

Golden Healer Medicine ~ Confidential Intake Form

Name _____ Birth Date _____ Today's Date _____
Address _____ City, State, Zip _____
Phone (day) _____ (evening) _____
Is it ok to leave a message? Y N How did you hear about our office? _____
Email _____ Would you like to receive email updates and specials? Y N
Occupation _____ Single Married Partnered Divorced Widowed
Emergency Contact _____ Phone _____ Relationship _____

Primary Insurance – if applicable

Insurance Carrier _____ Plan Name _____
ID/Subscriber # _____ Group # _____
Primary on Policy? Y N, answer following for Primary Insured: Insured's ID # _____
Legal Name _____ DOB _____ Relationship to You _____

Secondary Insurance – if applicable

Insurance Carrier _____ Plan Name _____
ID/Subscriber # _____ Group # _____
Primary on Policy? Y N, answer following for Primary Insured: Insured's ID # _____
Legal Name _____ DOB _____ Relationship to You _____

Motor Vehicle or Work Accident Claims – if applicable

Insurance Carrier _____ Claim # _____ Claim Submitted? Y N
Date of Injury _____ In _____ State Adjuster's Name _____
Claims Address _____ Carrier or Adjuster Phone _____
Attorney's Name _____ Phone _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I hereby authorize Kenton Family Wellness Center to submit claims to my insurance carrier(s) or their intermediaries for all services rendered by Kenton Family Wellness Center and direct them to issue payment directly to Kenton Family Wellness Center. I understand I am responsible for all charges not covered by my insurance company.

Patient or Guardian Signature

Date

Privacy Practices

As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

LEGAL RESPONSIBILITIES OF KENTON FAMILY WELLNESS CENTER

As mandated by Federal and State legal requirements, your protected health information must be kept secure. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE

Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

TREATMENT

Use and disclosure of your protected health information may be provided to a physician or other healthcare provider (including those of Kenton Family Wellness Center) providing treatment to you. However, this information will not be provided unless you have requested so in writing.

PAYMENT

Your protected health information may be used and disclosed to obtain payment for services we provided to you.

HEALTHCARE PROCESSES

We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION

At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

PERSON INVOLVED IN CARE

In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

MARKETING HEALTH-RELATED SERVICES

The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

REQUIRED BY LAW

Your protected health information may be used or disclosed if required by law.

ABUSE OR NEGLECT

As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

NATIONAL SECURITY

Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

APPOINTMENT REMINDERS

Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, emails, or letters.

PATIENT RIGHTS

ACCESS

At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you \$0.83 per page for the first 30 pages and \$0.63 for every page after that plus \$19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

DISCLOSURE ACCOUNTING

Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

RESTRICTIONS

You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

ALTERNATIVE COMMUNICATION

Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

AMENDMENT

You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

ELECTRONIC NOTICE

If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way.

I have read and understood the HIPAA privacy policies of Kenton Family Wellness Center

Patient or Guardian Signature

Date

Health History

Below you will find a number of questions related to your health history. For your convenience, we have tailored this information to be applicable to all modalities available at our clinic. While not all of the questions may seem directly related to your main complaint or reason for seeking care, your answers to these questions will inform your treatment throughout the course of your care at Kenton Family Wellness Center. Therefore, we ask you to be as thorough and thoughtful as possible as you consider the questions below.

What is the main issue you would like to address in your treatment?

When did this issue begin?

What was the cause of the condition? (if known)

Is it getting worse? Yes No Is it aggravated by: Standing Sitting Driving Stress

How does this problem interfere with your daily activities? (sleep, work, other)

Have you consulted a primary care physician? Y N If yes, did they provide you with a diagnosis?

What other treatments have you tried and what were the outcomes?

What are other health concerns you have today?

Name of Your Primary Care Physician: _____ Phone: _____

Seen for what condition? _____ Date of Last Visit: _____

I hereby authorize Kenton Family Wellness Center to contact my primary care physician, as needed:

Signature

Date

Diagnostics

Which diagnostic studies have you had in the past **year**?

Electrocardiogram (EKG) X-Ray Bone Density Scan (DEXA) Electroencephalogram (EEG)
 Mammogram CT Scan Blood Drawn MRI Other: _____

Was a condition diagnosed as a result?

