# Camden Whole Health

**91 Elm Street Camden, ME ~ (207) 230-1131**

Date: _____

**Patient Info:**

Name: _____

Phone: _____(H)_____(C)

(*Circle # where we can leave a voice message*)

Address: _____

_____

E-mail: _____

Add you to Camden Whole Health's e-mail list? (Y) (N)

In Case of Emergency Contact:

Name: _____
Phone: _____
Relationship: _____

**PERSONAL INFORMATION**

Date of Birth: _____
Age: _____ SS#: _____
Employer: _____
Address: _____

**SOCIAL HISTORY**

Occupation: _____

# Years: _____ Satisfied? _____

Marital Status: _____

Do you have any children? _____

Do you take care of anyone besides your children?

_____

**# HOURs** you spend doing the following:

TV (per day): _____ Outdoors (per day): _____

Working (per work day): _____

List any major hobbies: _____

_____

Religious/spiritual preferences: _____

Have you ever been physically, mentally or sexually abused:_

Do you feel safe at home? _____

**EXERCISE**

Do you exercise as much as you would like to? Y N

Goals: # days/week _____ #minutes _____

Types: _____

Height: _____ Weight: _____

**HEALTH CONCERNS**

Please list in order of importance (to you) any health concerns you would like to address here:

1. _____
2. _____
3. _____
4. _____
5. _____

List any other MAJOR MEDICAL CONDITIONS you have now or have had in the past: _____

_____
_____
_____
_____

List any SURGERIES or HOSPITALIZATIONS: _____

_____
_____
_____

List all PRESCRIPTION DRUGS and the name of the prescribing DOCTOR:

_____
_____
_____
_____
_____
_____

Are you ALLERGIC to any medications? Y N
If Yes, which: _____

List all OVER THE COUNTER medications, vitamins, supplements and herbal formulas that you use on a regular basis: _____

_____
_____
_____
_____
_____
_____

List all other physicians, alternative care providers and therapists you see regularly: _____

_____
_____
_____
_____

How did you hear about our practice? _____

_____
_____

If you were referred by someone, would you mind sharing who referred you? _____

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## FAMILY HISTORY

Please indicate which conditions listed below an immediate family member has experienced.

**G**=Grandparent **P**=Parent **S**=Sibling **C**=Child

Heart Disease or Heart Attack:_____ G P S C
High Cholesterol:_____ G P S C
Diabetes (Type 2/Adult):_____ G P S C
Rheumatoid Arthritis:_____ G P S C
Auto-Immune Disease:_____ G P S C
Type:_____
Liver Disease_____ G P S C
Kidney Disease _____ G P S C
Cancer:
Type:_____ G P S C
Type:_____ G P S C
Type:_____ G P S C
Epilepsy _____ G P S C
Stroke _____ G P S C
Mental Illness _____ G P S C
Glaucoma _____ G P S C
Cataracts _____ G P S C
Asthma _____ G P S C
Eczema _____ G P S C
Hay fever or Hives _____ G P S C
Other Conditions not listed above:
_____ G P S C
_____ G P S C

## LIFESTYLE

Sleep: Average # hours per night: _____
*Usual time to bed:* _____
Usual time you get up: _____
Are you satisfied with your sleep? Y N
Explain: _____

Energy: Do you wake rested? Y N
When is your energy best? _____
When is your energy lowest? _____

Mood: Are you satisfied with your mood? Y N
Explain: _____

Have you ever been treated for?
Personality Disorder: ___ Depression: ___ Anxiety: __

Do use **tobacco**? Y N
Have you ever used tobacco? Y N
# Years: _____ #Packs/day: _____

Do you consume **alcohol**, **beer +/or wine**? Y N
# Servings day: _____

Do you consume **caffeine**? Y N
# Servings day: _____

## VACCINATIONS

Circle all vaccinations you have received:

| | | | |
|---|---|---|---|
| DPT: | Diphtheria | Pertussis | Tetanus |
| MMR: | Measles | Mumps | Rubella |
| Polio | Hepatitis B | Chicken Pox | Other |

## SPECIALIZED TESTING

Have you had any of the following (circle & explain):

Ultrasound MRI CT scans X-Ray
Endoscopy Colonoscopy BoneDensityScan
Explain: _____
_____

**SEXUALITY:** Heterosexual: __ Homosexual: __
Bisexual: __ Transgender: __

## MEN'S HEALTH

Have you ever experienced any of the following?

| | | |
|---|---|---|
| Prostate Issues | Y | N |
| Dribbling Urine or Difficulty Starting | Y | N |
| Premature Ejaculation | Y | N |
| Erectile Dysfunction | Y | N |
| Testicular Pain or Masses | Y | N |

## WOMEN'S HEALTH

Age of first menses _____
Age of last menses (if menopausal) _____
Length of Cycle (e.g. 28 days)_____
Duration of Cycle (e.g. 5 days)_____
Date of last GYN exam or Pap smear:_____
Do you do self breast exams? Y N

**Have you ever experienced any of the following?**

| | | |
|---|---|---|
| Vaginitis | Y | N |
| Sexually Transmitted Disease | Y | N |
| Irregular cycles | Y | N |
| Painful menses | Y | N |
| Endometriosis | Y | N |
| Heavy Flow | Y | N |
| Spotting between menses | Y | N |
| Ovarian cysts | Y | N |
| Cervical dysplasia or an "Abnormal Pap" | Y | N |
| Breast tenderness | Y | N |
| Abnormal Mammogram | Y | N |
| Breast mass or lump | Y | N |
| Nipple discharge | Y | N |
| PMS | Y | N |

