SALMON CREEK CLINIC

Natural Health Care
Jared L. Zeff, ND, Lac, LLC

Contact Information

Name				**Date**	
Age	**DOB**		**Sex (circle one)**	**F**	**M**
Address					
City		**State**	**Zip**		
Telephone		**Alternative #**	**Email**		
Occupation		**Hours Per Week?**	**Retired?**		
Employer			**Education?**		

Emergency Contact

Next of kin or another emergency contact:	
Relationship	
Address & Phone Number	

Permissions for Alternative Contact *[permissions required for anyone that may contact our clinic on your behalf]*

Name						
Relationship						
Address & Phone Number						
Permission level:	All Access	☐	Appointments Only	☐	Medicinary Items	☐
Military Status		Date of Service		Where Did you serve?		

Health History Questionnaire

Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Clearly print your information and mark anything you do not understand with a question mark.

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

1.
2.
3.
4.

Last received medical care?

When?
Where?
What was the reason?

Family History

Check all Applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health – *G: Good F: Fair P: Poor*						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hay fever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age (at death)						
Cause of death						

For the following sections, please check Yes or No!

Childhood Illness

	Scarlet Fever	**Meningitis**	**Rheumatic Fever**	**Mumps**	**Measles**
YES					
NO					
Other?					

Immunizations

	Diphtheria	***MMR***	***Polio***	***Pertussis***	***Tetanus Shot (non-antitoxin)***
Yes					
No					
Other					

Current Medications

Do you take or use?	***Antacids***	***Appetite Suppressants***	***Cortisone***	***Laxative***	***Pain Relievers***	***Sleeping Pills***	***Thyroid***	***Tranquilizers***
Yes								
No								

Other (List all that you are currently taking. Use separate sheet of paper if needing room):

Current Supplements *List all that you currently take*

Review of Symptoms

For the following, please circle.

Y = a condition you have now | **N** = never had | **P** = a condition you have had in the past

General

Weight
Weight 1 yr. ago
Maximum Weight
When
Height

Energy

Fatigue Y P N

Skin

Rashes Y P N
Itching Y P N
Color Change Y P N
Lumps Y P N
Night Sweats Y P N

Head

Headaches Y P N
Head Injury Y P N

Eyes

Impaired Vision Y P N
Corrective Device Y P N
Eye Pain Y P N
Tearing Y P N
Dryness Y P N
Double Vision Y P N
Glaucoma Y P N
Cataracts Y P N

Ears

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

Nose and Mouth

Frequent Colds Y P N
Sore Tongue Y P N
Gum Problems Y P N
Hoarseness Y P N
Teeth Problems Y P N
Sinus Problems Y P N

Neck

Lumps Y P N
Swollen Glands Y P N
Goiter Y P N
Pain or Stiffness Y P N

Respiratory

Cough Y P N
Sputum Y P N
Spitting up Blood Y P N
Wheezing Y P N
Asthma Y P N
Bronchitis Y P N
Pneumonia Y P N
Pleurisy Y P N
Emphysema Y P N
Difficulty Breathing Y P N
Pain when Breathing Y P N
Shortness of Breath Y P N
At night Y P N
Lying down Y P N
Tuberculosis Y P N

Cardiovascular

Heart Disease Y P N
Angina Y P N
High Blood Pressure Y P N
Murmurs Y P N
Rheumatic Fever Y P N
Chest Pain Y P N
Swelling in ankles Y P N
Palpitations or Fluttering Y P N

Gastrointestinal

Trouble Swallowing Y P N
Heartburn Y P N
Change in Thirst Y P N
Change in Appetite Y P N
Nausea Y P N
Vomiting Y P N
Vomiting Blood Y P N
Bowel Movements Y P N
How Often
Is this a Change?
Blood in Stool Y P N
Belching or passing gas Y P N
Jaundice (yellow skin) Y P N
Liver Disease Y P N
Gall Bladder Disease Y P N
Ulcer Y P N
Hemorrhoids Y P N

Urinary

Pain on Urination Y P N
Increased Frequency Y P N
At Night Y P N
Inability to hold urine Y P N
Frequent Infections Y P N
Kidney Stones Y P N

Female Reproduction

Age Menses Began
Average Number of days
Length of Cycle
Bleeding Between Periods Y P N
Are Cycles Regular? Y P N
Pain during intercourse Y P N

Painful Menses	Y N
Vaginal problems	Y N
Excessive Flow	Y N
Birth Control	Y N
What Type?	
Number of Pregnancies	
Number of Live Births	
Number of Miscarriages	
Number of Abortions	

Difficulty Conceiving	Y P N
Menopausal Symptoms	Y P N
Are you sexually active?	Y P N
Sexual Difficulties	Y P N
Venereal Disease	Y P N

Please check one of the following options:

