please select all that apply and write in date.)

- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ C-Section (If applicable)
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy (If applicable)
- ☐ Joint Replacement
- ☐ Prostate Surgery (If applicable)
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation (If applicable)
- ☐ Valve Replacement
- ☐ Vasectomy (If applicable)
- ☐ Other:

Family History: Do you have a family history of any of the following?
(**Please "X" the boxes that apply to you**)

	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems	Other
Mother															
Father															
Sister															
Brother															
Maternal Grandma															
Maternal Grandpa															
Paternal Grandma															
Paternal Grandpa															
Maternal Aunt															
Maternal Uncle															
Paternal Aunt															
Paternal Uncle															
Other															

☐ Adopted ☐ Family History Unknown

Social History: Please answer the following questions regarding your social history:

Tobacco Use

Tobacco Use: ☐ Never Smoker ☐ Former Smoker ☐ Passive Smoke Exposure (Second Hand) ☐ Current Smoker
☐ Other
Start Date:_________________ End Date:_________________
Type of tobacco used: ☐ Cigarettes ☐ Cigars ☐ Pipe
Packs/Day:_________________ Years:_________________
Smokeless Tobacco: ☐ Current User ☐ Former User ☐ Never Used ☐ Unknown
Types: ☐ Snuff ☐ Chew
Quit Date (if applicable):_______________________________
If you are a current tobacco user: Are you ready to quit? ☐ Yes ☐ No

Do you drink alcohol?	☐ Yes	☐ No

If Yes, how many of the following do you have per week?
Drinks/Week: Glasses of Wine_______________ Cans of Beer________________Shots of Liquor______________

Do you currently use any of the following recreational or street drugs? (Please select all that apply):

☐ E-Cigs	☐ Marijuana	☐ Opioids	☐ Heroin
☐ Methamphetamine	☐ Amphetamines	☐ PCP	☐ Ecstasy
☐ LSD	☐ Ketamine	☐ Mescaline	☐ Psilocybin
☐ Cocaine	☐ Crack	☐ Nitrous Oxide	☐ Solvent Inhalants
☐ Barbiturates	☐ Benzodiazepines	☐ IV	☐ Other

If yes to Marijuana: ☐ Medicinal? ☐ Recreational? ☐ Both?
If yes to any of the drugs above how many times per week estimate do you use them? ________________________________

What is your current birth control method? (Please select all that apply):

Sexually Active: ☐ Yes ☐ No

Birth Control/Protection:

☐ Abstinence	☐ Cervical Cap	☐ Condom	☐ Hormonal Patch
☐ Implant	☐ Injection	☐ Inserts	☐ IUD
☐ IUS	☐ Pill	☐ Rhythm	☐ Spermicide
☐ Sponge	☐ Surgical	☐ Vaginal Ring	☐ Withdrawal
☐ Vasectomy	☐ Menopause	☐ None	☐ Other

Partners? ☐ Male ☐ Female ☐ Both ☐ Another

Sexual Orientation/Gender Identity (this helps our clinicians give you the best care possible)**:**

What is your birth sex?	☐ Male	☐ Female	☐ Unknown	☐ Another:_______________
What gender do you identify as?	☐ Male	☐ Female	☐ Trans	☐ Another:_______________
What is your pronoun?	☐ He	☐ She	☐ They	☐ Another:_______________

Do you have any children? Yes No If so, what are their ages:

Do you exercise regularly? Yes No If so, how often and what type of exercise?

Do you have any dietary restrictions or food intolerances? Yes No If so, what?

Additional Medications/Supplements?

Name of Medication/Supplement	Dose	Frequency Taken

CONTINUED ON NEXT PAGE

Review of Systems: Please circle below if you've experienced in the last six months: Y= Yes N= No

Constitutional

Fever	Y	N	Chills	Y	N	Weight Loss	Y	N
Malaise/Fatigue	Y	N	Sweating	Y	N	Weakness	Y	N

Skin

Rash	Y	N	Itching	Y	N	Color changes	Y	N

Head, Ears, Eyes, Nose, Throat

Headaches	Y	N	Hearing Loss	Y	N	Ringing in Ears	Y	N
Ear Pain	Y	N	Ear Discharge	Y	N	Nosebleeds	Y	N
Congestion	Y	N	Migraine headaches	Y	N	Sore Throat	Y	N

