Timothy Murbach, ND

Naturopathic Physicians
Individualizing Health Care

(503) 383-1256

Salem Natural Medicine

Blending The Best Of
Science And Nature

Your Choice For Primary Care

PATIENT HEALTH HISTORY

Patient's Name: _____
First Middle Last

Natural medicine health care is possible only when the physician completely understands the patient's physical, mental, and emotional conditions. The information you provide helps your physician understand your needs and how to help you reach your health goals. Please write legibly and answer all questions thoroughly. Feel free to mark anything you may have a question about.

Birth date: _____ Gender (circle one): M F Other

Address: _____

City: _____ State: _____ Zip code:_____

Telephone numbers: home _____ cell _____ work _____

Email:_____

Marital status: Single Married Partnership Separated Divorced/Widowed

With whom do you live? Spouse Partner Parents Friends Children Alone

Spouse/S.O. Name: _____ Spouse/S.O. birth date: _____

Your Occupation: _____ Hours per week:_____

Employer: _____ Employer address: _____

Emergency contact:_____

Relationship: _____ Telephone number: _____

If someone other than patient is responsible for payment or is primary on your insurance, please complete the following:

Name of responsible party: _____ Birth date: _____

Relationship to patient: _____ Phone #: _____

Employer & address:_____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Salem Natural Medicine to release information necessary to secure payment.

Signature: _____ Date:_____

Methods of communication :

Salem Natural Medicine or individual health care providers will call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, please **indicate where it is appropriate to leave messages for you (no personal health information will be disclosed)**:

☐ Home message machine ☐ With family members ☐ At work ☐ Never leave messages

☐ Please contact me at the following telephone number: _____

Note: Appointment reminders are sent via Email.

How did you hear about our clinic? _____

What are your primary health concerns? List as may as you can, in the order of their importance to you.

1) _____

2) _____

3) _____

4) _____

5) _____

What are the primary expectations you have for your visit today to our clinic?

1) _____

2) _____

3) _____

Is this your first visit to a Naturopathic Physician? _____

Are you currently receiving health care? If yes, where and from whom? Please provide contact information (phone and address) if available. If not, when did you last visit a doctor's office, medical clinic, or hospital and why?

_____

_____

_____

_____

_____

_____

Self History

General

Height: _____ Weight: _____. Weight 1 year ago:_____ Maximum weight: _____ When: _____

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

Primary interests and hobbies? _____

Type(s) of exercise?_____ _____

How often and How long? _____

Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

Friends & Family

0 1 2 3 4 5 6 7 8 9 10

Physical Environment

0 1 2 3 4 5 6 7 8 9 10

Health

0 1 2 3 4 5 6 7 8 9 10

Career

0 1 2 3 4 5 6 7 8 9 10

Relationships/Romance

0 1 2 3 4 5 6 7 8 9 10

Recreation

0 1 2 3 4 5 6 7 8 9 10

Money

0 1 2 3 4 5 6 7 8 9 10

Personal Growth/Spirituality

0 1 2 3 4 5 6 7 8 9 10

Check the appropriate box:

	Yes	No
In a supportive relationship		
History of abuse		
Have you had any major traumas		
Use recreational drugs		
Had drug/alcohol treatment		
Drink alcohol? Beer/ Wine/ Spirits. How many drinks daily:_____		
Ever feel you should cut down on drinking alcohol		
Have people annoyed you by criticizing your drinking		
Felt bad/ guilty about drinking		
Ever have an eye-opener		
Use tobacco? How many packs daily: ___ How many years: ____		

Enjoy your work?	Yes	No
Take vacations		
Spend time outside		
Watch TV? Hours daily ____		
Read? Hours daily ____		
Eat 3 meals daily		
Go on diets more than twice yearly		
Drink black tea? How much daily _____		
Drink coffee? How much daily _____		
Drink soda or energy drinks		
Use artificial sweeteners		
Add sugar to food		
Add salt to food		

Any known environmental exposures (chemicals, pesticides, heavy metals, etc.)? _____

_____

_____

What hospitalizations or surgeries have you had and when? _____

_____

_____

_____

What diagnostic imaging studies have you had?

