

How did you hear about our clinic? _____

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

Self and Family History

What hospitalizations or surgeries have you had? _____

What diagnostic imaging studies have you had?	Bone density scan	Mammogram
Electrocardiogram	Electroencephalogram	X-rays
	CT scan	MRI

Medications and/or Supplements

Do you take or use any of the following?

Pain relievers (aspirin, ibuprofen)	Diet pills, appetite suppressants		
Cortisone (cream or pills)	Thyroid medication	Antacid	
Laxatives	Tranquilizers	Antibiotics	Sleeping pills

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

General

Height: _____ Weight: _____ lbs. Weight one year ago: _____ lbs.

Maximum weight: _____ lbs. When? _____

When during the day is your energy best? _____ worst? _____ (2)

Family History

Do you have a family history of any of the following :

Anemia	Diabetes	Heart disease	Respiratory disease
Arthritis	Epilepsy	High blood pressure	Stroke
Asthma	Gall Bladder disease	Kidney disease	Thyroid problems
Cancer	Glaucoma	Liver disease	Tuberculosis
Cataracts	Hay fever/hives	Mental illness	

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

Cause of death _____

Is your mother still living? Yes; her age _____ No: age at time of death _____

Cause of death _____

Childhood Illnesses

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

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 immunization.

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

Ringings	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
Arthritis	Y P N	Broken bones	Y P N	Sciatica	Y P N

Eyes

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

Nose/Sinuses

Stiffness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N
Hay fever	Y P N	Nose bleeds	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/stressed	Y P N
Anxiety	Y P N	Depression	Y P N		

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
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Venereal disease	Y P N	Premature ejaculation	Y P N		

Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____

Length of cycle _____ Duration of menses _____

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	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N
Birth control	Y P N	If yes, what type?	_____		

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Number of abortions _____

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 associated 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 (18 years or older)

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 3rd 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 Practice 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?

Cash Checks (checks accepted with valid Drivers Lic., Addr. & phone number)

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: _____

Relationship to the patient: _____ Phone #: _____

Employer and Address: _____

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

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 time of services.

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 voice-mail or with a person answering the phone – no personal health information will be disclosed.

I agree with MWHC’s standard method of communication.

Please change as follows: _____

Please contact me at the following telephone number: _____

I prefer not to receive reminder calls.

We require at least 24 hour advance notice for canceling appointments.

Signature of patient or patient’s responsible party

Date