2104C N. Willis St, Portland, Oregon 97217 503-475-4370 Dr. Glenda Culbertson DC, LAc
Goldenhealermedicine.com

Musculo-Skeletal Pain

Please indicate any areas of pain or discomfort:

Draw the area of your symptoms using these symbols:

(mark on the figures)

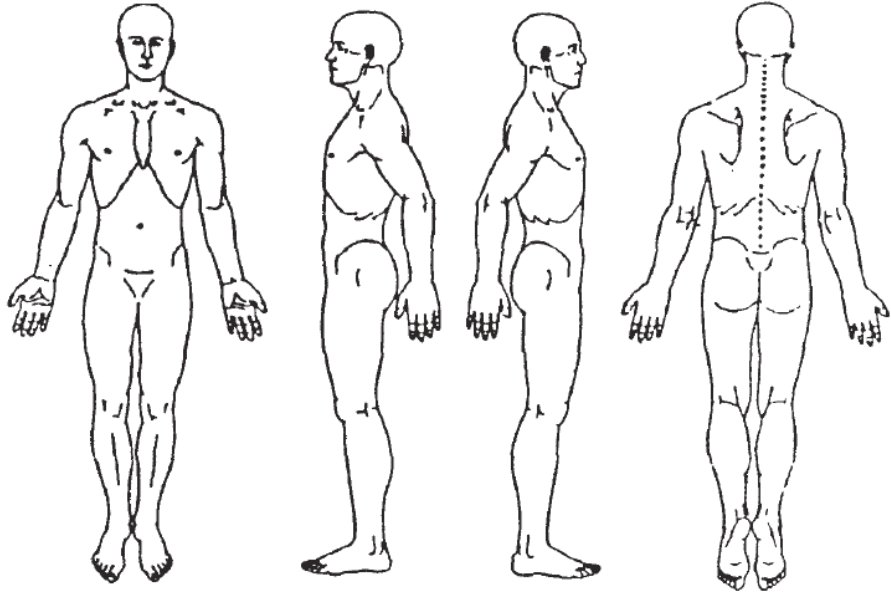
XXX = ache

* = sharp/stab

ooo = numb/tingle

→ = shooting

//// = stiff/tight



DO YOU HAVE ANY OF THE FOLLOWING?

- | | | | |
|---|---|------------------------------------|--|
| <input type="checkbox"/> Generalized muscle pain or stiffness | <input type="checkbox"/> Swollen, painful, stiff joints | <input type="checkbox"/> Bone pain | <input type="checkbox"/> Tremors, twitches |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Loss of strength | <input type="checkbox"/> Hernia | <input type="checkbox"/> Breast Implants |
| | | | <input type="checkbox"/> Other _____ |

Current Medications

Do you take or use?

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Antacids | <input type="checkbox"/> Sleep Aids | |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Hormones | <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Antidepressants/anti-anxiety | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Cholesterol medication | <input type="checkbox"/> Blood Pressure medication | |

If you take or use the following, please list (use back of page, if necessary):

Prescription Medications:

Vitamins/Supplements/Herbals/Homeopathics:

Over-the-Counter Medications:

Hospitalizations, Surgeries & Accidents

- | | | |
|---|--|--|
| <input type="checkbox"/> Tonsils: _____ | <input type="checkbox"/> Cysts/Tumors: _____ | <input type="checkbox"/> Appendix: _____ |
| <input type="checkbox"/> Gallbladder: _____ | <input type="checkbox"/> Uterus/Ovaries: _____ | <input type="checkbox"/> Other: _____ |

What other hospitalizations, surgeries or accidents have you had? (include date)

2104C N. Willis St, Portland, Oregon 97217 503-475-4370 Dr. Glenda Culbertson DC, LAc
Goldenhealermedicine.com

Symptoms

Please place a **check mark** next to all symptoms are you **currently** experiencing or have experienced in the **past year**. If there are multiple symptoms listed on one line, please **circle** all that apply.

General

- | Height: | Current Weight: | Weight 1 Year Ago: | Max Weight: | When: |
|--|--|--|--------------------------------------|-------|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Puffiness or Swelling | <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Fatigue | |
| <input type="checkbox"/> Easy to Bleed or Bruise | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Tremors | |
| <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Sweating without exertion | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Weight Loss | |
| <input type="checkbox"/> Always Cold | <input type="checkbox"/> Changes in Appetite | <input type="checkbox"/> Cravings | <input type="checkbox"/> Weight Gain | |
| <input type="checkbox"/> Always Hot | <input type="checkbox"/> Weakness | <input type="checkbox"/> Sudden Energy Drops | <input type="checkbox"/> Other | |