Bone density scan Mammogram Electrocardiogram Electroencephalogram

X-rays CT scan MRI

Other_____

<u>Immunizations</u>

Please indicate any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria Polio Measles/Mumps/Rubella (MMR) Tetanus

Pertussis Other _____

Infectious Illnesses

Please indicate whether you have had any of the following conditions:

Diptheria	Mumps	Polio	Meningitis
German measles	Rheumatic fever	Mononucleosis	Chicken Pox
Measles	Scarlet fever	Sexually transmitted infections	

Other _____

Past and Ongoing Medical Problems

Please circle. YES= present condition NEVER =never had the condition PAST = past condition

Cataracts	YES	NEVER	PAST	Ovarian cysts	YES	NEVER	PAST
Glaucoma	YES	NEVER	PAST	PMS	YES	NEVER	PAST
Arrhythmia	YES	NEVER	PAST	Uterine Fibroids	YES	NEVER	PAST
Atherosclerosis	YES	NEVER	PAST	Fibrocystic Breasts	YES	NEVER	PAST
Heart Attack	YES	NEVER	PAST	BPH	YES	NEVER	PAST
Heart Block	YES	NEVER	PAST	Inguinal Hernia	YES	NEVER	PAST
Heart Failure	YES	NEVER	PAST	Kidney Disease	YES	NEVER	PAST
Heart Murmur	YES	NEVER	PAST	Arthritis	YES	NEVER	PAST
Asthma	YES	NEVER	PAST	Chronic Fatigue Syn	YES	NEVER	PAST
COPD	YES	NEVER	PAST	Fibromyalgia	YES	NEVER	PAST
Pneumonia	YES	NEVER	PAST	Eczema	YES	NEVER	PAST
Tuberculosis	YES	NEVER	PAST	Seizure Disorder	YES	NEVER	PAST
Celiac Disease	YES	NEVER	PAST	Depression	YES	NEVER	PAST
Chrons Disease	YES	NEVER	PAST	Sleep Apnea	YES	NEVER	PAST
Gallbladder Disease	YES	NEVER	PAST	Diabetes	YES	NEVER	PAST
Liver Disease	YES	NEVER	PAST	Hypothyroidism	YES	NEVER	PAST
Irritable Bowel Syn	YES	NEVER	PAST	Hyperthyroidism	YES	NEVER	PAST
Ulcerative Colitis	YES	NEVER	PAST	Anemia	YES	NEVER	PAST
Ulcers	YES	NEVER	PAST	Thrombophlebitis	YES	NEVER	PAST
Cervical Dysplasia	YES	NEVER	PAST	Lupus	YES	NEVER	PAST
Endometriosis	YES	NEVER	PAST	Other _____			
Cancer	YES	NEVER	PAST				

Type Adrenal Breast Colon Kidney Leuk/Lymph Lung Melanoma Skin Pancreatic
Pituitary Prostate Testicular Thyroid Other_____

Treatment Surgical Resection Radioablation Chemotherapy Radiation Other

Diet History

Typical Meals (i.e. what you ate yesterday):

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

How much/often do you consume of the following (please circle one for each food)?

Soda or carbonated beverages	NEVER	RARELY	SOMETIMES	FREQUENTLY
White flour products	NEVER	RARELY	SOMETIMES	FREQUENTLY
Fried foods	NEVER	RARELY	SOMETIMES	FREQUENTLY
Raw foods	NEVER	RARELY	SOMETIMES	FREQUENTLY
Refined sugar	NEVER	RARELY	SOMETIMES	FREQUENTLY
Red meat or pork	NEVER	RARELY	SOMETIMES	FREQUENTLY
Tap water	NEVER	RARELY	SOMETIMES	FREQUENTLY
Bottled/filtered water	NEVER	RARELY	SOMETIMES	FREQUENTLY
Fresh vegetables	NEVER	RARELY	SOMETIMES	FREQUENTLY
Fresh fruit	NEVER	RARELY	SOMETIMES	FREQUENTLY
Margarine	NEVER	RARELY	SOMETIMES	FREQUENTLY
Green leafy vegetables	NEVER	RARELY	SOMETIMES	FREQUENTLY
Sweets/deserts	NEVER	RARELY	SOMETIMES	FREQUENTLY
Candy	NEVER	RARELY	SOMETIMES	FREQUENTLY
Margarine	NEVER	RARELY	SOMETIMES	FREQUENTLY
Cook with shortening or oils other than coconut, olive, or butter	NEVER	RARELY	SOMETIMES	FREQUENTLY

