Portland Family Health

Welcome to Portland Family Health!

We are honored that you have chosen us as part of your wellness team. Here, we believe that the collaboration of minds for a client's health is greater than one perspective alone. We each present unique specialties, that when combined, create a holistic and superior health team to benefit your care

I authorize the practitioners of Portland Family Health to use and disclose health information about me, which may include written records or spoken words regarding health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, and similar types of health-related information. This may be done to make decisions about, plan for care and treatment, and consult with other health care providers in my course of care. I may also request that some of my health information not be disclosed.

In summary, I would like to give specific permission for any of the Portland Family Health providers to communicate with each other regarding my care to best collaborate on my behalf.

Patient/Guardian signature: _____ Date: _____

If the patient is a minor, I (print name) _____ as the parent or guardian, authorize treatment to be provided to: _____ (minor).

4004 SE Woodstock Boulevard Portland, Oregon 97202 Phone: (503)777-0444 | Fax: (503)777-0445 www.portlandfamilyhealth.com

NATURE'S PATH
Family Wellness

Jennifer Curtiss ND
naturespathfamilywellness.com
at Portland Family Health

4004 SE Woodstock Blvd Suite 4
Portland, OR 97202
p: 503-777-0444 fax: 503-777-0445

New Patient Intake Form

Name _____ Date _____

Age _____Date of Birth _____/_____/_____ Gender

Address_____ City _____State _____ Zip code _____

Telephone # (cell/home) _____ (work) _____

Email address_____

Occupation _____ Employer _____Hours/week _____

Work address _____

Relationship status (single, in a relationship, married, etc._____
Live with: Spouse _____Partner _____Roommates _____ Children _____Alone _____

Who referred you/how did you hear about Dr. Curtiss?_____

What are your most important health concerns, in order of importance?

1. _____
2. _____
3. _____

Allergies:

Please list all drug allergies with reactions:_____

_____

Please list environmental and food allergies or sensitivities with reaction:

_____

_____

Medications:

Do you take or use?

Laxatives	Y N	Cortisone	Y N	Tranquilizers	Y N
Pain relievers	Y N	Appetite suppressants	Y N	Thyroid medication	Y N
Birth control	Y N	Antacids	Y N	Sleeping medication	Y N

Please list **all** prescription medications, over the counter medications, vitamins, or supplements, you are taking (list doses if known, attach separate page if needed):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Do you currently use tobacco? Y N Have you in the past? Y N Forms? _____

Recreational drugs, frequency of use, and delivery method_____

Typical Food Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks: _____
Beverages:_____
How many alcoholic drinks do you have per week_____

General

Height _____ Current weight _____ lbs.
Weight 1 year ago _____ Maximum weight _____ When? _____
When during the day is your energy the best? _____ Worst? _____

How would you rate your overall health? Excellent ____ Good ____ Fair ____ Poor ____
When, where, and by whom did you last receive medical care?
_____

First day of your last menstrual period (female)? _____/_____/_____

Medical History and Review of Systems (Please circle)

Y = a condition you have now P = a condition you have had in the past N = never had

CONDITION	Y	P	N
Mood Swings?	Y	P	N
Poor concentration?	Y	P	N
Anxiety	Y	P	N
Depression	Y	P	N
Memory Problems	Y	P	N
Adrenal Dysfunction	Y	P	N
Thyroid Problem	Y	P	N
Hot or Cold Intolerance	Y	P	N
Hypoglycemia	Y	P	N
Change in Appetite	Y	P	N
Change in Thirst	Y	P	N
Chronic Immune condition	Y	P	N
Chronic Fatigue	Y	P	N
Chronic Swollen Glands	Y	P	N
Skin Rashes, Eczema, Hives, Itching	Y	P	N
Acne	Y	P	N
Slow Wound Healling	Y	P	N
Headaches, Migraines	Y	P	N
Earaches, Decreased Hearing, Tinnitus	Y	P	N
Chronic Sinus Congestion/Infection	Y	P	N

Medical History and Review of Systems (Please circle)

Y = a condition you have now P = a condition you have had in the past N = never had

