

## BOTHELL NATURAL HEALTH ~ NEW PATIENT REGISTRATION FORM

All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them with Dr. Bowen.

### PATIENT INFORMATION / PROFILE

Name:	Date of Birth:	Gender: M F Other
Address:	Single Partnered Married Divorced	
(zip)	Number of people in household:	children?
Occupation:	Employer / School:	
Education completed: <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other		
Travel Outside US? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where / When?	

### CONTACT INFORMATION

Phone Numbers: <input type="checkbox"/> Phone (work): <input type="checkbox"/> Phone (home): <input type="checkbox"/> Phone (cell / pager):
<b>Check the box next to the number where we can leave a private message that may contain confidential health information</b>
Name of Spouse or Partner:
Name(s) of Children:
Emergency Contact : home phone:
Relationship to patient: work phone:

### REFERRALS AND ADJUNCTIVE CARE

Are you currently under medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes For:
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible):
How did you find Dr. Bowen? <input type="checkbox"/> Insurance Referral: <input type="checkbox"/> Physician Referral: <input type="checkbox"/> Patient Referral: <input type="checkbox"/> Other:
Referring Physician or Patient Name:
Who is your Primary Care Physician (PCP)?
Clinic Name, Address and phone:
Have you ever consulted with or been treated by a naturopathic physician, acupuncturist, chiropractor, nutritionist or massage therapist before? <input type="checkbox"/> No <input type="checkbox"/> Yes When? Who? (circle those that apply)

### HEALTH CONCERNS (please list in order of importance to you)

1.	4.
2.	5.
3.	6.
Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Months?	
Is your condition injury or accident related? <input type="checkbox"/> No <input type="checkbox"/> Yes, auto accident <input type="checkbox"/> Yes, work related	
What goals do you have from your visit today and overall?	
What expectations do you have of your physician?	

## MEDICATIONS AND SUPPLEMENTS

Medications & dose:	
1.	4.
2.	5.
3.	6.
Supplements (vitamins, herbs, etc):	
1.	4.
2.	5.
3.	6.

## HEALTH HISTORY / REVIEW OF SYSTEMS

<b>Allergies or Reactions to:</b>	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin / antibiotics	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local anesthetics
	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Nuts	<input type="checkbox"/> Scents	<input type="checkbox"/> Other:
<b>History of serious illness, accidents, hospitalization or operations (description, date):</b>				
<b>Childhood Illnesses:</b>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella
	<input type="checkbox"/> German measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Other:
Have you ever been touched in a way that made you uncomfortable without your permission?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been physically or emotionally abused?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have concerns with abuse / violence in your life now?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

### Please check if you have or have ever had:

Condition	Never	Past	Current	Physician's Notes
<b>1. General</b>				
Weight loss / gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Max weight:      Min. wt:      Current Wt:
Fever / Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue / Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heat / Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cold Hands and Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sweats / Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2. Skin</b>				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rashes / Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hair or nail dryness / changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yellow / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. Head</b>				
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. Eyes</b>				
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Corrective Lenses / Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Ears	Never	Past	Current	Physician's Notes (Con't)
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing of Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6. Nose</b>				
Sinus congestion or infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>7. Mouth / Throat</b>				
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cavities / Root canals / toothaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bitter or Metallic taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8. Lungs</b>				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Breathing / Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain / Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough: Persistent or Bloody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9. Cardiovascular</b>				
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots in Legs or Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling (Edema) of hands, feet, legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmurs / Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Circulatory Problems (raynauds, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10. Gastrointestinal</b>				
Loss of / Excess Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty or pain with swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indigestion / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gas / Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea (with or without blood?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colitis / Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anal Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood or Mucus in Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Black tarry or "coffee ground" stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol / Lipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. Genitourinary</b>	<b>Never</b>	<b>Past</b>	<b>Current</b>	
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency to Urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wake to Urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty holding urine (sneeze / cough)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease / Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. Musculoskeletal</b>				
Muscle pain / spasm / strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint pain / sprain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis (type: )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Back Problems (type: )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>13. Endocrine</b>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hormone Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>14. Blood / Lymphatic</b>				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood / Lymph disease or cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>15. Allergic / Immune</b>				
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer / Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune (scleroderma, hashimotos, lupus, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever / Asthma / Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Environmental / Animal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>16. Neurologic</b>				
Epilepsy / Seizures / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with walking / coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paralysis / weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>17. Psychologic</b>				
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Sexual Health Information