Family History	Father	Mother	Brothers			Sisters			Other Relatives		
			1	2	3	1	2	3			
Age (if living)											
Allergies											
Asthma											
Arthritis											
Autoimmune Disorder											
Celiac Disease											
Cancer											
Glaucoma											
Diabetes											
Heart Trouble											
High Blood Pressure											
Stroke											
Epilepsy											
Tuberculosis											
Substance Abuse											
Mental Disorder											
Suicide											
Alzheimer's/ Dementia											
Kidney Trouble											
Thyroid Disorder											
Other Conditions											
Age at Death											
Cause of Death											

For autoimmune, cancer, glaucoma, diabetes, heart trouble, mental disorders, kidney trouble, and thyroid disorder, please indicate specific type if known.
For Other Relatives please indicate who by using S = son; D = daughter; GF = grandfather; GM = grandmother; U = uncle; A = aunt; C = cousin.
Please indicate side of family by preceding the above abbreviations with a P = paternal or M = maternal.

Medications and/or Supplements

Please list, by name, any prescription medications, over-the-counter medications, vitamins, or other supplements you are regularly taking. Include dose (for products containing multiple ingredients give full trade name and brand in lieu of dose) and number of times per day taken, who prescribed it and what is it prescribed or taken for.

Format Examples (follow format exactly, use extra sheet if more space is needed):
Vitamin D3, 2000 IU, 1 softgel 1 time daily with food, self for general health
UltraHigh Multivitamin (Mountain Peak Nutritionals), 2 caps 3x daily, John Doe, ND for general health
Cortisol Manager (Integrative Therapeutics), 2 tabs daily at bedtime, John Doe, ND for insomnia/adrenal stress
Metformin, 1000 mg, 1 tab 2 times daily with meals, Jane Doe, MD for diabetes

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

10)_____

11)_____

12)_____

(continue on back if necessary)

Review of Systems

Please read carefully and check all that apply

Constitutional

[ ] Fatigue	[ ] Head injury	[ ] Weight loss	[ ] Chills
	[ ] Headache	[ ] Weight gain	[ ] Fever

Explain _____

_____

_____

Review of Systems (continued)

Please read carefully and check all that apply

Eyes

[ ] Vision changes [ ] Tearing [ ] Blurred vision [ ] Glasses/contacts
[ ] Pain [ ] Dryness [ ] Spots
[ ] Redness [ ] Discharge [ ] Double vision

Ears

[ ] Hearing impairment [ ] Vertigo [ ] Discharge
[ ] Ringing [ ] Pain

Nose/Sinuses

[ ] Congestion [ ] Nose bleeds [ ] Loss of smell [ ] Sinus problems
[ ] Discharge [ ] Pain [ ] Obstruction

Mouth/Throat

[ ] Sores [ ] Dental problems [ ] Jaw clicks [ ] Pain
[ ] Gingival bleeding [ ] Use of dentures [ ] Hoarseness [ ] Sore throat

Neck

[ ] Lumps [ ] Tenderness
[ ] Pain [ ] Stiffness

Breasts

Date of last mammogram _____

[ ] Lumps [ ] Swelling [ ] Do self breast exams
[ ] Tenderness [ ] Nipple discharge

Cardiovascular

[ ] Chest pain [ ] Ankle swelling [ ] Discolored hands/feet [ ] Known heart disease
[ ] Palpitations [ ] Leg Pain [ ] High blood pressure
[ ] Lightheadedness [ ] Varicose veins [ ] High cholesterol
[ ] Fainting [ ] Blood clots [ ] Easily becoming short of breath during activity