Eyes

Blurred Vision	Y	N	Double Vision	Y	N	Light Sensitivity	Y	N
Eye Pain	Y	N	Eye Discharge	Y	N	Eye Redness	Y	N

Cardiovascular

Chest Pain	Y	N	Palpitations	Y	N	Shortness of breath lying down	Y	N
Claudication	Y	N	Leg Swelling	Y	N	Heart Murmur	Y	N
High blood pressure	Y	N	Blood clots	Y	N	Heart disease	Y	N

Respiratory

Cough	Y	N	Coughing up Blood	Y	N	Sputum Production	Y	N
Shortness of breath	Y	N	Wheezing	Y	N	Asthma	Y	N

Gastrointestinal

Heartburn	Y	N	Nausea/Vomiting	Y	N	Abdominal Pain	Y	N
Diarrhea	Y	N	Constipation	Y	N	Blood in Stool/black stool	Y	N
How many Bowel Movements per day:			Bloating	Y	N			

Genitourinary

Painful Urination	Y	N	Urgency	Y	N	Frequency	Y	N
Blood in urine	Y	N	Flank Pain	Y	N	Incontinence	Y	N

Male Reproductive

Hernias	Y	N	Testicular masses	Y	N	Sexual difficulty	Y	N

Female Reproductive

Age of first menses:	Age of last menses:	Number of pregnancies:
Number of live births:	Number of miscarriages:	Number of abortions:

Musculoskeletal

Muscle Pain	Y	N	Neck Pain	Y	N	Back Pain	Y	N
Joint pain	Y	N	Falls	Y	N	Muscle spasms	Y	N

Endocrine/Heme/Allergies

Excessive thirst	Y	N	Env. Allergies	Y	N	Easy Bruising/Bleeding	Y	N
Cold intolerance	Y	N	Excessive hunger	Y	N	Heat intolerance	Y	N

Neurological

Dizziness/fainting	Y	N	Loss of memory	Y	N	Tremor/Seizures	Y	N
Sensory Change	Y	N	Speech Change	Y	N	Numbness/tingling	Y	N

Emotional (Psychiatric)

Depression	Y	N	Suicidal Ideas	Y	N	Substance Abuse	Y	N
Hallucinations	Y	N	Nervous/Anxious	Y	N	Insomnia	Y	N

PSR ________

PSR ________

BASTYR UNIVERSITY

Patient Registration
PLEASE WRITE LEGIBLY

Patient Name: ____
Last Name First Name Middle Initial

What is your preferred first name? (Nickname, Chosen name, etc.) ______________________

Other name(s) that records may be kept under: ______________________

DOB (required)______________________ SSN:______________________

Address:______________________

City:______________________State:____________Zip Code: ______________

Email address:______________________

Phone: *Appointment reminders will be sent to 1st preference.*

1. □ Cell □ Home □ Work: (_____)__________________ **Confidential voicemail OK?** Yes No

2. □ Cell □ Home □ Work: (_____)__________________ **Confidential voicemail OK?** Yes No

The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Your answers are both voluntary and private.

What is your birth sex? □ Male □ Female □ Unknown □ Another: ____________
What gender do you identify as? □ Male □ Female □ Trans □ Another: ____________
What is your pronoun? □ He □ She □ They □ Another: ____________

Primary Language:______________________

Ethnic Group (Select One): □ Latino/Latina/Hispanic □ Non-Hispanic

Race (Select all that apply): □ Alaskan Native □ American Indian □ Asian □ Black □ Native Hawaiian □ Pacific Islander □ White □ Other/Unknown______________________

Are you active Military or a US Veteran? □ Yes □ No

Employment Status (Check one): □ Full Time □ Not Employed □ Part Time □ Retired □ Seasonal □ Self-Employed □ Student (Full Time) □ Student (Part Time) □ BCNH Student □ BCNH Staff/Spouse

Occupation:______________________Hours per Week: ____________

Employer:______________________Address:______________________

Marital Status: □ Single □ Married □ Significant other □ Widowed

Primary Care Provider (PCP) Information (Please select one of the following):

□ I wish to establish Primary Care with BCNH.

