

Natural Healthcare Northwest  
509 Olive Way, Suite 1315, Seattle, WA 98101  
(206) 382-9977

**PATIENT INFORMATION FORM**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth:     /     /

Social Security Number:     /     /

Single      Married      Life Partner      Divorced      Widowed

Occupation: \_\_\_\_\_

Name of Company: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

How Did You Hear About Us?

Referred by: \_\_\_\_\_ Advertisement in: \_\_\_\_\_

Coupon in: \_\_\_\_\_ Internet site: \_\_\_\_\_

Would you like an e-mail appointment reminder? Yes  No

**(Over Please)**

Please fill out the following information as accurately as possible. This information will help the doctor with diagnosis and treatment plans.

**Please List Specific Health Concerns in Order of Importance to You:**

1. \_\_\_\_\_

Date Began: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Have you seen other health care providers for this? Yes  No

If yes, what medications or treatments were given: \_\_\_\_\_

2. \_\_\_\_\_

Date Began: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Have you seen other health care providers for this? Yes  No

If yes, what medications or treatments were given: \_\_\_\_\_

3. \_\_\_\_\_

Date Began: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Have you seen other health care providers for this? Yes  No

If yes, what medications or treatments were given: \_\_\_\_\_

**Do you have any opinions regarding what may have caused your health conditions?** \_\_\_\_\_

\_\_\_\_\_

**Do you have any specific goals for your health?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical History

Allergies (Medications, Food, Environmental): \_\_\_\_\_

\_\_\_\_\_

### **Please List Past Surgeries or Hospitalizations:**

Surgery:	Date:
Name of Hospital:	Outcome:
Surgery:	Date:
Name of Hospital:	Outcome:
Other Hospitalization:	Date:
Treatment:	Outcome:
Other Hospitalization:	Date:
Treatment:	Outcome:
Injury:	Date:
Treatment:	Outcome:
Injury:	Date:
Treatment:	Outcome:

### **Please Indicate if You or a Relative Have Experienced Any of the Following:**

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Allergies	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mental Health Condition
<input type="checkbox"/> Asthma	<input type="checkbox"/> Migraines
<input type="checkbox"/> Auto immune Disorder	<input type="checkbox"/> Obesity
<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Depression	<input type="checkbox"/> Other Addiction
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Eczema	<input type="checkbox"/> Seizures
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Gout	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Disorder

**(Over Please)**

## Current Health Information

### Please List Medications You Are Taking:

Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:

### Please List Supplements / Herbs You Are Taking:

Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			

### Please Indicate Any of the Following:

<input type="checkbox"/> Smoke How Long:	Number/Day:
<input type="checkbox"/> Alcohol Type:	How Often:
<input type="checkbox"/> Caffeine What Drink:	How Often:
<input type="checkbox"/> Sugar How Much:	How Often:
<input type="checkbox"/> Artificial Sweetener Type:	How Often:
<input type="checkbox"/> Exercise Type:	How Often:
<input type="checkbox"/> Food Cravings What:	How Often:
<input type="checkbox"/> Sleep Problems Type:	How Often:
<input type="checkbox"/> Weight Change Gain/Loss:	When:
<input type="checkbox"/> Diet Restrictions	What:

I hereby allow my health insurance company to reimburse Natural Healthcare Northwest directly for services rendered by this office. I understand and agree to pay, in a timely manner, any fees not covered or denied by my insurance company, including annual deductibles. Co-payments are due at time of service.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_