Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Home Ph:(____)_____ Work Ph:(____)_____

Cell Ph:(____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? ❍ No ❍ Yes (specify): **❍ Home ❍ Work ❍ Cell**

Date of Birth: _____ Gender:_____ Other names that records may be kept under: _____

Are you a student at another university or college? Y N What is your current status? FT PT Are you currently employed? Y N

Employer/School: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #1: (____)_____ ❍ Home ❍ Work ❍ Cell Do you have special needs?: ❍ No ❍ Yes

How did you hear about us? ❍ Newspaper Ad ❍ News Story ❍ Mailer/Flyer ❍ Website ❍ Workshop/Event ❍ Medical Referral ❍ Friend/Family ❍ Yellow Pages ❍ T.V. Ad ❍ Insurance Co. ❍ Other: _____

The following information is requested for our grant and federal reporting requirements

Marital Status ***(circle one):*** Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership

Race/Ethnic Origin: African/African-American Asian Caucasian Native American Pacific Islander/ Native Hawaiian Mixed Race Other

Number of members in your household: _____ **Gross annual household income:** _____ /year

Terms of Admission

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so.. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call our medical records office at (206) 834-4151.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

(Ext Site version 1-3-11)

CONSENT FOR TREATMENT

***General Information*:** The Bastyr Center for Natural Health (BCNH) is a teaching clinic for students studying at Bastyr University and integrates a number of medical treatment modalities. BCNH 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 healthcare providers licensed in the State of Washington. 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 BCNH, your treatment may include any or all of the following general modalities: East Asian Medicine, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling. Some modalities may be used exclusively on some specialty shifts, but many BCNH clinic teams use multiple treatment modalities. All of our East Asian medical practitioner facultyare licensed in the State of Washington having completed graduate level training and national board certification. Please visit www.bastyrcenter.org for individual faculty biographies.

Methods, Procedures and Therapeutic Approaches: Clinicians 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, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Acupuncture: insertion of special sterilized needles or lancets at specific points on the body.
Topical Treatments and Prepping: includes cupping --a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha--rubbing on an area of the body with a blunt, round instrument.
Herbs/Natural Medicines: prescribing therapeutic substances which include plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.
Soft Tissue and Osseous Manipulation: use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.
Electromagnetic and Thermal Therapies: includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy and infrared and ultraviolet therapies or moxa (warming or indirect burning of an acupuncture point and hydrotherapies.)

Potential Risks: While not common, can potentially occur from any therapy. Some examples include but are not limited to: pain, discomfort, blistering, discolorations, infection, or burns from topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; loss of consciousness or deep tissue injury from needle insertions or needle breakage; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms. In addition, the patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pacemaker prior to any treatment.

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

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a 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 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 Center for Natural Health 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. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.
I hereby acknowledge that I am financially responsible for services rendered.

Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
Guardian/Personal Representative's Signature	Patient's Signature
Relationship/Representative's Authority	Date

Patient Profile

BASTYR CENTER FOR NATURAL HEALTH | the teaching clinic of Bastyr University

Last Name: _____ First Name: _____ Middle Initial: _____

Nickname: _____ Date of Birth _____/_____/_____ Gender: _____

A note to our patients: Please complete this **3-page questionnaire** as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.

What goals do you have for your visit at the clinic today?

_____

_____

Who is your Primary Care Provider? _____ Phone: (____) _____

Please list other providers/specialists involved in your care and their clinic phone number:

_____

_____

If you are seeking adjunctive Cancer support, who is your Oncologist?

Oncologist? _____ Phone: (____) _____

When was your last physical? _____ When did you last have bloodwork? _____

Please indicate the type of care you are seeking

☐ Primary management of my health
☐ Adjunctive care for my health
☐ On-going management of my health
☐ One time advice for my health
☐ I don't know at this time

Have you ever consulted a Naturopathic Physician, Acupuncturist, Nutritionist or Counselor before? ☐ Yes ☐ No

If YES, please circle which type of practitioner you've previously consulted with.

In general would you say your health today is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Patient Profile

BASTYR CENTER FOR NATURAL HEALTH | the teaching clinic of Bastyr University

Last Name: _____ First Name: _____ Date of Birth ____ / ____ / _____

Do you have any **medication allergies or any allergic reactions** to anything else? ☐ Yes ☐ No

If **YES** please explain: _____

_____

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if needed.

Name of medication *(such as Synthroid, Vitamin D, etc.)*	**Strength** *(88mcg, etc.)*	**Directions** *(such as 1 tablet twice a day, as needed, etc.)*
☐ Check if none		

Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition, if applicable such as mother (M), father (F), sibling (S) or maternal or paternal grandmother/grandfather (MGM, MGF, PGM, or PGF).

Condition	SELF	RELATIVE	Condition	SELF	RELATIVE
Allergies			HIV/AIDS		
Anemia			Hypertension		
Anxiety			Irritable Bowel Syndrome		
Arthritis			Kidney Disease		
Asthma			Meningitis		
Blood Transfusion			Nerve/Muscle Disease		
Cancer			Osteoporosis		
Cataracts			Parkinson's/Alzheimer's		
Congestive Heart Failure			Seizures		

Patient Profile

Medical History continued

Last Name: _____ First Name: _____ Date of Birth ____ / ____ / _____

Condition	SELF	RELATIVE	Condition	SELF	RELATIVE
Clotting Disorder			Sickle Cell Anemia		
COPD			Stoke		
Depression			Substance Abuse		
Diabetes			Thyroid Disease		
Emphysema			Tuberculosis		
GERD			Ulcers		
Glaucoma			Other		
Heart Attack			Other		
Heart Murmur			Other		

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization: *Date:*

_____ ____ / ____ / ____

_____ ____ / ____ / ____

Social History

Do you use any of the following substances regularly?

☐ Coffee/Black Tea/Cola ☐ Alcohol ☐ Recreational Drugs ☐ Tobacco- Current/Past/Never

If Current or Past Tobacco Use: Packs Per Day: _____ How Long: _____ Quit: _____

Please mark those that apply: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced Other: _____

Do you have children? ☐ Yes ☐ No If YES, what are their ages: _____

Do you follow any particular diet restrictions? ☐Yes ☐No If Yes, please describe: _____

_____

Do you exercise regularly? ☐Yes ☐No If YES, please describe type of exercise and how often. _____

_____

_____ _____

Patient/Guardian (Print Name): **Date**

_____ _____

Patient/Guardian Signature: **Date of birth**

Reviewed by Provider and ready to be scanned to EPIC (Initals): _____ **Date:** _____ / _____ / _____