WILD FERN NATURAL HEALTH POLICIES

Congratulations on making your health a priority by choosing Wild Fern Natural Health and naturopathic medicine to assist you in attaining your personal health goals. You are on your way! As licensed primary care providers in the state of Oregon, we can help your entire family address both acute and chronic health concerns with treatments such as routine, sleep, nutrition, hydrotherapy, botanicals/herbs, homeopathy, flower essences, and many other therapies. We are always delighted to co-manage healthcare with your other providers and fully support your informed choices about YOUR health care.

Establishing Care with Us - All new patients are required to establish care via an initial visit, during which your doctor will spend a significant amount of time (possibly longer than you are used to!) reviewing your personal health history. She will gather information about your current health concerns, priorities, and goals, developing a treatment plan to meet those needs. This visit will be directed toward prevention, prioritizing areas of concern, and conveying naturopathic philosophy as it pertains to your health issues and goals.

Scheduling - All scheduling happens by calling the Wild Fern Natural Health office at **(541) 708-0066**. Please schedule routine visits as early as possible to secure an appointment time that best suits your needs. If you are ill and need to be seen quickly, call the clinic early in the day to increase the chances of being fit into the day's schedule.

Apothecary or Prescription Refills - Apothecary items can be purchased during open clinic hours. Please call ahead to ensure we have the products you need or to make custom preparations. Payment can be taken over the phone and products set aside for your convenience during business hours. For pharmaceutical refill requests, your pharmacy can fax refill requests to **(541) 708-0971**. We require **at least 1 week advance notice** for refills of pharmaceuticals or custom preparations. Most apothecary products can also be ordered online 24/7 and shipped directly to your home via our Virtual Apothecary found at http://WildFernNaturalHealth.com/apothecary.

Contacting Your Doctor - There are TWO Ways to Communicate with Your Physician:

1. **In Person** - Your scheduled office visit is the best way to get focused, thorough care.
2. **By Phone** - The office manager can help answer questions or pass along a message to your physician.
    - Phone messages are always returned as quickly as possible.
    - The office manager will let you know if your question requires scheduling an appointment.

If you are experiencing a **medical emergency, call 911 or go to the Emergency Room or Urgent Care.

Fragrance Free Clinic - In order to be respectful of the chemical sensitivities of our patients, we ask that you refrain from applying products containing synthetic fragrance, such as lotion, perfume, cologne, etc. on days that you will be visiting our clinic.

Cell phones/Electronics - We aim to provide a serene atmosphere at the clinic. Please silence your cell phones while visiting the clinic. Please also refrain from taking calls or using laptops in the reception area. If it is necessary for you to take a call or get some work done on a computer while you are waiting, we ask that you do so outside.

FEES –
New Patients: All new patients are required to establish care with us via an initial visit. ***A 50% non-refundable deposit is required to schedule a New Patient Visit.***

Returning Patients: All returning visits, including in-office/phone/virtual visits, are scheduled according to the approximate time the doctor needs to address concerns, review lab results, perform procedures, etc. Visit fees are based upon this approximate time, the nature and complexity of the visit, as well as the physician's time spent pre- or post-visit. ***Payment in full is required at the time of each visit.***

No-Show/ Short-notice cancellations: You will be charged ***the full cost of your scheduled visit*** if you cancel your appointment with less than 24 hours' notice, if you arrive after the start-time of your appointment and cannot be seen, or if you do not arrive to your appointment at all. Please note: Patients who no-show or cancel with less than 24 hours' notice twice will be asked to prepay for any future visits.

Insurance Billing - If you are covered by health insurance, we can provide a bill, containing visit and diagnostic codes, for YOU to submit to your insurance carrier for potential reimbursement. We provide these bills only upon request, only on the day of service. We will not communicate with your insurer on your behalf regarding pre-authorization, coverage or reimbursement.

Informed consent:
I, ____, I have read and understand these Policies & Pricing at Wild Fern Natural Health and agree to these conditions. I understand that my deposit for establishing care is non-refundable and I agree to the conditions of the No-Show/Short Notice Cancellation Policy. I acknowledge that I am accepting treatment from a naturopathic doctor. I understand there are intrinsic differences between care received from naturopathic doctors and medical doctors. At this time, it is my decision to pursue naturopathic treatment for any condition I have. Also, I understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution of any or all condition that I may have. I have read, understood and been offered a copy of the health information privacy act.

______________________________ ______________________________
Patient Date

______________________________ ______________________________
Physician Date

OCTOBER 2018

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

	Date:	
Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB**
Primary Care Physician:	Phone number:	

Other healthcare practitioners:
Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.:

Name:	**Type of practice:**	**Phone number:**

Date of last physical exam:	**Date of last pap & gyn exam or prostate exam:**	**Date of last fasting blood labs:**

Please list your current health concerns in order of their importance to you

Concern:	**Date of onset:**
1.	
2.	
3.	
4.	
5.	

