Liz Wallace, ND, LAc, MSOM

Naturopathic Physician • Licensed Acupuncturist

## Confidential Health History and Adult Intake

Patient Name: (Last) ______________________ (First) ______________________ Date: ______________

Address: (Street / PO Box) ______________________ (City / State / Zip) ______________________

Date of Birth: ____________ Age: __________ Male ___ Female ___

Phone: (Home) ______________________ (Work with Extension) ______________________

Phone: (Mobile) ______________________ Email: ______________________

Emergency Contact: ______________________ Phone: ______________________ Relationship: ______________

Occupation: ______________________ How Many Children Do You Have? ______________________

Marital Status: Single ___ Married ___ Seperated ___ Divorced ___ Other ___

With Whom Do You Live: Spouse ___ Family ___ Friends ___ Alone ___ Children ___ Other ___

## What Are Your Concerns For Which You Are Seeking Healthcare? (List Primary Concern First)

1. ______________________________________________

Date of Onset: ______________________________________________

2. ______________________________________________

Date of Onset: ______________________________________________

3. ______________________________________________

Date of Onset: ______________________________________________

4. ______________________________________________

Date of Onset: ______________________________________________

Are You Seeking Primary Care from Dr. Liz Wallace?: Yes _____ No _____

If No, Who is Your Primary Healtcare Physician?: (Name) ______________________ (Phone) ______________

For What Concern Did You Last Receive Medical Healthcare? ______________________________

Date of Care: ______________________________________________

## Confidential Family History

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

| | FATHER | MOTHER | BROTHERS | SISTERS | SPOUSE | CHILD |
|---|---|---|---|---|---|---|
| Age (if living) | | | | | | |
| Health (G=Good/P=Poor) | | | | | | |
| Age at death (if deceased) | | | | | | |
| Check (X) those applicable: | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Heart Disease | | | | | | |
| High Blood Pressure | | | | | | |
| Stroke | | | | | | |
| Epilepsy | | | | | | |
| Mental Illness | | | | | | |
| Asthma, Hayfever, Hives | | | | | | |
| Anemia | | | | | | |
| Kidney Disease | | | | | | |
| Glaucoma | | | | | | |
| Tuberculosis | | | | | | |
| Sexually Transmitted Disease | | | | | | |

## Childhood Illnesses (Check V for Vaccination or Y if You Had Disease)

| | | | | | |
|---|---|---|---|---|---|
| Scarlet fever | V Y | Diphtheria | V Y | Rheumatic Fever | V Y |
| Mumps | V Y | Measles | V Y | German Measles | V Y |

## Hospitalization and Surgery

What hospitalizations and surgeries have you had?

__________ year:_____ __________ year:_____

__________ year:_____ __________ year:_____

__________ year:_____ __________ year:_____

## Medications and Supplements

List any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking:

(1) __________ (5) __________

(2) __________ (6) __________

(3) __________ (7) __________

(4) __________ (8) __________

Circle each that you currently use:

Laxatives Y N    Pain Relievers Y N    Antacids Y N    Cortisone Y N    Appetite Suppressants Y N

Antibiotics Y N    Tranquilizers Y N    Thyroid Medication Y N    Sleeping Pills Y N

## General History

Weight: _______lbs. Height: ________ Weight 1 year ago: ________lbs.

Maximum Weight: ________lbs. When: ________ Blood Type: ____________

## Review of Symptoms

Answer Questions or Check Any of the Following You Have or Have Had in the Past 6 Months.