□ I see BCNH for ancillary/adjunctive care only. My Primary Care Physician (PCP) is: ______________________

□ If seeking adjunctive cancer support, who is your oncologist? ______________________

- Last physical: ____________ Date of Last bloodwork: ______________________

□ Other providers: ______________________

PATIENT REGISTRATION FORM CONTINUED

Guarantor (Person who is financially responsible for the account):

Name:____ Relationship to the patient: ____________________

Address (if different from patient): ____

City:____ State:_______________________ Zip:____________________

Social Security Number: _____________________________ Gender: □ M □ F DOB:______________________________

Emergency Contact/Other Guardian Name: ____

Relationship: ____ Legal Guardian? □ Yes □ No

Primary Phone:____________________________________Work Phone: ____

Please provide your insurance information below:

Primary Insurance Company: __________________________________ Group # _________________________________

Member ID #____ Relationship to Subscriber:_________________________

Claims Address: ____

Subscriber Name (if other than patient):_____________________________________ DOB: _________________________

Secondary Insurance Company: __________________________________ Group # _________________________________

Member ID #____ Relationship to Subscriber:_________________________

Claims Address: ____

Subscriber Name (if other than patient):_____________________________________ DOB: _________________________

Check if applicable: □ Auto Accident □ Workers compensation Date of Accident: ____________ Claim#:______________

****Please be prepared to present your insurance card at check-in at each visit****

How did you hear about us?

□ Friend/patient □ Event/health fair □ Shuttle/Bus □ Staff/student □ Physician: ________________

□ Radio/TV □ Walk by □ Social media □ Yelp □ Website: _________________

□ Please sign me up for the Clinic newsletter so I can stay up to date regarding clinic hours, events and discounts.

Research is vital to the advancement of natural medicine. If Bastyr has a research study, I can help with:

□ Yes! Please contact me for future research participation

I certify the above information is true and correct to the best of my knowledge. I acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

____ ______________________________________

Patient/Guardian Signature **Date**

Financial Agreement

BASTYR University CLINIC

Thank you choosing Bastyr University Clinic to seek your health care.

What you should know:

Health insurance is a contract between you and your insurance company. It's best if you know which services your insurance will cover before you receive care. That way, there are no surprises for either of us. If you are not sure about your coverage, please ask your insurance company. Refer to the back of your insurance card. If you don't have insurance, we have many discounted contracts you may qualify for; please ask us.

Insurance billing

- Contract coverage: Bastyr contracts with many insurance plans. If we are in your health plan's network, you are expected to pay any cost shares at the time of service
- Non-contracted: If your insurance plan is not contracted with Bastyr we will bill your insurance as a courtesy to you. You are responsible for the full cost of care. If your insurance does not pay within 45 days, the balance will be billed to you.

Care or services not covered by your insurance plan

Bastyr has many services that are non-covered by insurance plans. Some services might be considered experimental for research purposes only by your insurance company. If that is the case, you will be responsible for the full cost. We expect payment at the time of the service.

Nonpayment

If you have not pay your bills within 30 days after receiving your final notice you will be turned over to the collection agency Professional Credit Services. You will be responsible for any collection agency fees that apply. If you have large unpaid balances and make no arrangement or payments, you may be reported to a credit bureau and denied additional services at Bastyr Center. If this happens, we can help you transfer your care.

Returned Checks

Bastyr charges $28 for any returned checks.

Questions?

Please contact our Billing Office at 206.834.4183, if you have any questions about anything in our policy.

Consent to contact

Acknowledgement of our policies. You consent to being contacted by Bastyr or any organization we may assign your account to.

Signed: ______________________________

Patient Cancellation and No-Show Agreement

BASTYR University CLINIC | YOUR PARTNER IN NATURAL HEALTH CARE

Patient Information

Welcome to Bastyr University Clinic. We are glad you have made an appointment for yourself or a family member.

To provide you with high-quality care, it is important for you to keep your scheduled appointment with the medical provider. Valuable time has been reserved for you or your family member. A missed appointment or late cancellation results in lost time that could have been given to another person wanting to receive care.