Heterosexual
Bisexual
Homosexual

Breasts

Do You Self-Exam	Y P N
Lumps	Y P N
Pain (or tenderness)	Y P N
Nipple discharge	Y P N

Male Reproductive

Hernias	Y P N
Testicular Masses	Y P N
Testicular Pain	Y P N
Penis problems	Y P N
Are you sexually active?	Y P N
Sexual Difficulties	Y P N
Prostate Disease	Y P N
Venereal Disease	Y P N
Discharge or Sores	Y P N

Please check one of the following options:

Heterosexual
Bisexual
Homosexual

Musculoskeletal

Joint Pain or Stiffness	Y P N
Arthritis	Y P N
Broken Bones	Y P N
Muscle Spasms	Y P N
Weakness	Y P N

Peripheral Vascular

Deep Leg Pain	Y P N
Cold Hands and Feet	Y P N
Varicose Veins	Y P N
Thrombophlebitis	Y P N

Neurologic

Fainting	Y P N
Seizures	Y P N
Paralysis	Y P N
Muscle Weakness	Y P N
Numbness or Tingling	Y P N
Loss of Memory	Y P N

Emotional

Depression	Y P N
Mood Swings	Y P N
Anxiety	Y P N
Tension	Y P N

Endocrine

Hypothyroid	Y P N
Heat or Cold Intolerance	Y P N
Excessive Thirst	Y P N
Excessive Hunger	Y P N

Blood

Anemia	Y P N
Easy Bleeding or Bruising	Y P N

Habits

What are your main hobbies and interests?

Do You Exercise?	Y N

What Forms?

How often do You Exercise?

Do you eat three meals daily?	Y N
Awaken rested	Y N
Sleep well	Y N
Average 6-8 hours' sleep	Y N
Enjoy your work	Y N
Spend time outside	Y N
Watch television	Y N
How many hours a day	
Read	Y N
How many hours a day	
Take vacations	Y N
Been treated for drug dependence	Y N
Use recreational drugs	Y N
Use alcoholic beverages	Y N
Been treated for alcoholism	Y N
Use tobacco	Y N

With whom do you live? *(Check the best option)*

Spouse ____ Partner ____ Relatives ____ Friends/Roommate ____ Alone ____ Parents ____

Relationship Status

Married ____ Separated ____ Divorced ____ Widowed ____ Single ____ Significant Partnership ____

Permissions for Research:

The naturopathic community is interested in furthering the goal of naturopathic medicine through scientific investigations and research. Would you consent to our use of your medical records by qualified investigators under protocols approved by an appropriate Institutional Review Board? Your anonymity will be guaranteed.
(Please Circle) **Y N**

Signature _____ Date _____

Patient Responsibility Statement –

By reading and initialing below, you understand and agree to the following.

Scheduling ~ it is best that appointments are scheduled in advance. The Salmon Creek Clinic is unable to guarantee that an appointment time will be available on short notice. We value your time and strive to keep appointments at their set time. We encourage our patients to be responsible for their own health care, which includes scheduling. We aspire to ensure that your scheduled visit is dedicated to you. If you are more than 15 minutes late for your appointment, you may be asked to reschedule and will be held responsible for the full cost of a missed appointment, or your appointment may still be held but charged at the full rate of scheduled time and using only the duration of time remaining.

It is the individual's responsibility to follow up and/or schedule an appointment if warranted.

Cancellation and missed appointment charges:

A valid credit card or debit card will be required at time of initial appointment scheduling; to guarantee appointment time is held. Card will not be charged unless we receive notice of cancelation or rescheduling less than 24 business hours prior to your appointment time, or you do not show up for your appointment.

New Patients – Due to the significant time reserved in the doctor's schedule for new appointments, a 24-hour business day cancellation is required for all new patient appointments. All new patient appointments that are canceled without a 24-hour notice will be subject to being billed the full cost of the appointment time held ($425.00).

Established Patients – appointments with less than 24-hour business day notice will be charged the full cost of the appointment time reserved.

Initials_____

- Medicinary and Supplements ~ Medicinary refills can be ordered by either calling the clinic directly at (360) 823-8121 or by emailing the office staff at salmoncreekclini@aol.com with specific refill needs; this includes size, item, and urgency. Refills requested will take a minimum of 24-48 hours from the time of request, dependent on stock available. All medicinary items are required to be paid in full at the time of request and will only be held for a maximum of two weeks from time of request. Failure to obtain requested items will result in re-stocking at patient's expense.

