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

GENERAL INTAKE

Name: _____ **Date of Service**:_____

Age: _____ **Date of Birth**: _____ **Gender**:_____

Address:_____

City:_____ **State**:_____ **Zip**:_____

Phone Numbers:

Please write number in the space provided	May we contact you at this number?	Can we leave messages for you at this number?
Home:	☐ Yes ☐ No	☐ Yes ☐ No
Work:	☐ Yes ☐ No	☐ Yes ☐ No
Cell:	☐ Yes ☐ No	☐ Yes ☐ No

Text Messages:
May we send you text messages including appointment reminders? ☐ Yes ☐ No

(If you opt in, we will send you text message appointment reminders when you have scheduled an appointment at Elevate Health. You can opt out at any time by contacting our reception at 406-219-3631. Agreement to receive a text message is not a condition of purchasing a good or service. Message and data rates may apply.)

Email:
Email Address:_____

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

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

Emergency Contact:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

How did you hear about Elevate Health?_____

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 Elevate Health on this date.

_____ _____ _____ _____
Patient's Signature Date Parent/Guardian's Signature Date

_____ _____
Print Patient's Name Print Parent/Guardian's Name

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Acknowledgment of Responsibility for Payment and Payment Agreement

Welcome to Elevate Health. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read the following statements and sign below.

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 are $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 Signature Date

_____

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

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NATUROPATHIC MEDICINE INTAKE - ADULT

Name: _____ **Date of Birth:** _____ **Date of Service:** _____

Do you see any of our other providers at Elevate Health? ☐ Yes ☐ No
If yes, which provider(s)? _____

Are you currently receiving healthcare from any providers outside of Elevate Health? ☐ Yes ☐ No
If yes, please list provider's name and type of practitioner: _____

_____

If no, when and where did you last receive healthcare? _____

What was the reason? _____

Has any other family member already been a patient at Elevate Health? ☐ Yes ☐ No

If yes, what is family member's name? _____

INSURANCE (we can also make a copy of your card instead of you writing the information here.)

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

Member's Name: _____ Member's DOB (if not the patient): _____

Member ID # _____ Group # _____

HEALTH CONCERNS

What are your top health concerns? Please list in order of importance:

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

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

_____

ALLERGIES

☐ No Known Allergies

Are you hypersensitive or allergic to:

Any drugs? ☐ Yes ☐ No _____

Any foods? ☐ Yes ☐ No _____

Any environmental or chemical allergens? ☐ Yes ☐ No _____

CONTEXT OF CARE REVIEW

My goal as your doctor is to gain a clear understanding of you physically, mentally, and emotionally. The following information will help me both in evaluating your overall health as well as developing a safe and effective course of treatment. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in assisting you in your healthcare needs.

Why did you choose to come to Elevate Health?

What expectations do you have of me as your healthcare provider?

What expectations do you have for this initial visit?

What ***long-term*** expectations do you have for your work with me?

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 do not support your health?

What potential obstacles do you foresee in addressing your health goals?

Who in your life is a support to you and will be a resource as you work to achieve your health goals?

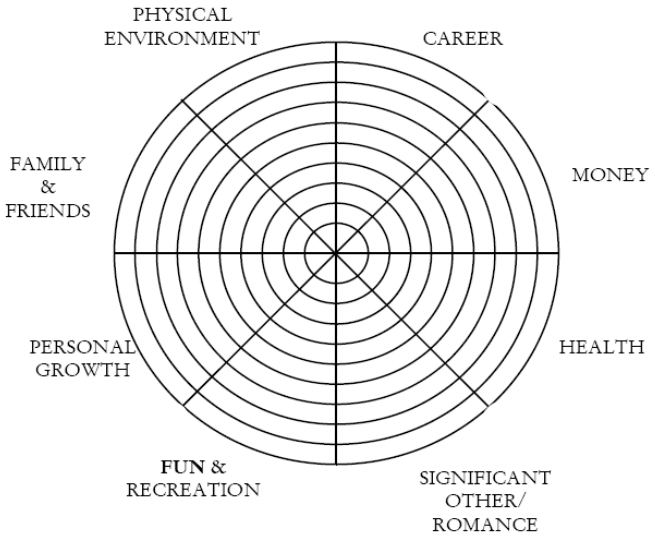
What do you love to do?

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, starting from the center point radiating outward.



CURRENT MEDICATIONS: 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):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take or use any of the following (please check all that apply):

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

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please check all that apply)
S=self, M= mother, F=father, Si=siblings

	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				

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?_____

CHILDHOOD ILLNESSES

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

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

HOSPITALIZATIONS/SURGERY/IMAGING

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

Event	Year	Event	Year

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: ☐ Yes ☐ No If yes, what kind and how often? _____

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

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

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

Please check all that apply:

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

Live with:

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

Occupation:_____ Hours per week:_____

Employer: _____

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

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CONSENT FOR TREATMENT – NATUROPATHIC MEDICINE

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.

_____ Consent to Injections: I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with this practice. I understand there are risks to injections including but not limited to **severe pain**, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risk and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ Consent to Intravenous Therapy: I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

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, medications, 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