Are you currently sexually active?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	With:	<input type="checkbox"/> Men	<input type="checkbox"/> Women	<input type="checkbox"/> Both	
Have you been sexually active with:	<input type="checkbox"/> Men	<input type="checkbox"/> Women	<input type="checkbox"/> Prostitute				
<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Both	<input type="checkbox"/> Neither	<input type="checkbox"/> Bisexual	<input type="checkbox"/> IV drug user		
Are you satisfied with your sex life?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Do you practice safer sex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have need for birth control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes					
Method of birth control currently used				Number of sexual partners this year?			
STDs	<input type="checkbox"/> HIV	<input type="checkbox"/> Herpes	<input type="checkbox"/> HPV/ Warts	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Hepatitis
<b>Notes:</b>							

### Male Health Information

Condition	Never	Past	Current	Physician's Notes
Difficult Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Testicular Pain / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impotence / Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Notes:</b>				

### Female Health Information

Menstrual History	Obstetric History			
Age at first period	Have you ever been pregnant <input type="checkbox"/> No <input type="checkbox"/> Yes			
Date last menstrual period began	Age at first pregnancy			
Periods regular? <input type="checkbox"/> No <input type="checkbox"/> Yes	Number of pregnancies			
Days between periods	Number of living children			
Length of flow	Number of stillbirths			
Heaviness of flow	Number of miscarriages <span style="float: right;">When in pregnancy?</span>			
Color of flow	Number of tubal pregnancies			
Clots (size? Sm, Med, Lg) <input type="checkbox"/> No <input type="checkbox"/> Yes	Number of abortions <span style="float: right;">When in pregnancy?</span>			
Pain with ovulation? <input type="checkbox"/> No <input type="checkbox"/> Yes	Number of Cesarean sections			
Pain with Menses? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of last pregnancy			
Menopause? <input type="checkbox"/> No <input type="checkbox"/> Yes	Difficulty conceiving <input type="checkbox"/> No <input type="checkbox"/> Yes			
	Difficulty with pregnancy <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>PMS Symptoms:</b> <input type="checkbox"/> None <input type="checkbox"/> Bloating/swelling	Difficulty with labor or delivery <input type="checkbox"/> No <input type="checkbox"/> Yes			
<input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Acne <input type="checkbox"/> Mood Swings	Difficulty with breast feeding <input type="checkbox"/> No <input type="checkbox"/> Yes			
<input type="checkbox"/> Digestive changes <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache	Future OB plans <input type="checkbox"/> No <input type="checkbox"/> Yes			
<input type="checkbox"/> Other				
Vaginitis Symptoms:	Never	Past	Current	Risk Factors
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Abnormal paps <input type="checkbox"/> No <input type="checkbox"/> Yes
Irritation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did your mother take DES? <input type="checkbox"/> No <input type="checkbox"/> Yes
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did your mother ever miscarry? <input type="checkbox"/> No <input type="checkbox"/> Yes
Odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you do self breast exams? <input type="checkbox"/> No <input type="checkbox"/> Yes
Pain with sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long term Hormone Replacement? <input type="checkbox"/> No <input type="checkbox"/> Yes
Trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bacteria (BV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Notes:</b>				

## Family History

Mother:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause	Age:
Father:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause	Age:
Siblings:	Number living:	Number deceased:	Causes / Ages:	
Children:	Number living:	Number deceased:	Causes / Ages:	
<b>Has any family member had:</b>	<b>Yes</b>	<b>Which Relative(s) &amp; Age of Onset</b>	<b>Physician's Notes</b>	
Diabetes	<input type="checkbox"/>			
Severe allergies	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>			
Heart Attack	<input type="checkbox"/>			
Blood clots in lungs or legs	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>			
High Cholesterol	<input type="checkbox"/>			
Kidney Disease	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>			
Thyroid problems	<input type="checkbox"/>			
Colitis / Crohn's	<input type="checkbox"/>			
HIV / AIDS	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>			
Birth Defects	<input type="checkbox"/>			
Drinking or Drug problems	<input type="checkbox"/>			
Breast Cancer	<input type="checkbox"/>			
Colon Cancer	<input type="checkbox"/>			
Ovarian Cancer	<input type="checkbox"/>			
Uterine Cancer	<input type="checkbox"/>			
Other Cancer:	<input type="checkbox"/>			
Mental Illness/Depression	<input type="checkbox"/>			
Alzheimer's	<input type="checkbox"/>			
Other:	<input type="checkbox"/>			
	<input type="checkbox"/>			