- Patients arriving more than 15 minutes late to their appointment will be subject to the providers' discretion as to whether they can be seen. Late arrivals may also be subject to an abbreviated visit.
- If a patient cannot be seen, or is more than 20 minutes late for a scheduled visit, it will automatically be considered a no show.

You will receive a reminder call two days ahead and remind you of your appointment; however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment, please call 24 business hours in advance. You may also leave a message with our scheduling desk. Every late cancel/no-show will be recorded in your chart. Multiple late cancels and no-shows can end your ability to make advance appointments or receive care at Bastyr University Clinic.

We realize that an emergency may occur and/or you may not be able to notify us. We will discuss that situation with you when it happens.

- **After One (1) Late Cancel/No Show: You will be reminded of our Late Cancel/No Show policy.**
- **After Two (2) Late Cancels/No Shows: There will be a charge of $40 for appointments in Team Care, or $60 for appointments in Practitioner Care. (Bastyr Students will be charged $30.)**
- **After Three (3) Late Cancels/No Shows: Advanced scheduling privileges will be suspended for three months. You can still be seen on a same-day scheduling basis only, depending on provider availability. We cannot guarantee that you will be seen.**

Thank you for working with us to ensure that services are provided to all our patients in the best possible way.

Acknowledgement of Cancellation and No-Show Agreement

______________________________ ______________

Signature **Date**

______________________________ ______________

Print name **Date of birth**

______________________________ ______________

Name of patient if minor **Date of birth**

Consent for Treatment

BASTYR University CLINIC

General Information: Bastyr University Clinic is a teaching clinic for students studying at Bastyr University California that includes a Practitioner Care Department, where independent providers rent space from Bastyr to see patients in their private practice. Bastyr University Clinic's teaching clinic uses a "Team Care" approach where faculty supervisors and student clinicians work as a team to address your health concerns. Student clinicians, depending on their levels of experience, may observe or participate in the care provided but are always supervised by health care providers licensed in the State of California. Your medical history, treatment plan and progress is discussed (without identifying information) among other student clinicians for educational purposes at the clinic and evaluated by the supervising faculty for appropriateness and effectiveness. Due to the diversity of modalities offered at Bastyr University Clinic, your treatment may include any or all of the following general modalities: Naturopathic Medicine, Physical Medicine, Homeopathy, Mind-Body Medicine and Nutritional Counseling. Some modalities may be used exclusively on some specialty shifts, but many Bastyr University Clinic teams use multiple treatment modalities.

Please visit www.BastyrClinic.org for individual faculty biographies.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform general diagnostic procedures, psychological counseling, lifestyle counseling, exercise prescriptions, acupuncture, ayurvedic services, topical treatments, herbal medicine, natural medicine, dietary advice and therapeutic nutritional counseling, soft tissue and osseous manipulation, electromagnetic and thermal therapies. See brief description of methods, procedures and approaches.

I understand that California State law does not authorize naturopaths to treat me for any **cancer or malignancy** and that I am required to be under the care of a medical doctor or osteopathic physician (oncologist) while receiving care at the Bastyr University Clinic.

I am currently under the care of ______________________________
I recognize that I am here for supportive therapies only.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Bastyr University Clinic or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. **I hereby acknowledge that I am financially responsible for services rendered.**

____
Patient's Name (PRINT)

____
Guardian/Personal Representative's Name (PRINT)

____
Patient's Signature

____
Guardian/Personal Representative's Signature

____
Date

____
Relationship/Representative's Authority

Notice of Privacy Practices Acknowledgement Form

BASTYR University CLINIC | YOUR PARTNER IN NATURAL HEALTH CARE

Patient Name: ________________________________ **Date of Birth :** ______ / ______ / ______
(please print)

Bastyr University Clinic is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. A parent or guardian should sign for patients under age 18. Please return to staff. If you have questions concerning the management of your health care information at our clinic, or if you wish schedule an appointment to view your medical record, please call our medical records office at 858.246.9700.

________________________________ ________________
Print Name **Date**

________________________________ ________________
Patient/Legal Guardian/Representative's Signature **Date**

____
Relationship to Patient

OFFICE USE ONLY

Staff member's initials: ____________________

☐ I offered the Notice but the patient or patient's representative is unable or refuses.

☐ I have updated the NPP Flag in Epic

☐ Reason ________________________________