801 W Main St, Suite 1C
Bozeman, MT 59715
Ph. (406) 219-3631
Fax (406) 760-1809
www.ElevateHealthMT.com

ADULT DEMOGRAPHIC INFORMATION

Name: _____ **Date of Service**: ____/____/____

Age: _____ **Date of Birth**: __/____/____ **Gender**: ☐ Female ☐ Male_____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): ____-____-____(cell)____-____-____ (work)____-____-____

Email address: _____

Would you like to be added to our email newsletter?: ☐ Yes ☐ No

Please check all that apply:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live with:

☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Occupation: _____ Hours per week: _____

Employer: _____

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? ☐ No ☐ Yes_____

_____

Emergency contact: _____ *Relationship:* _____

Phone: ____-____-____ Cell Phone: ____-____-____

Address: _____

ALLLERGIES: (Please list all known allergies and reactions to these allergens): _____

_____

_____

INSURANCE

Insurance Name: _____ Insurance Phone #____-____-____

Member's Name: _____ Member's DOB: ____/____/____

Member ID #_____ Group #_____

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ADULT INTAKE

Name: _____ **Date of Birth**: ____/____/____

Date of Service:____/____/____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are most possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. *Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.*

Why did you choose to come to this clinic?

What do you know about the Naturopathic approach?

What expectations do you have from this visit to our clinic?

What *long-term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?

(Rate from 0 to 10, 10 being 100% committed.)

0% > 0 1 2 3 4 5 6 7 8 9 10 <100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health and adhering to the therapeutic protocols, which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

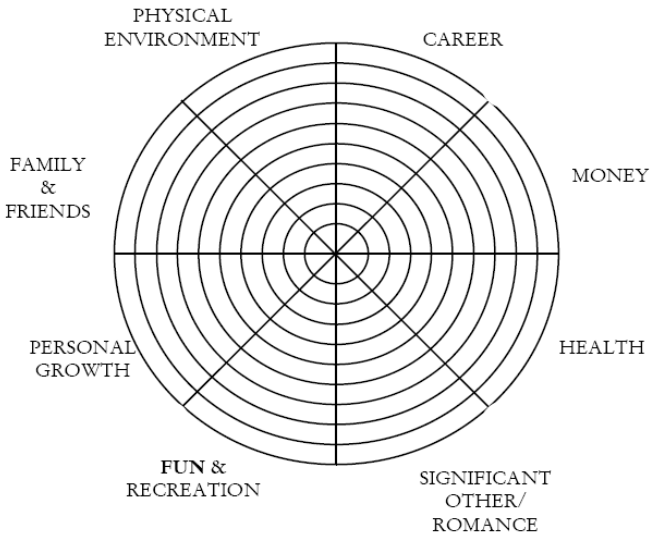
WHEEL OF BALANCE

Wellness is a balance of many factors.

Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? ☐ No ☐ Yes

If yes, where and from whom?_____

If no, when and where did you last receive medical or health care?_____

What was the reason?_____

What are your most important health problems? List as many as you can in order of importance:

1)_____

2)_____

3)_____

4)_____

5)_____

Do you have any known contagious diseases at this time? ☐ No ☐ Yes If yes, what?_____

_____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please check all appropriate)

	S	M	F	Si		S	M	F	Si
☐ Cancer					☐ Heart Disease				
☐ Diabetes					☐ High Blood Pressure				
☐ Arthritis					☐ Glaucoma				
☐ Anemia					☐ Mental Illness				
☐ Hives					☐ Kidney disease				
☐ Tuberculosis					☐ Asthma				
☐ Epilepsy					☐ Stroke				
☐ Hay fever					☐ Thyroid Condition				
☐ Addiction					☐ Depression				

S=self, M= mother, F=father, Si=siblings

Are both parents still living? ☐ Yes ☐ No If no, how old were they when they passed and what did they pass from?_____

Any other relevant family history?_____

What is your family heritage?_____

CHILDHOOD ILLNESSES

Please check any of the following you had as a child:

☐ Rheumatic fever	☐ Diphtheria	☐ Chicken pox	☐ Measles
☐ German Measles	☐ Scarlet fever	☐ Mumps	☐

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

Event	Year	Event	Year

ALLERGIES

☐ No Known Allergies

Are you hypersensitive or allergic to:

Any drugs? ☐ No ☐ Yes_____

Any foods? ☐ No ☐ Yes_____

Any environmentals or chemicals? ☐ No ☐ Yes_____

CURRENT MEDICATIONS

Do you take or use any of the following (please check and list which ones):

☐ Laxatives	☐ Birth Control Pills
☐ Pain Relievers	☐ Antacids
☐ Antibiotics	☐ Cortisone
☐ Tranquilizers	☐ Sleeping Pills
☐ Thyroid Medication	☐ Hormone Replacement

Please list any prescription **medications**, **over the counter medications**, **vitamins** or other **supplements** you are taking (please attach an extra page if you need more room):

1.	4.
2.	5.
3.	6.