## Social & Lifestyle

Habits	Yes	No	Details	Notes
Current Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	
Past Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	
Quit?	<input type="checkbox"/>	<input type="checkbox"/>	When?	
Alcohol consumption Types:	<input type="checkbox"/>	<input type="checkbox"/>	Per day? Per week?	
Recreational Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	Type:	
Ever been treated for drug or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	When?	
Seat Belt Use	<input type="checkbox"/>	<input type="checkbox"/>		
Caffeine Use (coffee, tea, cola)	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day? Type?	
Regular Exercise? Types:	<input type="checkbox"/>	<input type="checkbox"/>	How much?	
Health Hazards at home / work?	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Social</b>				
Happy with relationship status?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have a good support network of family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	Who?	
What is your predominant emotion?				
<b>Lifestyle</b>				
Do you enjoy your work?	<input type="checkbox"/>	<input type="checkbox"/>	Hours per week:	
Stress Level	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	
Stress source	<input type="checkbox"/> Money	<input type="checkbox"/> Job	<input type="checkbox"/> Family/ Relationship	
What do you do to relieve stress?				

Sleep	Yes	No	Details
Problems falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Problems staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wake during the night?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wake rested in the am?	<input type="checkbox"/>	<input type="checkbox"/>	
Usual bed time / rising time:	Hours of sleep daily:		
Dreams?			
<b>Diet</b>			
Do you follow a particular Diet?			
Known food allergies / intolerances?			
What is a typical breakfast for you?			
Typical Lunch?			
Typical Dinner?			
Snacks?	Dessert / Treats?		
How much water do you drink per day?			

**EXAM AND IMAGING HISTORY (Indicate date, doctor's name or place of most recent)**

Physical Exam	HIV test
Pap Smear	Chest X-ray
Mammogram	EKG
Colonoscopy	STD screen
Prostate check	Cholesterol screen
TB test	Bone density check

**IMMUNIZATION HISTORY**

Immunization	Date	Boosters
Tetanus – Diphtheria		
Measles-Mumps-Rubella (MMR)		
Varicella		
Hepatitis A		
Hepatitis B		
Flu shot		
Other:		

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date reviewed with patient



**Christine Bowen, N.D.**  
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## CLINIC POLICIES

### **FEES**

- **Office Visits:** Fees for appointments are determined by many factors including time spent, procedures performed and complexity of your health care needs. We can give an estimate for each visit upon patient request. Reduced rates may apply to those who do not have insurance coverage who pay their bill in full at the time of service. Late patients will be charged for the full price of the original appointment time.
  - **INSURANCE.** We are out-of-network with all insurance companies. All visits must be paid for in full at the time you are seen. Some lab orders may be eligible for insurance coverage. Any non-covered services or any non-covered fees are the patient's responsibility. You may be eligible for out-of network reimbursement for visits or other services. Please request a "coded bill" at your visit to submit to your insurance company for possible patient reimbursement. Each person's insurance policy is different from the next; please check with your insurance company to ask about out-of-network reimbursement.

**Laboratory Testing:** All laboratory tests will be billed to the patients' insurance company by the laboratory or billed to the patient if you do not carry insurance. Any remainder balance not covered by the insurance company is the sole responsibility of the patient. Some labs ordered may require patient payment and may not be eligible for insurance payment.

**E-Mails:** Fees may apply. The doctor is available by e-mail for simple clarification or updates on health status. E-mail is not to be used for sole case management. The doctor will not have your case information in front of her while replying to your e-mail so be sure to include all pertinent information in your e-mail correspondence. If your questions or health needs exceed a simple e-mail reply, we will ask you to make an appointment for an in office visit to address your healthcare needs. Multiple e-mails sent per day requiring multiple responses will be subject to a fee that will not be billable through insurance. Please allow 24-48 hours (during business hours/days only) to receive your e-mail reply.

**Phone Consultations:** \$40.00/15 minutes minimum charge. Phone consultations are provided for established clients only under special circumstances determined by the physician. The minimum fee is charged for any phone consultation up to 15 minutes. Phone consultations that extend beyond 15 minutes will be rounded up in 15 minute increments. This fee is not charged in the following cases: when you require clarification of on-going therapy and when the doctor has asked you to call. If there is any question about this service you are welcome to ask in your call or your email inquiry. The physician will respond to your inquiry within 24 hours; however, due to unexpected medical emergencies a response is sometimes delayed. If the doctor has not responded within 24 hours, please call or email the doctor again.

**Copies/Administrative Fees:** Copies of patient chart notes or any request that incurs an expense to the clinic will be charged to the client. Fees will be variable depending on the extent of the request.

**Appointment cancellations:** Any no-show appointments or appointments cancelled **without 24 hours notice will be billed \$55.00.** These fees will be the patients' responsibility (not billable to insurance).

### **PAYMENT**

Payment is due at the time of service for office visits and pharmacy products that are not covered by insurance. Dr. Bowen accepts checks, cash, credit card (Visa, Mastercard and Discover) and money orders. Invoices and receipts are available by request.