### Lifestyle Habits

_ Main Interests and Hobbies? ________________________________________

_ Exercise, What Kind? ________________________________________

How Often Do You Exercise? ____________________

_ Average 6-8 Hrs. of Sleep

_ Sleep Well

_ Awake Rested

_ Have a Supportive Relationship

_ History of Abuse

_ Major Traumas

_ Use Recreational Drugs

_ Treated for Drug Dependence

_ Drink Coffee

_ Drink Black or Green Tea

_ Drink Cola or Other Sodas

_ Add Salt to Your Food

_ Eat Refined Sugar

_ Enjoy Your Work

_ Take Vacations

_ Spend Time Outside

_ Watch TV? How Much?____________________________

_ Read? How Often? ____________________________

_ Drink Alcoholic Beverages? # Per Week ______________

_ Treated for Alcoholism

_ Use Tobacco Currently

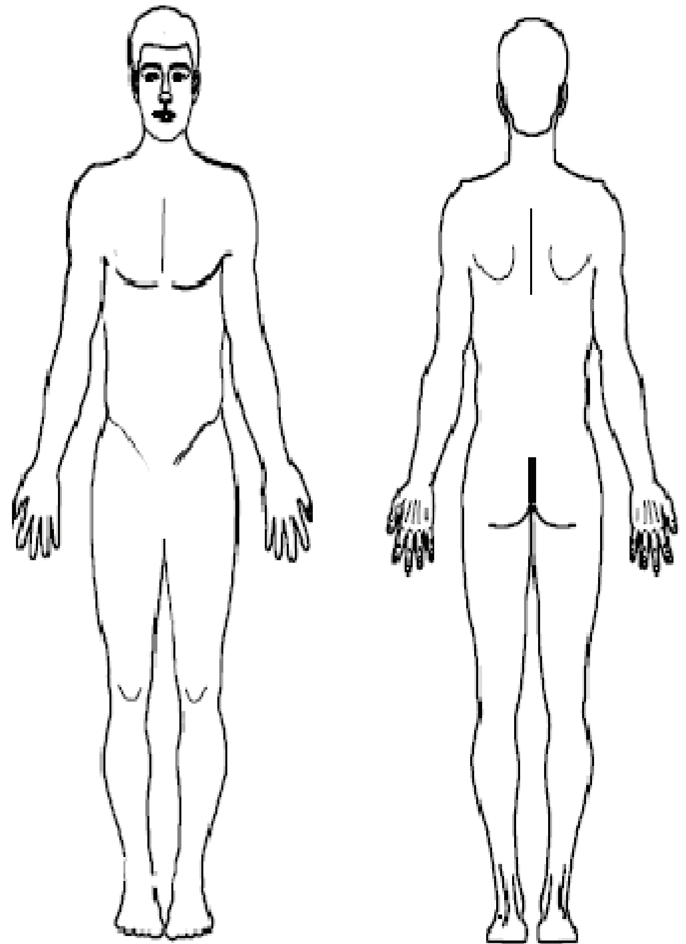
_ Used Tobacco in the Past

How Many Years? ______________________

How Many Packs Per Day? ____________________

_ Have a Religious/Spiritual Practice

**Please shade in areas (on figures) where you are experiencing pain**



## Review of Systems *(Continued)*

Circle the response that applies:
Y: Condition You Have Now   P: Condition You Have Had in the Past   N: Condition You Have Never Had

### SKIN
| | | | |
|---|---|---|---|
| Rashes | Y | P | N |
| Eczema, Hives | Y | P | N |
| Acne, Boils | Y | P | N |
| Itching | Y | P | N |
| Color Change | Y | P | N |
| Lumps | Y | P | N |
| Night Sweats | Y | P | N |

### HEAD
| | | | |
|---|---|---|---|
| Headache | Y | P | N |
| Head Injury | Y | P | N |

### EYES
| | | | |
|---|---|---|---|
| Impaired Vision | Y | P | N |
| Glasses or Contacts | Y | P | N |
| Eye Pain | Y | P | N |
| Tearing or Dryness | Y | P | N |
| Double Vision | Y | P | N |
| Glaucoma | Y | P | N |
| Cataracts | Y | P | N |

### EARS
| | | | |
|---|---|---|---|
| Impaired Hearing | Y | P | N |
| Ringing | Y | P | N |
| Earache | Y | P | N |
| Dizziness | Y | P | N |

### NOSE and SINUSES
| | | | |
|---|---|---|---|
| Frequent Colds | Y | P | N |
| Nose Bleeds | Y | P | N |
| Stuffiness | Y | P | N |
| Hay Fever | Y | P | N |
| Sinus Problems | Y | P | N |

### MOUTH and THROAT
| | | | |
|---|---|---|---|
| Frequent Sore Throat | Y | P | N |
| Nose Bleeds | Y | P | N |
| Hay Fever | Y | P | N |
| Sinus Problems | Y | P | N |

### NECK
| | | | |
|---|---|---|---|
| Lumps | Y | P | N |
| Swollen Glands | Y | P | N |
| Goiter | Y | P | N |
| Pain or Stiffness | Y | P | N |

