CONFIDENTIAL PATIENT INFORMATION

EVERGREEN CENTER FOR INTEGRATIVE MEDICINE
2008 NE 65th St
Seattle, WA 98155
(206) 729-0907

❑ Dr. Bobbi Lutack
❑ Dr. Paris Preston
❑ Dr. Cara Hartz
❑ Dr. Traci Taggart

Patient Information	First Name:	MI:	Last Name:
Street Address:			
City:	State:		Zip:
SSN:	Gender: ❑ M ❑ F		Home phone:
Date of Birth (mm/dd/yyyy): / /	Age:		Alt phone: ( )
Email Address:			
Employment: ❑ Employed ❑ F/T Student ❑ P/T Student ❑ Retired ❑ Other			
Employer:			Work phone: ( )
Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed ❑ Dependent ❑ Other			
❑ Parent ❑ Guardian ❑ Spouse ❑ Partner Phone: ( )			
Emergency Contact:	Relationship:		Phone: ( )
Who referred you to us?			

Primary Health Insurance	Insurance Company Name:	Phone: ( )
Claims address:		
Name of Insured:		Insured's DOB: / /
Relationship to you: ❑ Self ❑ Parent ❑ Spouse ❑ Dependent ❑ Other:		
ID # on card:		Group #:
Employer of insured:		

Secondary Insurance, AUTO or L&I:	Insurance Company Name:	Phone: ( )
Is this visit injury-related? ❑ yes ❑ no Work-related? ❑ yes ❑ no Auto Accident? ❑ yes ❑ no If yes, State:		
Claims address:		
City: State: Zip:	Adjuster's Name (if known):	
Name of Insured:		Insured's DOB: / /
Relationship to you: ❑ Self ❑ Parent ❑ Spouse ❑ Dependent ❑ Other:		
Claim # or ID #:	Policy # (Auto) or Group #:	
Injury Date / Effective Date: / /	Employer of Insured:	

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician. ***Please note that all the doctors at ECIM are sole proprietors.***

Signature _____ Date _____

SEXUAL HISTORY	
Are you currently sexually active? ❑ yes ❑ no	If yes, are you sexually active with: ❑ men ❑ women ❑ both
In the past, have you been sexually active with: ❑ men ❑ women ❑ both	
Do you have any need for birth control? ❑ yes ❑ no	If yes, method currently used:
Do you practice safer sex? ❑ yes ❑ no	Have you ever had/have sexual difficulties? ❑ yes ❑ no
Have you ever had chlamydia, gonorrhea, herpes, HIV/AIDS or warts? ❑ yes ❑ no	
Have you ever been touched in a way that made you feel uncomfortable without your permission? ❑ yes ❑ no	
Have you ever been physically or emotionally abused? ❑ yes ❑ no	
Do you have any concerns about violence in your life now? ❑ yes ❑ no	

FEMALES		
Age at first period:	Date of last period: / /	Have you reached menopause? ❑ yes ❑ no
Periods last(ed) _____ days and occur(ed) every _____ days		
Did your mother take DES? yes no	Did your mother haves any miscarriages? yes no	
Do you check your breasts?	Have you ever had an abnormal Pap smear?	
Have you ever been pregnant?	Your age at first pregnancy:	
Number of pregnancies:	Number of living children:	Number of stillbirths:
Number of miscarriages: When in pregnancy?		Number of tubal pregnancies:
Number of abortions: When in pregnancy?		Number of Cesarean sections:
Date of last pregnancy:		

HABITS
Tobacco (circle): Cigarettes / Smokeless Tobacco / Pipe / Cigars How much?
Alcohol: Number of drinks per day / week / month (circle one):
Coffee: Number of cups per day:
Drugs (circle): Marijuana / Cocaine / Crack / Amphetamines / Injectables / Other: How often?
Exercise: Number of times per week / month (circle one): Type of exercise:
Environmental Exposure (circle): Pesticides / Herbicides / Solvents / Heavy Metals / Noise / Other:
Explain any further details:

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DIET	
Do you follow any special diet? ❑ yes ❑ no	If yes, describe:
Are you satisfied with your diet now? ❑ yes ❑ no	
Are you aware of any food allergies? ❑ yes ❑ no	If yes, what?

