SALMON CREEK CLINIC

Natural Health Care

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Nutritional Questionnaire

		Date: / /	
Name		Parent/Guardian	
Age	DOB / /	Phone ( ) -	
Address			
City	State	Zip	
Email			

Please tell us who referred you?

Primary Health Concerns:

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?			

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. There is no expressed or implied guarantee of any specific outcome with your treatment provided by the physicians of the Salmon Creek Clinic or staff. The care provided may or may not be a treatment for a specific disease, and may be preventive in nature, designed to improve your overall health and well-being.

Initials_____

3. The Salmon Creek Clinic physicians and staff will always strive to provide full disclosure of all information relevant to a person's care, and to answer all questions a patient may have, to the patient's satisfaction. The better one understands, the more fully one can participate in one's own healing. We encourage all questions regarding any aspect of care. Please feel free to ask about any aspect of care, future care, expected outcome, and what to do if any difficulties or possible negative outcomes should arise.

Initials_____

4. 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_____

5. 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 of 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. Our billing staff may have to disclose your examination and treatment records and your billing records to an insurance carrier or official government agency, if requested.

   Initials_____

3. Personnel of the Salmon Creek Clinic may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 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

_____ _____

Authorized Signature Date