If yes describe: _____
Menopausal Symptoms Y N
If yes describe: _____
Do you use Birth Control? Y N
If yes describe: _____
# Pregnancies:_____
# Miscarriages:_____
# Abortions:_____
# Live Births:_____

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# Adoptions: _____
Problems in Pregnancy or Labor: _____

## Gastrointestinal:

**Do you have a history of, or currently experience?**

| | | |
|---|---|---|
| Diarrhea | Y | N |
| Constipation | Y | N |
| Blood, mucus in stool | Y | N |
| Crohn's Disease | Y | N |
| Ulcerative Colitis | Y | N |
| Colon Cancer | Y | N |
| Colon Polyps | Y | N |
| Irritable Bowel Syndrome | Y | N |
| Intestinal Parasite | Y | N |
| Infection: Candida | Y | N |
| : Bacteria | Y | N |

## Urinary:

| | | |
|---|---|---|
| Do you now, or in the past, have had frequent urinary tract infections? | Y | N |
| Leakage of urine | Y | N |

**Have you ever experienced, or been screened for any of the following? Please describe:**

| | | |
|---|---|---|
| Thyroid disorder | Y | N |
| Cardiac/heart related issues | Y | N |
| Lung disease | Y | N |
| Skin disease or disorder | Y | N |
| Mononucleosis or other viral issues | Y | N |
| Cancer | Y | N |
| Autoimmune disease | Y | N |
| Lyme disease or other tick – borne illness | Y | N |

**ADDITIONAL INFORMATION:**

**HIPAA Notice of Privacy Practices and Consent:** I hereby consent to the use and disclosure of my protected health information by Dr. Katy Morrison, N.D., L.Ac. for the purposes of treatment, payment and healthcare operations or as otherwise required by law.

- Dr. Morrison has posted her Notice of Privacy Practices which provide 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 methods 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 Dr. Morrison. I understand that while Dr. Morrison may honor these requests, she is not required by law to do so.
- I am aware that Dr. Morrison reserves the right to change the terms of her Notice of Privacy Practices and to make new Notice provisions effective for all protected health information that she maintains. In the event of amendments, Dr. Morrison will make available a revised Notice for my review.

**Alternative Method of Communication Request:**

As a courtesy, it is Dr. Morrison's health policy to call your home phone number one to two working days prior to your scheduled appointment to remind you of the appointment time and date. 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 Dr. Morrison's standard method of communication.

☐ Please change as follows:

Please contact me at the following phone number: _____

**Statement of Financial Responsibility:** I understand and agree to the following:

- Services rendered "visit fees" are my responsibility as the patient or patient's responsible party unless I have Maine Community Health Options (MCHO) insurance in which case, I am responsible for my co-pay at the time of service.
- Laboratory fees I choose to have done at Camden Whole Health clinic that are billed by Dr. Morrison's office are due at the time of service (unless I have been notified of an exception for those with MCHO insurance).
- 100% of the cost of Naturopathic and Chinese medicines dispensed by Camden Whole Health clinic are due at the time of purchase.
- 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, I agree to pay all the costs and expenses, including attorney fees. I hereby authorize Dr. Morrison to release information necessary to secure payment.
- I agree to pay a $50 fee if I fail to be present within fifteen minutes of my schedule office visit time without leaving a voicemail message at 230-1131 within 24 hours. (Charges apply to all patients at the time of a second missed appointment.)
- I agree to begin paying finance charges on bills that are not paid within 90 days of bill date.
- I agree to request all modifications to this financial agreement, in writing, prior to the visit with Dr. Morrison.

**Consent to Treat:**

I understand that my care as a patient of Dr. Katy Morrison, licensed naturopathic doctor, acupuncturist and herbalist is directed by Dr. Morrison. I agree to provide written permission for her to consult with other practitioners at Camden Whole Health if necessary unless I am referred by Dr. Morrison to them in which case the permission to share information is presumed unless I provide written notice regarding limitations. I agree that if I am being treated by Dr. Katy Morrison, Dr. Barbara MacDonald or Dr. Deborah Moskowitz, who have a practice-sharing agreement, that one shared chart may be used unless I provide written notice withdrawing this consent.

**I have fully read and understood the above agreements and authorizations. I hereby certify that I have completed this Patient Health History truthfully and to the best of my knowledge.**

_____ _____

**Patient (18 years of age or older)** **Date**

_____ _____

**Parent, Legal guardian, responsible party other than self** **Date**

# Camden Whole Health

Patient Name_____Insurance ID#_____

**NOTE: You need to make a choice about receiving these health care items or services.**

We expect that your insurance will not pay for the item(s) or services(s) that are described below. Your Insurance Company does not pay for all of your health care costs. Your Insurance Company only pays for covered items and services when your insurance company's rules are met. **The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it.** Your Insurance Company will most likely deny coverage for:

Telephone conferences. This service is not covered by insurance.

The estimated cost for these item(s) and services $__45-$85_____.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you may have to pay for them yourself.

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.**

☐ **Option I** **I understand that anytime I choose to receive this service in 2018 it will not be covered by insurance and I will be financially responsible.**

☐ **Option 2** **No. I have decided not to receive the items or services. I will not receive these items or services.**

**Dr. Deb Moskowitz, ND**
**Dr. Barbara MacDonald, ND, LAc**
**Dr. Katy Morrison ND, LAc**
**91 Elm Street, Camden Maine 04843 (207) 230-1131**