Respiratory

[ ] Cough [ ] Wheezing [ ] Shortness of breath
[ ] Sputum [ ] Difficulty breathing [ ] Shortness of breath lying down
[ ] Spitting/coughing blood [ ] Pain with breathing [ ] Shortness of breath that wakes you

Review of Systems (continued)

Please read carefully and check all that apply

Gastrointestinal

[ ] Trouble swallowing	[ ] Belching	[ ] Easy satiety	[ ] Mucus in stools
[ ] Heartburn/ Reflux	[ ] Flatulence	[ ] Food sits in stomach	[ ] Undigested food in stools
[ ] Nausea	[ ] Bloating	[ ] Anal itching	[ ] Shiny/greasy stools
[ ] Vomiting	[ ] Indigestion	[ ] Vomiting Blood	[ ] Poorly formed stools
[ ] Constipation	[ ] Abdominal pain	[ ] Blood in or on stools	[ ] Abnormal stool color
[ ] Diarrhea	[ ] Change in appetite	[ ] Black tarry stools	

How many bowel movements per day? _____ What color are they? _____

Urinary

[ ] Pain/ discomfort	[ ] Hesitancy	[ ] Post-void dribbling	[ ] Blood in urine
[ ] Frequent urination	[ ] Decreased force	[ ] Unable to hold urine	[ ] Discharges
[ ] Urgency	[ ] Split stream	[ ] Frequency at night	[ ] Frequent infections

Reproductive (Male)

[ ] Testicular mass	[ ] Diminished libido	[ ] Other sexual difficulties	[ ] Heterosexual
[ ] Genital pain/ itching	[ ] Erectile dysfunction	[ ] Do self testicle exams	[ ] Homosexual
[ ] Genital sores	[ ] Premature ejaculation	[ ] Sexually active	[ ] Bisexual
[ ] Genital discharge	[ ] Problems with orgasm	[ ] Multiple sex partners	

[ ] Use birth control (if yes, what type) _____

Reproductive (Female)

Age of first menses _____ Age of last menses (if menopausal) _____

Length of cycle (period-to-period)_____ Duration of menses (# days of bleeding)_____

Date of last menstrual period _____ Date of last annual exam/ PAP _____/_____

[ ] Painful menses	[ ] Pelvic pain	[ ] Genital sore	[ ] Heterosexual
[ ] Irregular cycle	[ ] Fertility issues	[ ] Vaginal dryness	[ ] Homosexual
[ ] Heavy flow	[ ] Frequent infections	[ ] Problems with orgasm	[ ] Bisexual
[ ] Clotting	[ ] Diminished libido	[ ] Physical arousal problems	
[ ] Vaginal discharge	[ ] Bleeding after intercourse	[ ] Other sexual difficulties	
[ ] Bleeding between periods	[ ] Pain with intercourse	[ ] Sexually active	
[ ] Premenstrual cramping	[ ] Genital pain/ itching	[ ] Multiple sex partners	

[ ] Use birth control (if yes, what type?) _____

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Number of abortions _____

Review of Systems (continued)

Please read carefully and check all that apply

Musculoskeletal

[ ] Joint pain	[ ] Muscle pain	[ ] Swelling	[ ] Muscle spasms
[ ] Stiffness	[ ] Back pain	[ ] Redness	[ ] Limited range of motion

Skin

[ ] Rashes	[ ] Dry Skin	[ ] Color changes
[ ] Itching	[ ] Lumps	

Neurological

[ ] Loss of consciousness	[ ] Numbness	[ ] Vertigo	[ ] Difficulty walking
[ ] Seizures	[ ] Tingling	[ ] Memory loss	
[ ] Paralysis	[ ] Tremors	[ ] Disorientation	
[ ] Muscle weakness	[ ] Nerve pain	[ ] Changes in mentation	

Emotional

[ ] Mood swings	[ ] Tension	[ ] Changes in thought content
[ ] Anxiety	[ ] Nervousness	[ ] Trouble concentrating
[ ] Stress	[ ] Sadness	[ ] Thoughts of harming self or others

Sleep:

