Mercy & Wisdom
HEALING CENTER

8401 SE Powell Blvd, Portland, Oregon 97266
Tel: (503) 227-1222 Fax: (503) 227-1555
Online: www.mercyandwisdom.org
501(c) (3) Tax ID # 76-0767257

PATIENT HEALTH HISTORY/DEMOGRAPHIC INFORMATION

All demographic data will be kept confidential and will be used solely for statistical purposes. This information is needed in order for us to access grants, donations, and other assistance programs that are vital to the continuation of our clinic. Your participation is not mandatory, however, it is greatly appreciated.

Patient's Name: ____
First Middle Last

Address: ______________________________ City: ________________________ State: ______

Phone Number: (____)______________________________ Zip Code: _____________________
(to be used for appointment reminders and all clinic communication)

DO YOU HAVE INSURANCE? Includes limited liability, Medicare, OHP, etc. (*this information will not affect your payment status*) (Circle One) Yes No

Birth Date: _____________________ Gender: (Circle One) M F MTF FTM

RACE (Circle One or More)

Black/African American Asian Caucasian Other

Hawaiian/Pacific Islander Hispanic/Latino Native American/Alaskan Native

Primary Language: ________________________ Interpretation Requested: Yes No

Employer: _______________________________ Occupation: ______________________________

MARITAL STATUS:

❑ Single ❑ Married ❑ Partnership ❑ Separated ❑ Divorced

HOUSEHOLD INCOME: *The total income that supports you, your spouse or partner, and your dependents. A dependent is anyone 18 or under for whom you provide 50% or more of all financial support. Income **does** include SSI and unemployment benefits.*

Gross Monthly Income: ____________________ (If Applicable) Number of dependents: ______

Spouse/Partner's Monthly Income: ________________________

EMERGENCY CONTACT: _________________________________ Relationship: _________________
Name

Telephone Number: (____)_______________________

HEALTH HISTORY INTAKE

Natural Medicine Healthcare is only possible when the practitioner completely understands the patient's physical, mental, and emotional concerns. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. Please provide the most detailed account of your health history possible.

What are your most important health concerns? What would you like to address?
____

When did you last visit a doctor's office, medical clinic, or hospital, or receive counseling? Please explain:____
____

How did you hear about our clinic? ____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, medications…)? If yes, list and explain: ____
____

SELF AND FAMILY HISTORY

What hospitalizations or surgeries have you had? Please explain: __________________________
____
____

What diagnostic imaging studies have you had?

☐ Electroencephalogram ☐ Bone density scan ☐ X-rays

☐ Electrocardiogram ☐ CT scan ☐ Mammogram ☐ MRI

GENERAL

Weight: _______________lbs. Weight one year ago: _______________lbs.

Maximum weight: _______________lbs. When?: _______________

When during the day is your energy best? _________________ worst? _________________

MEDICATIONS & SUPPLEMENTS

Do you take or use any of the following?

☐ Pain relievers (incl. aspirin, ibuprofen) ☐ Diet pills, appetite suppressants

☐Thyroid medication ☐Cortisone (cream or pills) ☐ Laxatives

☐ Antibiotics ☐ Antacid ☐ Sleeping pills

Please list all prescriptions, over-the-counter medications, herbs, vitamins, or other supplements you are taking:

____

____

____

____

____

____

FAMILY HISTORY

Do you have a family history of any of the following? Please Circle:

Anemia	Arthritis	Asthma	Cancer
Cataracts	Diabetes	Epilepsy	Gall Bladder Disease
Glaucoma	Hay fever/hives	Heart Disease	High Blood Pressure
Kidney Disease	Liver Disease	Mental Illness	Respiratory Disease
Stroke	Thyroid Problems	Tuberculosis	Mental Illness

Is your mother still living? Yes; her age _________ No; age at time of death __________

Cause of death ______________________

Is your father still living? Yes; his age _________ No; age at time of death __________

Cause of death ______________________

CHILDHOOD ILLNESSES

Have you had any of the following conditions as a child/adolescent? Please circle:

Diphtheria	Mumps	German Measles	Rheumatic Fever
Measles	Scarlet Fever	Other: ___________________________	

Past Immunizations

Have you had any of the following immunizations? If unsure, please write a question mark beside the vaccination listed.

Diphtheria	Polio	Measles/Mumps/Rubella (MMR)
Tetanus	Pertussis	Other: ___________________________

Review of Systems

Please circle.
Y=Yes, present condition. P=Problem of the past. N=No, never had the condition.

