NOR CAL Natural Medicine
June E. Stevens, ND
1135 Pine Street, Suite # 112
Redding, CA 96001
Phone: (530) 691-4115
Fax: (530) 691-4116

How did you hear of us?
Internet: ___Radio/TV: ___Sign:___ Lecture:____Family/Friend:___Name:_____
Were you referred by another Health Care Provider?___Yes ___ No
If "Yes", please provide referring Physicians name: _____

Patient Demographics

Name: _____ Sex: _____Gender: _____ Date of Birth: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____

Additional Patient Information

Today's Date: _____ Primary Care Physician: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ St: _____ Zip: _____
Name of nearest relative not living with you: _____ Relation: _____Phone: _____
Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)
Name of Spouse/Significant Other: _____
Whom may we contact in an emergency: _____ Relation: _____
Emergency Contact #: (____) _____

Insurance Information (Please provide card for Copying)

Insurance Company: _____ Phone: _____
Name of Insured: _____ Relationship to Insured: _____
S.S.#: _____/_____/_____ Policy #: _____ Group#: _____

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Furthermore, in the event that payment is not made on this account, and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time the account is placed with the agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection. Releases may be requested prior to specific procedures being performed (i.e., minor surgery, etc.)

Clinic Policy requires full payment at the time of services

Patient's Signature_____ **Date**_____

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Patient Name: Date of Birth:

List in Order of importance your health concerns:

1) _____
2) _____
3) _____

Your Past Medical History:

1. _____
2. _____
3. _____

Name of your current Primary Care Physician? _____

Date of last blood work and with which physician: _____

Have you worked with a Naturopathic Doctor before? If so, who, when and for what? _____

Have you had any genetic testing (i.e. 23 & Me, Ancestry.com, MTHFR)? _____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when passed:						
Reason for death:						
Cancer and type	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
Thyroid condition:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

Other_____

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 3) _____
2) _____ 4) _____

Please Note When & Why You Have Had Each of the Following:

X-Rays/Ultrasounds: _____ MRI/Cat Scans: _____

Last Dental exam: _____ Last Eye Exam: _____

Have you been immunized? **Yes or No** Any vaccination reactions?

_____

Patient Name: _____ **DOB:** _____

List **Y**es (**Y**), **N**o (**N**) or in the **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: _____

Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes**: _____

_____

Soda Pop: Y N P **Ounces per day if Yes/Past**: _____ What do you put in your coffee? _____

Alcohol: Y N P **How often & how much if Yes/Past**: _____

Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P

Recreational Drugs: Y N P **Any Drug Addictions**: Y N P

Any Drug Treatment: Y N P **Medicinal Marijuana or CBD use:** Y N P **For What?** _____

List all Prescription Medicines & Nutrient Supplement/Herbs that you are *taking regularly* and *include brands and dosages*:

_____

_____

_____

_____

_____

List all known drug allergies and reaction you get when you take the medication:

_____

_____

_____

Review of Symptoms:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____

Maximum weight and when: _____ **Minimum weight as adult & when**: _____

Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please circle (**Y)** if you currently have the problem, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, what time of the day is it the worst: morning, afternoon, or evening? _____

If you have fatigue, can you do what you need to during the day? Y N

What is your Blood Type? (Circle one) A AB B O Unknown

Patient Name: _____ **DOB:** _____

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P

NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Postnasal drip:**	Y N P
Polyps:	Y N P		**Seasonal allergies:**	Y N P
EYES				
Dry/Watery:	Y N P		**Blurry vision:**	Y N P
Double vision	Y N P		**Cataracts/glasses:**	Y N P
Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under eyelid:**	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P

Patient Name: _____ **DOB:** _____

RESPIRATORY				
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
CARDIOVASCULAR				
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest pain:**	Y N P
URINARY TRACT				
Incontinence:	Y N P		**Pain w/ urination**	Y N P
Frequent infections:	Y N P		**Kidney stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P
GASTROINTESTINAL				
Heartburn:	Y N P		**Bowel movement freq:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gallbladder disease**	Y N P
Change in appetite:	Y N P		**Liver disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer**	Y N P
MALE GENITALIA				
Testicular pain/swelling:	Y N P		**Sexually active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P
Discharge:	Y N P		**Prostate disease/symptoms:**	Y N P
Impotency:	Y N P		**Sexual Orientation:**	Hetero Homo Bi