Initials_____

- Phone call policy ~ The Salmon Creek Clinic physicians encourage patients to call if you have questions after your office visit. It is understood by the Salmon Creek Clinic's physicians and staff that clarifying issues and answering basic questions could assist with the success in your health care. However, phone calls or questions that require a longer time frame (more than 5 minutes), may be billed as a phone consultation. All the Salmon Creek Clinic's patients are encouraged to make follow-up office visits; we recommend utilizing this time for multiple questions and for more

detailed clarification of information. We encourage our patients to contact the Salmon Creek Clinic directly, during regular business hours. Our clinic hours are Tuesday through Friday from 9:00am to 5:00pm. Please reserve evening and after hours contact numbers for severe or emergent situations only. In the case of emergency, if you unable to reach one of our physicians immediately, please call 911.

Initials_____

- Email Policy ~ Physicians and staff of Salmon Creek Clinic are happy to reply to questions and concerns through email correspondence. If the email correspondence becomes lengthy or excessive, the Salmon Creek Clinic physicians and staff reserve the right to request follow-up, either with an office visit or through a Telehealth consultation. Appropriate charges will apply. *Logistical emails (regarding payment, etc.) can be directed to salmoncreekclini@aol.com.

  Initials_____

- Payment ~ for your convenience we accept Cash, Check, Visa, MasterCard, Discover and American Express. Unless previously approved, payment is due in full at time of service.

  Initials_____

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 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_____

Digital Communications

Salmon Creek Clinic offers the choice to communicate electronically via email, text, and for Telehealth consultations.

What is Telehealth?

Telehealth is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using information and communication technologies.

Telehealth uses health information for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

During the Telehealth health service, details of your medical history, examinations, x-rays, and tests may be discussed using interactive video, audio and/or telecommunications technology.

All existing laws regarding privacy and security of your health information and copies of your medical records apply to this Telehealth health service and the audio and video information transmitted.

The Salmon Creek Clinic will do our best to protect the confidentiality of the patient identification and imaging data.

Initials_____

Before sending any electronic form of communication to the Salmon Creek Clinic, please read and understand the following information regarding the risks and conditions of the use of electronic communication.

Risks associated with electronic forms of communication

Transmitting patient information electronically has several risks that should be considered. These risks include, and are not limited to, the following:

- The circulation of electronic communications being forwarded and stored in numerous paper and electronic files.
- The immediate broadcasting of electronic communication worldwide, which can be received by many intended, and potentially unintended, recipients.
- Sending an electronic communication can easily be misaddressed and sent to a non-affiliated recipient.
- Electronic communication is easier to be falsified/impersonated than handwritten or signed documents.
- Backup copies of electronic communication may exist even after sender or recipient has deleted their copy.
- Employers and on-line services have a right to archive and inspect Electronic Communication transmitted through their systems.
- Electronic communication can be intercepted, altered, forwarded, or used without authorization or detection.

- Electronic communication can be used as evidence in court.

Initials _____

Conditions for the use of electronic forms of communication

The Salmon Creek Clinic will use all reasonable means to protect the security and confidentiality of any electronic communication sent and received.

- Although the Salmon Creek Clinic will strive to read and respond properly to electronic communications received, we cannot guarantee that any electronic communication will be received, read, or responded to within any period. Thus, this form of communication should not be used for medical emergencies or any other time-sensitive matters. **For emergencies call 911 or go to the nearest urgent care or emergency room**.
- All electronic forms of communications to or from the patients of the Salmon Creek Clinic concerning diagnosis or treatment will be printed out and, at the doctor's discretion, become a part of the patient's medical record.
- It may become necessary that a physician of the Salmon Creek Clinic forward electronic communication, internally, to the practice's team as necessary for diagnosis, treatment, reimbursement, and other handling. The Salmon Creek Clinic will not, however, forward communication to independent third parties without the patient's prior written consent, except as authorized or required by law.
- If the individual's electronic communication requires a response from Salmon Creek Clinic, and the individual has not received a response in a timely manner or within a business week, it is the individual's responsibility to follow up by telephone, to determine whether the intended recipient received the communication and when the recipient will respond.
- Individuals should not use electronic communication regarding sensitive medical information such as information regarding sexually transmitted infections, HIV/AIDS, mental health, developmental disability, or substance abuse.
- Individuals are responsible for informing Salmon Creek Clinic of any types of information that they desire not to be sent by an electronic form of communication, in addition to those listed in the above paragraph.
- The individual is responsible for protecting his/her password or other means of access to electronic communication. Salmon Creek Clinic is not liable for breaches of confidentiality caused by the individual or any third party.

Initials _____

Expectations of electronic communication

When communicating electronically, patients shall:

- Identify who you are in the body of the communication.
- Review the electronic communication to make sure it is clear, and that all relevant information is provided before sending to the Salmon Creek Clinic, staff, or physicians.
- Take precautions to preserve the confidentiality of all electronic communication, such as using a screen saver and safeguarding their computer and cell phone password. **Initials** _____

Signature	Date

Internal Use Only

_____ _____

Authorized Signature Date