[ ] 6-8 hours sleep nightly	Bedtime (typical) _____PM		Waketime (typical) _____AM
[ ] Trouble falling asleep	[ ] Snoring	[ ] Restless Leg Syndrome	[ ] Other sleep problems
[ ] Trouble staying asleep	[ ] Wake feeling rested and refreshed		

Endocrine

[ ] Heat intolerance	[ ]Excessive thirst	[ ] Brain fog	[ ] Hair loss
[ ] Cold intolerance	[ ]Excessive hunger	[ ] Hypoglycemia	[ ] Dry hair
[ ] Cold hands	[ ]Excessive urination	[ ] Brittle nails	[ ] Hot flushes/night sweats
[ ] Cold feet	[ ]Excessive perspiration		[ ] Seasonal depression

Blood/Lymph

[ ] Easy bruising	[ ] Slow wound healing
[ ] Easy/prolonged bleeding	[ ] Swollen glands

Allergic/Immunologic

[ ] Allergies: [ ] molds/ [ ] pollens/ [ ] grasses/ [ ] dust/ [ ] foods/ [ ] medications/ [ ] other _____

[ ] Frequent colds or flus [ ] Chronic infections [ ] Adverse vaccine reactions

Is there anything else you would like us know in order to serve you better? _____

_____

_____

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PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent for Treatment:

Naturopathic medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information. I understand that my care is directed by my physician(s) at Salem Natural Medicine and I consent to services rendered and provided.

I have fully read and understand the above agreement and authorization and I also understand that there is no guarantee for a specific cure or result.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

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HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____
Patient Name:

_____ _____
Signature Relationship to Patient
if signed by someone other than patient

_____
Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Salem Natural Medicine has provided me with a copy of its **Notice of Privacy Practices** that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact:

Timothy Murbach, ND • 503-383-1256

I also understand that I am entitled to receive updates upon request if Salem Natural Medicine amends or changes its **Notice of Privacy Practices** in a material way.

_____ _____

Signature Relationship to Patient
if signed by someone other than patient

_____

Date

THIS SECTION IS TO BE COMPLETED BY SALEM NATURAL MEDICINE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named client, but was unable to because:

Client declined to sign this Written Acknowledgment.

Other (specify): _____

_____ _____

Name and title of employee Date

TIMOTHY MURBACH, ND

Naturopathic Physicians
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Salem Natural Medicine

Statement of Financial Responsibility: I understand and agree to the following:

- Payment for services rendered are my responsibility as the patient or patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.
- Credit card payments are subject to an additional processing fee, not to exceed 5% of total payment.
- There is a $75 returned check fee.
- Any items from the medicinary must be paid in full upon receipt. There can be no refunds for products which have been opened, special order items, or for custom formulations.
- **Cancelled and missed appointment charges:**

  Due to the significant time set aside in the doctor's schedule for patient appointments, a 48 hour business day cancellation is required for all patient appointments. Weekend days are not included in this. Salem Natural Medicine does not double book appointment times, so when an appointment is made that time slot has been reserved for you. If you fail to keep this appointment, it prevents others from being treated.

  New Patients: All new patient appointments that are canceled without a 48 hour business- day notice will be charged a $200.00 cancellation fee. There are no exceptions.

  Established Patients: Any missed appointments, or cancellations with less than a 48 hour business-day notice will incur a charge of $100. There are no exceptions.

  Reasonable emergencies will be forgiven at our discretion.

- Phone Call/ email policy: Patients are welcome to call if you have questions after your office visit. Often, clarifying issues and answering basic questions can greatly enhance the success of your health care. Due to time constraints, however, phone calls or emails requiring longer than 5 minutes regarding existing treatments, or any new conditions will be billed as a phone or email consultation.

Insurance billing: If I am billing insurance for services rendered, I understand and agree to the following:

- I authorize Salem Natural Medicine to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.
- I am responsible for any and all charges that my insurance company will not cover.
- I must pay for all services in full until coverage has been verified by my insurance company Verification typically occurs **before** the 1st visit. Salem Natural Medicine will provide me with codes necessary for self-billing the insurance company, should verification be delayed or not possible.

By signing below, I _____ certify that I fully understand the above policies.

_____ _____

Signature of patient or patient's responsible party Date