Patient Name: _____ **DOB:** _____

FEMALE GENITALIA

Age period began:		**How often period occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual pain:**	Y N P
PMS:	Y N P	**Food cravings:**	Y N P
Times pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last pap smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually active:**	Y N P
Pain w/intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Bone density test:	Y N P	**If Yes, what were the results:**	
Sexual orientation:	Hetero Homo Bi		

Please list any birth control used and ages used: _____

_____

MUSCULOSKELETAL

Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P

NERVOUS

Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P

Mental/Emotional

Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych hospitalization:**	Y N P

Patient Name: _____ **DOB:** _____

Exercise

How often do you exercise? _____ **What type of exercise**? _____

For how long do you exercise? _____ **Hobbies**: _____

_____

_____

Sleep

How long per night? _____ **If you wake up, what is the reason**? _____

Nightmares: Y N P **Wake refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Sleep apnea Y N P **If Yes, C-PAP use** Y N

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with lead paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials? _____

_____

_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline, or other vapors? _____

Are you particularly sensitive to caffeine, medications, or supplements?

_____

Do you use pesticides, herbicides, or other chemicals around your home? _____

_____

_____

Social Life

Enjoy job: Y N P **Job/Position** _____ **Hours per week**: ___ **Highest Level of Education**: _____

Active spiritual practice: Y N P **Quality of significant relationship**: _____

History of sexual, mental/emotional, physical abuse: Y N **P** **If so, at what age and by whom**: _____

What is your greatest health concern? _____

How does it limit you the most? _____

_____ **How committed are you towards making valuable changes:** Little Moderately Very

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you follow a specific diet plan (i.e. vegan, gluten free)? _____

Allergies

List all known Allergies (medications, food, environmental): _____

I look forward to working with you.

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New Patient Office Policy

Our medical office operates as a fee for service cash-based practice. Currently, the State of California does not allow Naturopathic Doctors to contract with medical insurance companies, therefore we are not able to accept medical insurance coverage plans. We will provide you with an electronic copy of your invoice at the time of your visit, thus allowing you to submit directly to your insurance company for any potential reimbursement. As a fee for service practice, payment in full is expected at the time of service. Payments may be made with cash, check, debit card, or credit card (fee applies). We do charge a $35.00* returned check fee, in addition to bank fees, applied to any check not cleared for deposit.

Our office has a 24-hour cancellation/reschedule policy. If you are unable to make your scheduled appointment time for any reason, please contact our office a minimum of 24 hours prior to your scheduled appointment time to avoid a $150.00* fee for your missed appointment.

If you cancel/reschedule and/or no-call/no-show your scheduled appointment with our office three consecutive times, we will issue you a letter of dismissal from our practice.

By signing below, I have read and understand this policy. I guarantee full payment of all charges incurred as a patient.

Signature_____ Date_____

Printed Name_____

Parent of Guardian (minor)_____ Date_____

*Fees subject to change without notice

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NOTICE OF PRIVACY PRACTICES

To our patients – this notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information

Use and disclosure of your health information is certain special circumstances
The following circumstances may require us to use or disclose your health information:

1. The public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for you request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychology notes. You must submit your request in writing to June E. Stevens ND 1135 Pine Street Suite #112, Redding, CA. 96001.
   Note: We must respond to this request within 30 days.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to, June E. Stevens ND, 1135 Pine Street, Suite # 112, Redding, CA 96001. You must provide us with a reason that supports your request for amendment.
   Note: We must respond within 60 days. The privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make changes.
5. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to provide a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of Health and Human Services. To file a complaint with our practice, contact June E. Stevens ND. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Questions regarding this notice or our health information privacy policies, please contact June E. Stevens ND.

Signature confirms receipt of Patient Privacy Information.

Signature_____ Date:_____