Natural Health Care

Nutritional Questionnaire

Contact Information

Name		Date / /	
Age	DOB / /	Sex (circle one)	F M
Address			
City	State	Zip	
Email		Who were you referred by?	
Telephone ( ) -	Parent/Guardian		

What are your most important health problems? List in order of significance

1.
2.
3.
4.

Diet:

Usual Breakfast:

Usual Lunch:

Usual Dinner:

Snacks:

Coffee, Tea, Sodas, Beer, Wine?

Do you eat:	Often	Rarely	Never
Eggs			
Red Meats			
Chicken			
Fish			
Milk			
Cheese			
Yogurt			
Butter			
Margarine			
Bread			
Cooked Vegetables			
Potato/Yam			

Or:	Often	Rarely	Never
Fruits			
Salads			
Sugar			

List any foods that…

You Crave?

You react to?

You do not like?

3606 Main St. | Ste 201 | Vancouver, WA | 98663
Phone: (360) 823-8121 | Fax: (360) 823-812
Email – Salmoncreekclini@aol.com | Website – www.salmoncreekclinic.com

Informed Consent -

Any health care is not without its risks or is guaranteed to be successful. Naturopathic care is generally safer than other systems of medicine, but there are potential risks in what we do as well.

By reading and initialing below, you acknowledge your awareness and understanding of such risks.

1. The Salmon Creek Clinic, the physicians practicing within, and clinical staff do not recommend that you discontinue any other treatment or care provided by any other health care professional.

Initials_________

2. Acupuncture treatments may result in a bruise at the site of the needle insertion. Any needle insertion carries a small risk of infection, though we use only single-use, sterile needles to minimize any risk.

Initials_________

3. Natural healing may occasionally generate a "healing reaction." All new patients receive a paper, which discusses this, *Nature's Cure and the Process of Healing.* Generally, this will be a flu-like state with fever for a few days, but may be different from that, and may require expert attention and guidance to the next stage of healing.

Initials_________

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. Along with this consent form, a copy of the privacy notice that describes our privacy policies in detail will be available for your perusal at our clinic and can also be found on our website. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. We will make the changes available to you as soon as the changes are made.

Right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

We would like to share with you how we might be asked to use or disclose your health care information:

1. It may be that personnel of the Salmon Creek Clinic have to disclose your health information, including all your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health

condition. Unless we have received a patient authorized request from another practitioner.

Initials_________

2. It may be that our front office staff may need to disclose your treatment or examination records if asked for by your insurance company or official government agency.

Initials_________

3. Should you wish to work with your medical insurance carrier for potential reimbursement, it may become necessary for our billing staff to disclose your treatment and billing records.

Initials_________

4. Personnel of the Salmon Creek Clinic may need to use your name, address, phone number, or your clinical records to contact you to provide appointment reminders or information about treatment alternatives. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Initials_________

Right to revoke your authorization

You may revoke any of these authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Initials_________

By Signing below, I acknowledge and agree to the terms outlined above:

Signature_________________________________ Date______________________

Internal Use Only

______________________ ______________

Authorized Signature Date

3606 Main St. | Ste 201 | Vancouver, WA | 98663
Phone: (360) 823-8121 | Fax: (360) 823-812
Email – Salmoncreekclini@aol.com | Website – www.salmoncreekclinic.com