WEIGHT			
Current Weight:	Weight One Year Ago:	Maximum Weight:	Minimum Weight:

HEALTH CONCERNS	Below is a list of health concerns. PLEASE CIRCLE ITEMS THAT ARE CURRENT OR RECENT PROBLEMS FOR YOU. Please fill in the blanks where appropriate.
GENERAL: night sweats, fatigue/tiredness, weight problems, appetite changes, fever	
SKIN: rash, infection, growths, hair or nail problems, itching	
HEAD: frequent headaches, history of migraine, tension headaches, head injury	
EYES: vision problems, eye pain, double vision, eye redness, tearing problems	
EARS: hearing loss, ringing, earache, dizziness	
NOSE/SINUS: frequent colds, nose bleeds, sinus problems, frequent sneezing, blood, yellow/green nose discharge, hay fever/allergies, loss of smell, snoring	
MOUTH/THROAT: frequent sore throat, sore tongue, mouth, sores, hoarseness, dental problems	
NECK: swollen glands,enlargement, pain	
BLOOD: easy bleeding or bruising, history of anemia	
RESPIRATORY: cough, yellow/green sputum, coughing up blood, wheezing, pain on breathing, shortness of breath (lying down, with activity or at night), history of positive tuberculosis skin test	
HEART: chest pain or discomfort, history of high blood pressure, history of rheumatic fever, history of heart murmur, ankle swelling, dizzy spells, heart fluttering, history of heart attack, history of angina	
DIGESTION: trouble swallowing, heartburn, history of ulcers, abdominal pain, nausea, vomiting, blood in stool or vomit, black tarry stools, bowels move daily (more or less), abdominal bloating, belching, gas, hemorrhoids, history of hepatitis, history of blood transfusion (year _____), family/personal history of colon cancer, polyps	
URINARY: pain with urination, frequency, dribbling, frequent bladder infections, kidney stone history, blood in urine, foul smelling urine, unusual discharge	
BREAST/PELVIC: excessive menstrual bleeding/pain, discharge, odor, itching, sores, hot flashes or other menopausal symptoms, breast lumps, breast pain, family history of breast cancer, nipple retraction/discharge, yeast infections	
CIRCULATORY: varicose veins, pain in legs with walking, swelling of legs	
MUSCULOSKELETAL: joint pain or stiffness, history of broken bones, muscle cramps or spasms, weakness	
EMOTIONAL: depression, sleep problems, mood swings, anxiety, nervousness, tension, phobias, suicidal thoughts/plans, family history of psychiatric disorder	
ENDOCRINE: history of thyroid problems, diabetes, low blood sugar, excessive thirst, excessive hunger, weight gain, weight loss	

PAST MEDICAL HISTORY	Please indicate illness, date and place/provider.
Childhood illnesses:	
Adult Illnesses:	
Hospitalizations:	
Surgeries:	
Major Injuries:	

FAMILY HISTORY	List chronic illnesses of family members, such as cancer, heart disease, TB, diabetes, high blood pressure, alcoholism, etc. If deceased, please include age at death. No names necessary.
Mother:	
Father:	
Siblings:	
Grandparents:	

HEALTH DATA	Indicate most recent date, place and result
Physical Exam:	Mammogram:
Chest X-Ray:	Pap Smear:
EKG:	Syphilis Test:
TB Test:	Gonorrhea Test
Tetanus Booster	HIV Test
Cholesterol Test	

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MEDICATIONS	Include prescription, over-the-counter medicines and supplements (vitamins and minerals). Indicate dosages.

