Dr. Chikako Harper, ND, LMT

Naturopathic Solution LLC

7303 SW Beaverton-Hillsdale Hwy #204 Portland OR 97225
ph.503.297.3825 fax. 503.427.9834 cell. 503.477.0472

Patient Name (First, Last): _____ Date: _____

Age: _____ Date of Birth (mm/dd/yyyy): _____ Gender : _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home, cell, work): _____
*Do we have your permission to leave confidential messages on your voice mail? Y / N

Email: _____ Occupation / Employer: _____

Live with: ▫ Spouse ▫ Partner ▫ Parents ▫ Children ▫ Friends ▫ Alone ▫ Other (pets, etc)

Emergency Contact: _____ Phone: _____

Relationship of emergency contact person to you: _____

If the patient is a minor (under the age of 18), please provide the name(s) and signature(s) of parent(s)/legal guardian(s):

_____

How did you hear about us? _____

Who can we thank for referring you to us (name and phone number if applicable)?

_____

Primary Health Concerns / Goals for Visit:

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

Allergies:

Drug: _____ (Please circle) very mild, mild, moderate, sever

Environmental: _____ (Please circle) very mild, mild, moderate, sever

Food: _____ (Please circle) very mild, mild, moderate, sever

Medications / Supplements: List all medications / quantity

_____
_____
_____

Hospitalizations, Surgeries & Major illnesses / Dates

_____
_____
_____

Childhood Illness: Please circle if you have had in the past.

Scarlet fever	Diphtheria	Rheumatic fever	Mumps	Measles	German Measles	Others:

Immunizations: Please circle if you have had in the past.

Polio	Pertussis	Tetanus shot	Diphtheria	Measles	Mumps
Rubella	Flu shot	Others:			

Family History: Please circle if you have a family history of any of the following.

Alcoholism	Allergies	Anemia	Arthritis	Asthma	Alzheimer's	Cancer (type?)
diabetes	Epilepsy	Gallbladder disease	Glaucoma	Hay fever / hives	Heart disease	High blood pressure
HIV/AIDS	Kidney disease	Liver disease	Mental illness	Stroke	Tuberculosis	Thyroid disorder
Others						

Father's health status, age, (or cause/age of death): _____
Mother's health status, age, (or cause/age of death): _____
Sibling's health status, age(s): _____

Review of Systems: Please circle the symptoms or conditions that you currently have.

Headache	Head injury	TMJ/Jaw pain	Ringing in the ears	Dizziness	Ear pain	Impaired hearing
Sore throat	Sore tongue	Gum disease	Hoarseness	Dental cavities	Impaired vision	Glasses or contacts
Eye pain	Eye pain	Teary or dry eye	Double vision	Glaucoma	Cataracts	Frequent colds
Nose bleeds	Nose stuffiness	Hay fever	Sinus problem	Loss of smell	Lumps	Swollen glands
Goiter	Neck pain or stiffness	Coughing up blood or sputum	Asthma	Cough	Shortness of breath	Difficult breathing
Chest pain	Heart palpitation	Blood clots	Murmur	Fainting	High/low blood pressure	Swelling in ankles
Skin rashes	Skin itching	Acne	Hair loss	Eczema	Hives	Night Sweats
Skin color changes	Coldsores	Joint pains	Muscle spasms	Arthritis	Muscle weakness	Sciatica
Fracture	Nausea / vomiting	Vomiting blood	Blood in stool	Gallbladder disease	Liver disease	Jaundice
Change in thirst	Change in appetite	Trouble swallowing	Belching / gas / bloating	Heart burn	Ulcer	Hemorrhoids

Female Reproductive: Circle the symptoms or conditions that you currently have.

Last Menstrual cycle:		Average # of days:		Length of cycle:	
Age of first menses:	# of pregnancy:		# of live birth / # of miscarriage:		
Currently sexually active?	Y / N	Birth Control?	Y / N	What type?	

Please circle if you have any of the following symptoms.

Irregular cycle	Mid cycle spotting	Painful menses	Clotting	Heavy or light flow	PMS	low libido
Vaginal discharge	Pain with intercourse	Endo-metriosis	Ovarian cysts	Abnormal Pap	HPV	Sexually transmitted infection
Herpes	Condyloma (warts)	Breast pain / tenderness	Breast lumps	Nipple discharge	Difficulty conceiving	Menopausal symptoms

Male Reproductive: (Circle the symptoms or conditions that you currently have)

Hernias	Testicular masses	Testicular pain	Sexual difficulty	Prostate disease	Sexually transmitted infection	Penile discharge
Penile pain	Low libido	Are you sexually active? Y / N				

Do you use Tobacco?: Please circle.

Never	Former smoker	Everyday heavy smoker (>10pcs)	Everyday light smoker (<10pcs)	Some day smoker

Do you use alcohol? Y / N How much / how often? _____
Do you drink coffee/caffeine? Y / N How much / how often? _____
Do you exercise? Y / N How much / how often? _____

How much water do you drink each day? _____

How many hours of sleep do you get per night?_____ Waken rested? Y / N

Rate your stress level: Please circle.

None	Low	Moderate	High	Unbearable

What are your primary stressors? _____

Pharmacy Preference:
If you are currently taking prescription drugs, please provide your preferred pharmacy's information (pharmacy name, address, phone number)

_____

Start date & End date, Medication name, Dosage, Frequency, Adverse effects

_____

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Consent to Treat

I have been informed and understand that:

1. Any treatment or advice provided to me as a patient of Naturopathic Solutions, LLC is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another healthcare provider.
2. I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider and no physician or staff member is recommending that I refrain from seeking or following the advice of another licensed health care provider.
3. The treatment and therapies provided or recommended by this clinic ma be different from those usually offered by another licensed health care provider.

Signature: _____ Date: _____

Statement of Financial Responsibility:

I understand and agree to the following:

- Payments for services rendered are my responsibility as the patient or the patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.

Signature: _____ Date: _____

Insurance Billing:

If insurance is being billed for services rendered, I understand and agree to the fooling:

- I authorize the physician at Naturopathic Solutions, LLC to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support the insurance billing process only.
- I understand that it is my responsibility to provide adequate insurance billing information including a copy of a valid insurance card.
- I am responsible for any and all charges that my insurance company will not cover.

Signature: _____ Date: _____