GENERAL

Height:_____ Weight:_____ Weight one year ago:_____ Maximum Weight:_____

When were you at your maximum weight:_____

When during the day is your energy the best?_____ Worst? _____

Main interests and hobbies:_____

Exercise: ☐ No ☐ Yes If so, what kind and how often: _____

Watch TV: ☐ No ☐ Yes If so, how many hours per day?_____

Read: ☐ No ☐ Yes If so, how many hours per day? _____

Do you have a religious/spiritual practice? ☐ No ☐ Yes If so, what kind?_____

Is there anything else you would like to tell me that I haven't asked you about...

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Acknowledgment of Responsibility for Payment and Payment Agreement

Welcome to the private practice of Dr. Bronwyn Bacon, ND. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

Payment: Payment for all services and medicinary items are due at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a $35.00 NSF fee.

Phone calls and emails: Phone calls and emails regarding an existing health issue that require more than 5 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Email replies that require more than 10 min of the doctor's time - $35. Phone calls are $65 per 15 min increment, billed in 15 min increments.

After hour calls: For non-life threatening health related emergencies you may reach your physician by calling the clinic and leaving a message marked "urgent" and stating you would like a call back. A $75.00 charge will be applied for pages to your physician. Additional charges maybe applied for additional services beyond responding to the page.

Late cancelations: We require 48-hour notice for canceling any appointments. There is a charge of 50% of the service cost incurred when less than 48-hours notice is given.

No shows: You will be charged the cost of any scheduled visit that you neglect to come to without a call to alert the clinic that you will not be able to make the visit. Special exceptions will be made for extenuating circumstances.

Supplements: Your health care provider may prescribe supplements, which may be purchased at the clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

Pharmacy prescriptions: Your health care provider may prescribe medications, which will be sent to the pharmacy of your choosing if possible. When you are due for a refill of these prescriptions please contact the pharmacy directly and they will send your doctor the refill request. A visit may be required for medication refill.

I have read and understand the above-stated policies of Elevate Health and will comply with them in all respects. I understand that I am financially responsible for the services provided to me by Elevate Health regardless of insurance coverage. If my insurance company requires release of my medical records, I hereby give my permission by signing this form. I also certify that I have read the Notice of Privacy Practices and understand that disclosure of my protected health information may be necessary to secure payment for health care services.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature Date

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CONSENT FOR TREATMENT

Description of Naturopathic Medicine: Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Your Naturopathic Doctor will take a thorough case history, do a complete physical examination as indicated, and may take blood and urine samples. If your case requires, the physical exam may include more specific examination such as respiratory, cardiac, abdominal, musculoskeletal, neurological, gynecological, rectal, prostate or genital exams.

It is important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, and if you are on any medication, over the counter drugs or supplements. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please advise your Naturopathic Doctor immediately.

Methods, Procedures and Therapeutic Approaches: These may include, but are not limited to: herbs/natural medicines, psychological and/or lifestyle counseling, homeopathy, exercise prescriptions, dietary advice, therapeutic nutrition, injections, medication prescriptions, IV therapies, hydrotherapy, soft tissue, and physical manipulations.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Naturopathic medicine is a generally safe method of treatment, but may have some side effects. Risks include but are not limited to: pain, bruising, infection, loss of consciousness from needle insertions (blood draw), topical procedures, and hydrotherapies; allergic reactions to prescribed medications, herbs or supplements; aggravation of pre-existing symptoms; and soft tissue or bone injury from physical manipulations.

Prescribed Supplements and Medications: The herbs, remedies and nutritional supplements recommended are traditionally considered safe, however some may be toxic in larger doses. The medications, herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. Please notify the doctor listed below immediately of any unanticipated or unpleasant effects associated with the herbs, remedies or supplements.

Health Records: A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless so directed by you or your representative or otherwise permitted or required by law. You may arrange a time to look at your medical records during the clinic's business hours and can request a copy of it by paying the appropriate fee.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathic medicine and other procedures, and have had an opportunity to ask questions. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Bronwyn Bacon, ND, Elevate Health, or any of its personnel regarding cure or improvement of my condition. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient's Signature	Date	Guardian/Representative's Signature	Date

Print patients name	Relationship to Patient/Representative Authority

Naturopathic Doctor: Dr. Bronwyn Bacon, ND

NOTE THAT THIS FORM MUST BE SIGNED

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers, it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds or in cases of abuse.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please circle all that apply:

Please write number in the space provided	May we contact you at this number?		Can we leave messages for you at this number?		Can we send text message reminders to this number	
Home:	Yes	No	Yes	No	Yes	No
Work:	Yes	No	Yes	No	Yes	No
Cell:	Yes	No	Yes	No	Yes	No
Other:	Yes	No	Yes	No	Yes	No

Email:_____

May we contact you at this email, including sending you appointment reminders? Yes No

Patient Name (Please Print and sign below where indicated. Include parent/guardian name if patient is a minor.)

_____ _____ _____

Patient's Signature Print Patient's Name Date

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Name (if a minor) Date

_____

Relationship to patient

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Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Dr. Bronwyn Bacon, ND and Elevate Health on this date.

_____ _____

Date Signature

_____ _____

Patient Representative's Signature Relationship to Patient

Patient unable to sign because:

_____

_____

PRINT NAME OF PATIENT

_____

Street Address

_____

City, State and Zip Code