Current Medications: Include prescription, over-the-counter medicines and supplements (vitamins and minerals). Indicate dosages.

Drug Allergies:

Other Allergies:

Do you have an advance health care directive? ❑ yes ❑ no
If yes, please describe it:

Is there anything else you would like us to know that will help us provide you with better health care?

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Consent for Treatment

Methods, Procedures, and Therapeutic approaches: Your physician may perform any of the following procedures as necessary to give proper assessments,determine treatment approaches, treat, or otherwise address your health concerns.

General Diagnostic Procedures: Including but not limited to venipuncture, pap smears, radiology, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Psychological and Lifestyle Counseling, Exercise Prescriptions

Herbs/Natural Medicine: Prescribing of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, and tinctures (which may contain alcohol) topical creams, pastes, plaster washes, suppositories or other forms. Homeopathic remedies (often highly diluted quantities of a naturally occurring substance)may also be used.

Dietary Advice and Therapeutic Nutrition: The use of foods, diet plans, or nutritional supplements for treatment. This may include intramuscular vitamin injections.

Soft Tissue and Osseous Manipulation: The use of massage, neuro-muscular techniques, muscle-energy stretching or visceral manipulations of the extremities and spine including traction and craniosacral therapy.

Potential Risks: May include pain, discomfort, discolorations, infection, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat.or frictional therapies, allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms or conditions.

Potential Benefits: Restoration of health and the body's maximum functional capacity, relief of pain,and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they suspect or know they are pregnant, as some of the therapies used could present a risk to the pregnancy.

Statement of Consent For Treatment:

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 participating in these procedures at any given time. With this knowledge,I voluntarily consent to the above procedures, realizing and acknowledging that no guarantees have been given to me by my doctor/practitioner or any of their personnel regarding cure or improvement of my condition(s). I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or as otherwise permitted by law.

_____	_____	_____
Guardian/PatientsName(print)	Guardian/Patients Signature	Date

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Patient-Practitioner Relationship

I understand that I am a patient of_____, who is an independent practitioner at The Evergreen Center for Integrative Medicine. The Evergreen Center is not a group practice, but rather a facility where independent practitioners share office space. I understand that my medical care is the sole responsibility of the individual practitioner, not The Evergreen Center for Integrative Medicine or any of the other practitioners who may practice there.

If I am seeing more than one practitioner at this clinic, I understand that each practitioner is required to keep separate records and will be billing for services separately from any other practitioners at this clinic.

_____ _____

Patient Name (please print) Date

_____ _____

Patient/Guardian Signature Relationship to Patient

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Notice of Privacy Practices

The Evergreen Center for Integrative Medicine (ECIM) is required to provide you with a copy of its "Notice of Privacy Practices" document and to obtain written acknowledgement, if possible, that you have received it. This notice outlines the types of uses and disclosures that may occur involving your protected health information. It also describes your rights and explains how you may exercise those rights.

I understand that my protected health information can and will be used to:
* Provide and coordinate my treatment
* Obtain payment from third-party payers for my health care services
* Conduct normal health care operations such as quality assessment and improvement activities

I understand that my provider has the right to change the Notice of Privacy Practices and that I may request a current copy.

My signature below acknowledges that I have (please check one):

_____ been offered a copy of the Notice of Privacy Practices document and have accepted that copy.

_____ been offered a copy of the Notice of Privacy Practices document and have declined a copy. I understand that I can request a copy at any time in the future, and be given a current copy.

_____	_____	_____
Patient/Guardian Signature	Relationship to Patient	Date

Office Use Only

I hereby affirm that ECIM has made a good faith effort to provide a copy of the Notice of Privacy Practices to the above named patient and to obtain written acknowledgement of such.

Staff Initials: _____
Staff please check one:

_____ Pt offered but refused to sign _____ Pt. physically unable to sign

_____ Communication barrier / other reason: _____

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