### RESPIRATORY
| | | | |
|---|---|---|---|
| Cough | Y | P | N |
| Sputum | Y | P | N |
| Spitting up Blood | Y | P | N |
| Wheezing | Y | P | N |
| Asthma | Y | P | N |
| Bronchitis | Y | P | N |
| Pneumonia | Y | P | N |
| Pleurisy | Y | P | N |
| Emphysema | Y | P | N |
| Difficulty Breathing | Y | P | N |
| Pain on Breathing | Y | P | N |
| Shortness of Breath | Y | P | N |
| at Night | Y | P | N |
| Lying Down | Y | P | N |
| Tuberculosis | Y | P | N |

### CARDIOVASCULAR
| | | | |
|---|---|---|---|
| Heart Disease | Y | P | N |
| Angina | Y | P | N |
| High Blood Pressure | Y | P | N |
| Murmurs | Y | P | N |
| Rheumatic Fever | Y | P | N |
| Chest Pain | Y | P | N |
| Swelling in Ankles | Y | P | N |
| Palpitations, Fluttering | Y | P | N |

### GASTROINTESTINAL
| | | | |
|---|---|---|---|
| Trouble Swallowing | Y | P | N |
| Heartburn | Y | P | N |
| Change in Thirst | Y | P | N |
| Change in Appetite | Y | P | N |
| Nausea | Y | P | N |
| Vomiting | Y | P | N |
| Vomiting Blood | Y | P | N |

Bowel Movements
How Often? ____________
Is this a Change? ____________

| | | | |
|---|---|---|---|
| Blood in Stool | Y | P | N |
| Black, Tarry Stool | Y | P | N |
| Belching or Passing Gas | Y | P | N |
| Jaundice (Yellow Skin) | Y | P | N |
| Liver Disease | Y | P | N |
| Hemorrhoids | Y | P | N |

### URINARY
| | | | |
|---|---|---|---|
| Pain on Urination | Y | P | N |
| Increased Frequency | Y | P | N |
| Frequency at Night | Y | P | N |
| Inability to Hold Urine | Y | P | N |
| Frequent Infections | Y | P | N |
| Kidney Stones | Y | P | N |

### FEMALE REPRODUCTIVE
Age Menses Began? ____________
Average Number of Days? ____________
Length of Cycle? ____________

| | | | |
|---|---|---|---|
| Bleeding Between Periods | Y | P | N |
| Regular Cycles | Y | P | N |
| Pain During Intercourse | Y | P | N |
| Painful Menses | Y | P | N |
| Excessive Flow | Y | P | N |
| Birth Control | Y | | N |

What Type? ____________
Number of Pregnancies ____________
Number of Live Births ____________
Number of Miscarriages ____________
Number of Abortions

| | | | |
|---|---|---|---|
| Difficulty Conceiving | Y | | N |
| Menopausal Symptoms | Y | P | N |
| Sexually Active? | Y | | N |

Sexual Preference _ Heterosexual
_ Homosexual
_ Bisexual

| | | | |
|---|---|---|---|
| Sexual Difficulties | Y | P | N |
| Venereal Disease | Y | P | N |
| Do you do Breast Self-exam? | Y | P | N |
| Lumps | Y | P | N |
| Pain or Tenderness | Y | P | N |
| Nipple Discharge | Y | P | N |

### MALE REPRODUCTIVE
| | | | |
|---|---|---|---|
| Hernias | Y | P | N |
| Testicular Masses | Y | P | N |
| Testicular Pain | Y | P | N |
| Are you Sexually Active? | Y | | N |

Sexual Preference _ Heterosexual
_ Homosexual
_ Bisexual

| | | | |
|---|---|---|---|
| Sexual Difficulties | Y | P | N |
| Prostate Disease | Y | P | N |
| Venereal Disease | Y | P | N |
| Discharge or Sores | Y | P | N |

### MUSCULOSKELETAL
| | | | |
|---|---|---|---|
| Joint Pain or Stiffness | Y | P | N |
| Arthritis | Y | P | N |
| Broken Bones | Y | P | N |
| Muscle Spasms or Cramps | Y | P | N |
| Weakness | Y | P | N |

### PERIPHERAL VASCULAR
| | | | |
|---|---|---|---|
| Deep Leg Pain | Y | P | N |
| Cold Hands/Feet | Y | P | N |
| Varicose Veins | Y | P | N |
| Thrombophlebitis | Y | P | N |

### NEUROLOGIC
| | | | |
|---|---|---|---|
| Fainting | Y | P | N |
| Seizures | Y | P | N |
| Paralysis | Y | P | N |
| Muscle Weakness | Y | P | N |
| Numbness or Tingling | Y | P | N |
| Loss of Memory | Y | P | N |