**Returned Check Fee:** There is a \$25 fee for each returned check.

**Returned Medicine:** You may return **unopened medicine within thirty days of purchase** for a refund except for the following items: any acidophilus products, suppositories, compounded hormones and amino acids, and specially ordered or assembled items.

All fees are subject to change and patients will be kept abreast of these changes. If you have any questions regarding these guidelines please feel free to ask.

By signing below you are acknowledging agreement with the above clinic policies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





**Christine Bowen, N.D.**  
NATUROPATHIC PHYSICIAN  
**BOTHELL NATURAL HEALTH**

**Phone:(425) 485-7441**  
**Fax:(425)424-2384**  
**info@bothellnaturalhealth.com**  
**www.bothellnaturalhealth.com**

## **CONSENT FOR TREATMENT**

**GENERAL INFORMATION:** Dr. Bowen incorporates a wide variety of clinical tools in her practice. Most patients will receive a combination of treatment modalities drawing from her varied background in psychology, massage therapy, herbal medicine and naturopathic medicine. Diagnosis and treatment may include methods from any or all of the following treatment types: Naturopathic Medicine, Physical Medicine, Homeopathy, Lifestyle and Nutritional Counseling.

**METHODS, PROCEDURES AND THERAPEUTIC APPROACHES:** Dr. Bowen may perform any of the following procedures as necessary to give proper diagnosis, determine treatment approaches, treat or otherwise address your health concerns:

- ***General Diagnostic Procedures:*** including but not limited to: blood collection, imaging orders (ultrasound, x-ray, MRI, CT), lab analysis of blood, urine and stool, general physical exam, neurological and musculoskeletal assessments.
- ***Counseling:*** Compassionate and reflective listening, coaching in healthy lifestyle changes, nutrition and exercise.
- ***Topical Treatments and Prepping:*** prepping skin for puncture with alcohol, iodine or other antiseptic agents.
- ***Herbs and Natural Medicines:*** prescription of vitamins, minerals, and dietary supplements to achieve therapeutic goals; prescription and / or application of herbs in capsules, powders, teas, tinctures, plasters, pastes, suppositories, creams, salves, etc.; as well as highly dilute homeopathic remedies, intramuscular vitamin injections.
- ***Soft Tissue and Osseous Manipulation:*** use of massage, neuro-muscular techniques, muscle energy stretching, visceral manipulation, osseous manipulation of the spine and extremities, prescription and fitting for orthotics.
- ***Electromagnetic and Thermal Therapies:*** includes the use of ultrasound, low and high volt electrical muscle stimulation, micro current, infrared heat, moxibustion, and hydrotherapy.
- ***Minor Office Procedures:*** laceration care, cerumen removal
- ***Contraception:*** counseling and prescription
- ***Pharmaceutical prescriptions:*** of herbs, nutrients, hormones and antimicrobials when necessary

**POTENTIAL RISKS:** Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

**POTENTIAL BENEFITS:** Restoration of health and the body's maximal functional capacity; relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

**NOTICE TO PREGNANT WOMEN:** All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Bowen, regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

\_\_\_\_\_  
Patient Name (PRINTED)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**Christine Bowen, N.D.**  
NATUROPATHIC PHYSICIAN  
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## **Notice of Privacy Practices ~ Acknowledgement of Receipt**

Dr. Bowen is required to provide you with a copy of its “Notice of Privacy Practices” document, and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information. It also describes your rights and explains how you may exercise those rights.

I understand that my protected health information can and will be used to:

- Provide and coordinate my treatment among health care providers
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I understand that my provider has the right to change the Notice of Privacy Practices and that I may request a current copy at any time.

My signature below acknowledges that I have: *(please check one box)*

- Been offered a copy of the “Notice of Privacy Practices” document and have accepted that copy.
- Been offered a copy of the “Notice of Privacy Practices” document and have declined to take a copy. I understand that I may request a copy at any time in the future, and will be granted a current copy upon request.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian / Representative’s Signature

\_\_\_\_\_  
Date

### **OFFICE USE ONLY:**

I hereby affirm that Bothell Natural Health Center has made a good faith effort to provide a copy of the Notice of Privacy Practices document to the above named patient, and to obtain written acknowledgement of such.

Staff Initials \_\_\_\_\_

- Patient was offered form but refused to sign
- Patient was physically unable to sign acknowledgement
- Communication barriers
- Other \_\_\_\_\_

## **Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to an insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to reasonable requests on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies or procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services Office of Civil Rights  
 200 Independence Ave. S.W.  
 Washington D.C. 20201  
 (202) 619-0257  
 Toll Free: 1-877-696-6775