Patient Information Form

First Name: _____ Last Name: _____ Middle Name: _____

Preferred Name: _____

Date of Birth *(required)*: _____ Gender: _____

Address: _____ Unit #: _____ City: _____

State: _____ ZIP: _____ Email: _____

Phone

Appointment reminders will be send to 1st preference

1. ☐ Home ☐ Work ☐ Cell (_____) _____ 2. ☐ Home ☐ Work ☐ Cell (_____) _____

***Confidential voicemails OK?** ☑ Yes ☐ No ***Confidential voicemails OK?** ☐ Yes ☐ No

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Are you currently employed? ☐ No ☐ Yes Employee/Address: _____

Insurance Information (Type n/a if not applicable)

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber _____ Date of Birth *(required)*: _____

Please check below if applicable:

☐ Auto Accident ☐ Workers Compensation Date of accident or injury: _____ Claim #: _____

Parent/Guardian/Information

To be filled out if patient is a minor, or if someone other than the patient is medically and financially responsible for the patient.

Mother's Name *(minors only)*: _____

Legal Guardian? ☐ Yes ☐ No Date of Birth *(required):* _____

Father's Name *(minors only)*: _____

Legal Guardian? ☐ Yes ☐ No Date of Birth *(required):* _____

Other Legal Guardian Name: _____

Relationship to Patient: _____ Date of Birth *(required)*: _____

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the Informed Consent for Treatment form.

Patient Signature (*18 and older*): _____ Date _____

Parent/Guardian Signature : _____ Date _____

Patient Profile

IMPORTANT: Do you have any **medication allergies or any allergic reactions** to anything else? ☐ Yes ☐ No

If **YES** please explain:

_____

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if needed.

Name of medication *(such as Synthroid, Vitamin D, etc.)*	**Strength** *(88mcg, etc.)*	**Directions** *(such as 1 tablet twice a day, as needed, etc.)*
☐ Check if none		

Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition, if applicable such as mother (M), father (F), sibling (S) or maternal or paternal grandmother/grandfather (MGM, MGF, PGM, or PGF).

Condition	SELF	RELATIVE	Condition	SELF	RELATIVE
Allergies	☐	☐	HIV/AIDS	☐	☐
Anemia	☐	☐	Hypertension	☐	☐
Anxiety	☐	☐	Irritable Bowel Syndrome	☐	☐
Arthritis	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Meningitis	☐	☐
Blood Transfusion	☐	☐	Nerve/Muscle Disease	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐
Cataracts	☐	☐	Parkinson's/Alzheimer's	☐	☐
Congestive Heart Failure	☐	☐	Seizures	☐	☐

Patient Profile

Medical History continued...

Condition	SELF			RELATIVE			Condition	SELF			RELATIVE		
Clotting Disorder		☐			☐		Sickle Cell Anemia		☐			☐	
COPD		☐			☐		Stroke		☐			☐	
Depression		☐			☐		Substance Abuse		☐			☐	
Diabetes		☐			☐		Thyroid Disease		☐			☐	
Emphysema		☐			☐		Tuberculosis		☐			☐	
GERD		☐			☐		Ulcers		☐			☐	
Glaucoma		☐			☐		Other		☐			☐	
Heart Attack		☐			☐		Other		☐			☐	
Heart Murmur		☐			☐		Other		☐			☐	

Please list any surgeries or hospital stays you have had and their approximate date/year: *Type of surgery/reason for hospitalization:* *Date:*

_____ _____

_____ _____

Social History

Do you use any of the following substances regularly?

☐Coffee/Black Tea/Cola ☐Alcohol ☐Recreational Drugs ☐Tobacco- Current/Past

If Current or Past Tobacco Us Packs Per Day: _____ How Long: _____ Quit: _____

Please mark those that apply: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced Other: _____

Do you have children? ☐ Yes ☐ No If YES, what are their ages: _____

Do you follow any particular diet restrictions? ☐Yes ☐No If Yes, please describe:

_____

Do you exercise regularly? ☐Yes ☐No If YES, please describe type of exercise and how often:

_____

CASCADE HEALTH CLINIC, LLC
INFORMED CONSENT FOR TREATMENT

I, _____ , hereby authorize Dr. Sarah F Sadler, ND, and her covering physicians, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, and laboratory, x-ray.
Minor office Procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical Medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Pharmaceuticals: e.g., antibiotics, hormones, and other pharmaceutical medications
& Other Naturopathic Modalities

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from infections, venipuncture or procedures.

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.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Payment Policy: Payment is due at the time of service. If your insurance does not cover your visit, you are required to pay for any due bills before being seen. Cancellations must be made at least 24 hours in advance or patient will be billed for full amount of appointment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Cascade Health Clinic, LLC, or any of its personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my practitioner will answer any questions I have to the best of their ability.

Notice of Privacy Practices -- Acknowledgment
I understand that a record will by kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee, if any. I may also ask to correct that record. I understand that my medical record will by kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research or educational purposes, and that my identity will be protected and kept confidential. (Our **Notice of Privacy Practices** is available to you and describes in more detail how your health information may be used and disclosed, and how you can access your information.) By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Date Signature of Patient (Guardian if child)

Original: Chart
Copy: Patient (if requested)