CONDITION	Y	P	N
Dizziness	Y	P	N
Shortness of Breath	Y	P	N
Cough	Y	P	N
Wheezing	Y	P	N
Nose Bleeds	Y	P	N
Hay Fever	Y	P	N
Loss of Smell	Y	P	N
Chronic Sore Throat	Y	P	N
High Blood Pressure	Y	P	N
Low Blood Pressure	Y	P	N
Heart Disease	Y	P	N
Heart Palpitations	Y	P	N
High Cholesterol	Y	P	N
Intestinal Pain	Y	P	N
Intestinal Gas/ Distension	Y	P	N
Increased Belching or Passing Gas	Y	P	N
Heart Burn	Y	P	N
Constipation	Y	P	N
Blood in Stool	Y	P	N
Diarrhea	Y	P	N
Urinary Frequency	Y	P	N
Pain with Urination	Y	P	N
Urinary Tract Infection	Y	P	N

Medical History and Review of Systems (Please circle)

Y = a condition you have now P = a condition you have had in the past N = never had

CONDITION	Y	P	N
Musculoskeletal Pain	Y	P	N
Joint Pain or Stiffness	Y	P	N
Muscle Spasms	Y	P	N
Physical Injury	Y	P	N
Fertility Challenges	Y	P	N
History of Miscarriage in self or Partner	Y	P	N
Reduced Sex Drive	Y	P	N
Pain with Sex	Y	P	N
Sleep Disorders	Y	P	N
Stroke	Y	P	N
Cancer	Y	P	N
Liver Disease	Y	P	N
Kidney Disease	Y	P	N

Females Only

CONDITION	Y	P	N
Hot Flashes/Night Sweats	Y	P	N
Irregular Periods	Y	P	N
Abnormal Pap	Y	P	N
Menstrual Cramps	Y	P	N
Heavy Bleeding	Y	P	N
PMS	**Y**	**P**	**N**

Date and result of last pap _____# of Pregnancies_____# of Births _____

Habits

Sleep: average hours/night? _____

Sleep well? Y N Wake rested? Y N
Enjoy your work? Y N Have supportive relationships? Y N
Do you exercise? Y N What type of and how often?_____

Hours/day in front of a computer screen or TV? _____

Please list hospitalizations and surgeries:
_____

_____

_____

Family health history

Please list any major health problems with age of diagnosis if known.
Mother _____ Father _____

Siblings_____

Mother's side: Grandmother_____Grandfather_____

Father's side: Grandmother _____ Grandfather _____

Is there any information about your health you would like to add?
_____

_____

_____

Welcome to Nature's Path Family Wellness at the office of Portland Family Health. Your first initial intake will be focused on your health history. We are committed to identifying the cause of your symptoms and improving your health. If you have any questions or concerns, please ask.

Statement of consent on next page →

STATEMENT OF CONSENT

Print Name:_____

RELEASE OF INFORMATION
I authorize Dr. Curtiss to release my medical records and discuss health related issues to all Portland Family Health providers, case managers, insurance representatives and lawyers that are involved in my case.

BILLING INFORMATION

Dr. Curtiss is in network and bills for Blue Cross Blue Shield. If you have health insurance with Blue Cross Blue Shield, please find out from your insurance company what your co-pay rates are for naturopathic care.
For patients out-of-network, **insurance is not billed directly**. A statement will be provided that you may send to your insurance company for reimbursement as they allow. Patients out-of-network must pay at time of service.
General Rates: The initial visit is approximately $250 for 90 minutes. Follow-up visits are $90, per 30 minutes. Fees for additional services (injections, blood draw, etc.) may apply.

CANCELLATION AND NO SHOW POLICIES
Please **give at least 48 hours notice to cancel an appointment**. Without this notice, you will be charged a **missed appointment fee of $50**, due prior to your next appointment.

ACKNOWLEDGEMENT OF INDEPENDENT PRACTITIONER
Dr. Curtiss is an independent practitioner operating under her own licensure and liability insurances. Her practices are not affiliated with independent practitioners operating at the location of Portland Family Health. Any questions or concerns regarding your care need to be addressed with Dr. Curtiss.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
I understand that Dr. Curtiss will use and disclose health information about me, which may include written records or spoken words regarding health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, and similar types of health-related information, in the course of providing care to me. This may be done to make decisions about, plan for care and treatment, and consult with other health care providers in my course of care. I have the right to receive a written Notice of Privacy Practices should I request it. I may also request that some of my health information not be disclosed, and understand that Dr. Curtiss is not required by law to agree to such requests.

The signor certifies that he/she has read, understands, and agrees to the foregoing, and requests and consents to receive appropriate care from Dr. Jennifer Curtiss, ND.

Patient/Guardian signature: _____ Date: _____

If the patient is a minor, I _____ as the _____parent or _____guardian

of, _____ authorize Jennifer Curtiss, ND to provide treatment.