true health
MEDICINE, PC

Promoting true health and healing.

Jeff Clark, ND - Wendy Rogers, ND - Bijana Devo, ND - Anya Chang, ND

Office address:
8555 SW Tualatin Rd
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Mailing address:
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Office Phone: (503) 691-0901
Fax: (503) 691-9018
Medicinary: (503) 691-2016

Website: www.truehealthmedicine.com Email: Frontdesk@truehealthmedicine.com

PERSONAL INFORMATION

Name:_____Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home):_____(cell): _____E-mail address: _____

Insurance? No / Yes Insurance Name:_____ Phone #:_____

Policy/ID Number:_____ Group Number: _____

S.S#:_____Age: _____ Date of Birth: _____ Gender: Female ____ Male____

Married: _____Separated: _____Divorced: _____Widowed: _____Single:_____Partnership:_____

Live with: Spouse _____ Partner _____Parents _____Children _____Friends_____Alone_____ Other_____

Occupation: _____ Hours per week: _____Retired: _____

Employer: _____ Phone #: _____

Address: _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Next of kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Address: _____

GENERAL HEALTH REVIEW

Are you currently receiving healthcare? Y / N If yes, where and from whom: _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance:

1) _____
2) _____
3) _____

What is your reason for coming in today?

_____

_____

_____

CURRENT MEDICATIONS & SUPPLEMENTS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)_____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

GENERAL HEALTH HISTORY

Family History: Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hay fever/Hives	Osteoporosis	Metal Sensitivity	

Any other relevant family history? _____

Childhood Illnesses: Please circle whether you had any of these as a child:

Scarlet fever Diphtheria Rheumatic fever Mumps Measles German measles

Hospitalization, Surgery, Imaging: What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____Year:_____ _____Year:_____

_____Year:_____ _____Year:_____

_____Year:_____ _____Year:_____

Allergies: Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

General: Height: _____Weight:_____ lbs. Weight 1 year ago_____lbs.

Maximum Weight: _____lbs. When: _____

When during the day is your energy the best?_____worst? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Habits

Main interests and hobbies:_____

Do you exercise? Y N

If yes, what kind?_____ How often? _____

Average 6-8 hrs. sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	how many hours? _____	
Any major traumas?	Y N P	Read?	Y N
Use recreational drugs?	Y N P	how many hours? _____	
Been treated for drug dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? _____		Drink black/green tea?	Y N P
How many packs per day? _____		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N If yes, what?_____

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Reactions to vaccinations?	Y N P	Chronic infections?	Y N P
Chronic Fatigue Syndrome?	Y N P	Slow wound healing?	Y N P
Chronically swollen glands?	Y N P		

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Night Sweats?	Y N P
Lumps?	Y N P	Hair Loss?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	Shortness of breath while lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall Bladder disease?	Y N P	Is this a recent change?	Y N
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Male Reproduction

Hernias?	Y N P	Chlamydia?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Testicular masses?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Sexually transmitted infections?	Y N P
Sexual orientation: _____		Gonorrhea?	Y N P
Erectile dysfunction?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type? _____		Syphilis?	Y N P

Female Reproduction / Breasts

Age of first menses? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal) _____		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y N P
Duration of menses? _____ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms?		What type? _____	
_____		Number of pregnancies: _____	
_____		Number of live births: _____	
Endometriosis?	Y N P	Number of miscarriages: _____	
Ovarian cysts?	Y N P	Number of abortions: _____	
Abnormal Pap?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Are you sexually active?	Y N
Sexual difficulties?	Y N P	Chlamydia?	Y N P
Difficulty conceiving?	Y N P	Condyloma?	Y N P
Breast pain/tenderness?	Y N P	Syphilis?	Y N P
Do you do breast self-exams?	Y N P	Gonorrhea?	Y N P
Breast lumps?	Y N P	Herpes?	Y N P
Nipple discharge?	Y N P	Sexual orientation: _____	

Thank you for your time and effort. We look forward to providing you with the best possible care.

I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges of all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

I give my consent for these services. I will consult with my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Signature:_____ **Date:**_____

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Informed Consent for Treatment

I, _____, hereby authorize the doctors of True Health Medicine, P.C., to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures:** e.g., venipuncture, UA, Pap smears, radiography, laboratory.
- **Minor office procedures:** e.g., ear cleansing.
- **Naturopathic physical medicine:** e.g. craniosacral technique, muscle energy stretching, therapeutic massage techniques, heat and cold therapies, electric stimulation, manual therapies and other related treatments.
- **Medical use of nutrition:** therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections.
- **Western Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, gels, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling:** promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work, spiritual awareness, and social activities.

I recognize the potential risks and benefits of these procedures as described below:

- **Potential risks:** allergic reactions to prescribed herbs and supplements; side effects of natural medicines; inconvenience of lifestyle changes; injury from injections, venipuncture, or physical medicine.
- **Potential benefits:** restoration of health and the body's maximal capacity, relief from 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 know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Patient Signature:_____ Date:_____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **July 28, 2008.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

_____ _____

Date Signature

_____

Print Name

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OFFICE POLICIES

Welcome to our family of patients. The purpose of these policies is to enable our office to serve you to the best of our abilities.

Initials:

- **Making Appointments**: For healing to be most effective, the doctors often suggest a series of visits. In such cases, we advise that you schedule in advance to ensure continuity of appointments. _____
- **Cancellation Policy**: Missed appointments without prior notifications are subject to a $45 charge. Please give prior notice of at least 24 hours so the doctors can help other patients in that appointment time. Please, note that insurance does not cover this fee _____
- **Payment Policy**: We charge for services provided, and payment is due at the time of service. We offer a discount to clients who pay in full at the time of service. Any visit that is not paid for in full, including insurance billing, will be billed at our regular fee. Due to bank charges to us, we must charge a $25 fee for all returned checks. _____
- We do not bill insurance for supplement prescriptions and typically insurance companies will not cover them under their policies. ***We do not accept returns on any supplements. Please be sure before you buy. This policy is in effect for your safety***. _____
- **Motor Vehicle Accidents:** Please notify us if you are billing insurance for a motor vehicle accident. We will be happy to bill under your Personal Injury Protection coverage. _____
- **Collection Policy:** We may charge interest of 1.5% per month (18% APR) for unpaid balances after 30 days. If an account is over six month in arrears, it will be subject to legal collection. The key to avoiding this situation is communication. WE WILL WORK WITH YOU! Just talk to us. _____
- **Childcare Policy**: We do not offer childcare in this clinic. **Please do not leave children unattended**. _____
- **Please notify us** when your address and/or your phone number changes as soon as possible. _____
- **Cell Phones**: This office is a cell phone free-zone. Please take any calls outside the office and silence all cell phones upon entering the clinic. Thank you for helping to create a healing environment. _____
- Some physicians at True Health Medicine, PC (THM) use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow THM and its physicians to correspond with you via email in spite of these potential risks. _____

"PAYMENT AT TIME OF SERVICE OPTION" AGREEMENT

PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED. A written copy of the fees for specific services performed in this office is available upon request and all fees are subject to change without notice.
Initials:
_____ I agree to use this prompt payment option. I will pay in full at the time services are rendered.

OUR POLICY ON INSURANCE

You will be provided with a "superbill" with the appropriate information and codes on it for you to send in to your medical insurance company. It is your responsibility to be aware of the medical services covered by your insurance policy. You will pay True Health Medicine at the time of service and get reimbursed directly from your insurance company. The only exception to this rule will apply to MVA patients, in which case we will bill your automobile insurance policy coverage directly.

Patient Signature:_____ **Date:**_____