Skin/Hair

- | | | | |
|------------------------------------|----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hives | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Recent Hair Loss |

Head/Face

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Facial Paralysis | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Head Feels "Cloudy" or "Heavy" | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> TMJ Pain |
| <input type="checkbox"/> Dizziness | | <input type="checkbox"/> Lip/Tongue Sores | <input type="checkbox"/> Toothache |

Eyes

- | | | | |
|---|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Eye Pain/Strain |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Night Blindness |

Ears

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Congestion | |

Nose/Throat

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Headaches | <input type="checkbox"/> Sensation of Lump in Throat | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Trouble Swallowing | | |

Respiratory

- | | | | |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Phlegm |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Coughing up Blood |

Cardiovascular

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Edema/swelling |
| <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Irregular heart rhythm | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Previous heart attack |

Appetite/Thirst

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Increased /decreased appetite | <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Crave salty taste | <input type="checkbox"/> No thirst |
| | <input type="checkbox"/> Crave sour taste | <input type="checkbox"/> Always thirsty | |

Digestion

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Chronic gas | <input type="checkbox"/> Cramping | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Mucous in stool | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Irritable Bowel | |

Genito-urinary

- | | | |
|---|--|---|
| <input type="checkbox"/> Pain or burning on urination | <input type="checkbox"/> History of frequent infection | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Waking at night to urinate | <input type="checkbox"/> Difficulty urinating |
| | | <input type="checkbox"/> Kidney stones |

Sleep

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Waking frequently | <input type="checkbox"/> Snoring | |

Energy Level

- Fatigue
- Difficulty waking
- Heavy limbs
- Excessive energy
- Restlessness

Mental Health

- Anxiety
- Panic attacks
- Depression
- Bipolar disorder
- Phobias
- Sadness / grief
- Anger / irritability
- Fear / worry

Muscles and Joints

- Arthritis in:
- Bursitis in:
- Tendonitis
- Stiff or tight muscles
- Sciatica
- Neck pain
- Low back pain

Women's Health

- Irregular periods
- Heavy or light periods
- PMS
- Cramping
- Endometriosis
- Ovarian Cysts
- Uterine fibroids
- STD
- Irregular ovulation
- Miscarriage
- # of pregnancies:
- # of children:

Men's Health

- Difficult/unusual urination
- Erectile dysfunction
- STD
- Prostate Problems
- Discomfort or pain in genital area
- Diminished or excessive sexual drive

Miscellaneous

- Traveled outside the USA within the last two years to:
- Have you ever been diagnosed or exposed to the following:
- HIV Diagnosis & Treatment Dates: _____
- Hepatitis Diagnosis & Treatment Dates: _____
- Tuberculosis Diagnosis & Treatment Dates: _____
- Have you ever been exposed in significant or long-term doses to:
- Chemicals Toxins Radiation Other: _____

Habits/Lifestyle

- How do you rate your stress level on a scale of 1-10? 0 = lowest, 10 = highest: _____
- Do you consume:
- Cigarettes or tobacco _____ packs a day
- Coffee/tea/soda _____ cups a day
- Sugar _____ times a day
- Processed/Fast foods _____ times a day
- Alcohol _____ drinks per week
- Marijuana/other drugs _____ times per week
- How much water do you drink per day? _____
- Do you exercise regularly? Y N What and how often?

Typical Diet

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Do you strongly desire any particular foods?

Do you strongly dislike any particular foods?

Are there any foods that aggravate any of your symptoms or make you feel bad?

Allergies

Are you hypersensitive or allergic to any of the following? Please list.

Medications:

Environmental:

Foods:

Chemicals:

Plants:

Latex:

Animals:

MSG:

Pollens:

Other:

Family History

Please check here if you are adopted or otherwise unaware of your family's medical history

Please Check All that Apply	Self	Mother	Father	Grandparent	Siblings	Children	Spouse
Cancer							
Heart Disease							
Digestive Problems							
Respiratory Problems							
Urinary Tract Problems							
Diabetes							
Hypoglycemia							
Thyroid Disease							
Gall Bladder Problems							
High/Low Blood Pressure							
Anemia							
Migraines							
Stroke							
Epilepsy							
Tuberculosis							
Allergies							
Asthma							
Osteo/Rheumatoid Arthritis							
Blood Disorder							
Kidney Disease							
Lupus							
Birth Defects							
Mental Health Concerns							
Substance Dependency							
Age at death, if applicable	NA						
Cause of Death	NA						
Other							

Patient or Guardian Signature

Date