### EMOTIONAL
| | | | |
|---|---|---|---|
| Depression | Y | P | N |
| Mood Swings | Y | P | N |
| Anxiety or Nervousness | Y | P | N |
| Tension | Y | P | N |

### ENDOCRINE
| | | | |
|---|---|---|---|
| Hypo/Hyperthyroid | Y | P | N |
| Heat or Cold Intolerance | Y | P | N |
| Excessive Thirst | Y | P | N |
| Excessive Hunger | Y | P | N |

### BLOOD
| | | | |
|---|---|---|---|
| Anemia | Y | P | N |
| Easy Bleeding or Bruising | Y | P | N |

### *Thank You!*

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Name: ____________
SIGNATURE

Date: ____________

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## Insurance Information, Consent Form, Business Agreement

1. Release of Records/Payment: I authorize Dr. Liz Wallace to release my medical records relating to claim for benefits submitted. I further agree and acknowledge that I authorize Dr. Wallace to submit claims for benefits for services rendered, without obtaining my signature on each claim. Dr. Wallace uses an insurance billing agency, which will submit my claims. By signing below, I understand that I am financially responsible for all charges incurred for my dependents, or myself at time of service or for services not covered by my insurance company.

2. Cancellation and No Show Policy: By signing below, I understand that, without giving Dr. Wallace 24 hours notice to cancel or change an appointment, full payment for the missed appointment will be due prior to my next appointment.

3. I understand that I may receive naturopathic care, acupuncture treatment, manipulation, bodywork, supplements, herbals, and homeopathic medicines and may be referred for additional lab work.
   Dr. Wallace will utilize which treatment she feels is best for me, and I accept the risks and benefits to such treatments.

4. The 2007 Fee Schedule is based on “Time of Service” payments, and varies according to the complexity of visit and/or length of treatment.
   - Initial Visit: $125.00 - $175.00
   - Return Visits: $85.00 - $125.00

   I understand that, generally, I can expect to have weekly visits for 1 month, followed by bi-weekly visits for 2 months. The schedule may vary based on individual situations, and this timeline gives my body the optimal support for healing.

5. Acknowledgment of Notice of Privacy Practices: I understand that Dr. Wallace may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it. I am aware that Dr. Wallace reserves the right to change the terms of her Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that she may maintain. In the event of amendments, Dr. Wallace will make available a revised Notice of Privacy Practice for my review. I understand that I may also request that some of my health information not be disclosed and understand that Dr. Wallace is not required by law to agree to such request. I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Dr. Wallace at the following address:

2024 SE Clinton
Portland, Oregon 97202

Patient, Parent/Guardian (Please sign) ______________________________ Date ____________________

Patient Name (Please print) ______________________________________________

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## Insurance Information

Patient Name ______________________ Insurance ID# ______________________

Date of Birth ______________________ Email address ______________________

Name of Insured (if not Patient) ______________________ SSN of Insured ______________________

Date of Birth of Insured ____________ Employer ______________ Insured is: ☐Male ☐Female

Home Address ______________________________________________

Home Telephone Number ______________________________________________

Insured Relationship to Patient: ☐Spouse ☐Child ☐Partner ☐Other ______________________

Insurance Company ______________________ Address ______________________

Phone ____________ Adjuster ____________ Claim Number (Workers Comp) ______________________

ID # ______________ Group or Plan # ______________________

Emergency Contact ______________________________________________

Dr. Wallace will happily bill your insurance for your visit*; however, it is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums.

**Please be aware that this is not a guarantee of payment; if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.*

## For Office Use

1. Beginning Date of Coverage ______________ Ending Date of Coverage ______________
2. Referral from my Primary Care Physician (PCP) for Alternative Services? ☐Yes ☐No
3. Is Dr. Wallace In-Network? ☐Yes ☐No
4. Benefits for Following Services:

   Naturopathic: % Covered ____________ Co-pay/ Co-Insurance ____________ Year Max ____________

   Acupuncture: % Covered ____________ Co-pay/ Co-Insurance ____________ Year Max ____________

   Number of "Modalities" Covered Per Treatment: ______________________

   Number of "Units" Per Modality: ______________________

   Extended Visit: 99354 ☐Yes ☐No

   Exercise Therapy: 99112 ☐Yes ☐No

   Diagnosis Coverage or Limitations: ______________________
5. Co-pay per Visit or per Specialty? ______________________
6. Deductible $ __________ Amount of Deductible met so far $ __________ Date __________
7. Name of Representative Spoken with ______________________ Date __________

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