Head

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw/TMJ problems	Y P N

Ears

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

Neck

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

Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N
Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N

Musculoskeletal

Joint pain	Y P N	Muscle spasms	Y P N	Weakness	Y P N

Eyes

Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N
Glaucoma	Y P N	Eye pain/strain	Y P N	Tearing/dryness	Y P N
Spots in eyes	Y P N	Color blindness	Y P N	Double vision	Y P N

Nose/Sinuses

Stuffiness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N
Hay fever	Y P N	Nosebleeds	Y P N	Frequent colds	Y P N

Mouth/Throat

Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N
Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N

Respiratory

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

Cardiovascular

Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N
Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N	Low/high blood pressure	Y P N

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Changes in thirst	Y P N
Ulcers	Y P N	Black stool	Y P N	Coughing up blood	Y P N
Jaundice	Y P N	Hemorrhoids	Y P N	Gall bladder disease	Y P N
Heartburn	Y P N	Abdominal pain	Y P N	Blood in stool	Y P N
Liver disease	Y P N	How many bowel movements per day? ___________			

Urinary

Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N
Kidney stones	Y P N	Frequently at night	Y P N		

Blood/Peripheral Vascular

Anemia	Y P N	Cold hands/feet	Y P N	Thrombophlebitis	Y P N
Leg pain	Y P N	Easy bruising	Y P N	Varicose veins	Y P N

Neurological

Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N
Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N

Emotional

Mood swings	Y P N	Nervousness	Y P N	Tension/stress	Y P N
Anxiety	Y P N	Depression	Y P N	Other:__________________	

Endocrine

Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N
Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N

Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Testicular pain	Y P N	Prostate issues	Y P N	Sexual difficulty	Y P N
Venereal disease	Y P N	Sexually active	Y P N	Premature ejaculation	Y P N

Female Reproductive

Age of first menses ____________________ Age of last menses (if menopausal)__________

Length of cycle (Day 1 to Day 1)____________ Duration of menses (days bleeding)__________

Date of last annual exam ________________

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	Venereal disease	Y P N	PMS	Y P N
Cycles regular	Y P N	Bleeding between cycles	Y P N		
Sexual difficulty	Y P N	Abnormal Pap	Y P N		
Nipple Discharge	Y P N	Menopausal symptoms	Y P N		
Breast lump(s)	Y P N	Do self breast exams	Y P N		

Number of pregnancies ____________ Number of live births ____________

Number of miscarriages ____________ Number of abortions ____________

Sexual Health

Sexually active	Y P N	Practice safer sex	Y P N
Birth control	Y P N	If yes, what type?_________________	

Is there anything else you would like us know in order to serve you better?

____

____

____

Consent for Treatment:

I understand that my care as a patient at MWHC is directed by supervising staff physicians, licensed acupuncturists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care, as well as volunteer staff physicians who may be called upon for the purpose of consulting.

I recognize that MWHC is a teaching institution. I agree that persons who are students and resident physicians may participate in my care as part of the educational programs of the institution. I may be contacted by MWHC physicians for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at MWHC in any way.

I have fully read and understand the above agreements and authorizations.

_______________________________________ _______________________________

Patient Signature Date

_______________________________________ _______________________________

Parent, Guardian, Responsible Party Signature Date

HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my protected health information by MWHC for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- MWHC has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- 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 MWHC at the following address: 2 NW 3nd Avenue, Portland, Oregon 97209.
- I understand that while MWHC may honor these requests, they are not required by law to do so.
- I am aware that MWHC reserves the right to change the terms of their Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, MWHC will make available a revised Notice of Privacy Practices for my review.

Statement of Financial Responsibility

I understand and agree to the following:

- Payment for services rendered is my responsibility as the patient or patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- How will you be paying for your visit? Please circle one:

Check Cash Debit/Credit Card (MasterCard or Visa only)

- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.
- If someone *other than the patient* is responsible for payment, please complete the following :

Name of responsible party (if other than the patient):

____

Relationship to the patient: ________________________ Phone#: ________________________

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Mercy & Wisdom Healing Center to release information necessary to secure payment.

______________________________________ ______________________________

Signature Date

Insurance Billing Procedures

If I am billing insurance for services rendered, I understand and agree to the following:

- I must submit invoices from MWHC to my insurance carrier for reimbursement.
- I authorize MWHC to release pertinent medical records related to billing. This release applies to support of the insurance billing process only.
- **I am responsible for any and all charges at the time of service.**

Alternative Method Of Communication Request:

As a courtesy, it is MWHC´s policy to call your home on the day prior to your scheduled appointment to remind you of your appointment time. We may leave a reminder message on your voicemail or with a person answering the phone – no personal health information will be disclosed.

☐ I agree with MWHC's standard method of communication.

☐ Or, please change as follows:____

☐ Please contact me at the following telephone number:______________________________

☐ I prefer not to receive reminder calls.

We require at least 24 hours advance notice for cancelling appointments.

______________________________________ ______________________________

Patient or Responsible Party Signature Date