Previous medical diagnoses

Diagnosis:	Diagnosed by:	Date of diagnosis:
1.		
2.		
3.		
4.		
5.		

Traumas, Car Accidents, Injuries:

Surgeries and Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion?.. ☐ Yes ☐ No

MEDICATIONS		
Prescription Medications	Strength	Frequency Taken
Over The Counter Drugs	Strength	Frequency Taken
Vitamins and Other Supplements	Strength	Frequency Taken

ALLERGIES	
Name of Drug	Reaction
Allergies or intolerances to Foods:	
Environmental Allergies:	

Childhood Medical History	
Prenatal history:	Any complications during your mother's pregnancy with you? ☐ Yes ☐ No If so, describe:
Birth History:	☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐Vacuum ☐ Trauma? Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other, describe
Nourishment	As a baby, were you fed ☐ Breast milk ☐ Formula ☐ Mixed Do you know at what age you first were given solid foods? How would you describe your diet as a child?
Childhood Illness:	How often did you get sick as a child? What kind of illnesses did you usually experience? i.e. ear infections, sore throat, cough, allergies, asthma… How often did you take antibiotics? Other medications taken regularly as a child? Did you ever have: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio ☐ Pertussis ☐ Other infectious diseases
List Any Other Medical Problems You Had As A Child:	
Vaccinations:	☐ I am fully vaccinated ☐ I am selectively vaccinated ☐ I am not vaccinated Last tetanus booster: Do you get the flu vaccine? Check those vaccinations you've had: ☐ Chicken Pox ☐ MMR ☐ DPT ☐ Pneumonia ☐ Hepatitis ☐ Polio ☐ HIB ☐ PPD Ever had an adverse reaction to vaccine? ☐ Yes ☐ No
Home Environment:	
How many children in your family?	Your birth order (3rd of 4 kids…)
What adults lived with you?	
Was your home safe?	
Did you have any traumas or losses as a child?	
Did you grow up in the city, suburbs or in a rural area?	
Any difficulties in school?	
Did anyone in your home smoke or use drugs regularly?	

FAMILY HEALTH HISTORY

Are you adopted? .... ☐ Yes ☐ No
Please check boxes below for any known conditions of family member. Please note their relationship to you below.

☐ High blood pressure	☐ Diabetes	☐ Allergy	☐ Epilepsy
☐ Tuberculosis	☐ Stroke	☐ Cancer	☐ Substance abuse
☐ Heart disease	☐ Kidney disease	☐ Obesity	☐ Osteoporosis
☐ Thyroid disorder	☐ Arthritis	☐ Autoimmune disease	☐ Other

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Brothers and Sisters	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandparents (Mother's Side)**			
	☐ M ☐ F			***Male***			
	☐ M ☐ F			***Female***			
	☐ M ☐ F			**Grandparents (Father's Side)**			
	☐ M ☐ F			***Male***			
	☐ M ☐ F			***Female***			

OTHER LIFESTYLE FACTORS

Activity: please list your activities and duration of exercise in chart provided

Type of activity	Day per week	Minutes per day

After moderate or vigorous exercise, do you feel ☐ great ☐ drained

Weight:

Current weight ☐ don't know
Ideal body weight
Do you have, or have you ever had, an eating disorder?
☐ Binging ☐ Purging ☐ Avoidance of food
Do you diet to lose weight? .... ☐ Yes ☐ No
Do you take medications, herbs or supplements to lose weight?............... ☐ Yes ☐ No

HOME	
	Is your home a sanctuary for you? .... ☐ Yes ☐ No
	Who lives with you?
	Name Relationship
	Do you live with animals? If so, describe
	Does your home have lead paint? .... ☐ Yes ☐ No
	Is your home moldy? .... ☐ Yes ☐ No
	Do you have ☐ telephone? ☐ electricity/heat? ☐ enough food?
	Is your home safe? .... ☐ Yes ☐ No
	Is there a gun in your home?... ☐ Yes ☐ No
OCCUPATION	How many hours a week do you work? How many days a week?
	Do you spend most of your day at a desk or computer?............................ ☐ Yes ☐ No
	Do you take vacations? .... ☐ Yes ☐ No
	Are you happy in your work?

HABITS			
Food:	How many times a day do you eat? What % of food that you buy is organic% How often do you eat out?		
Alcohol:	Do you drink alcohol? .... ☐ Yes ☐ No If yes, what kind?____________________ How many drinks per week? _____ Are you concerned about the amount you drink? .... ☐ Yes ☐ No Have you considered stopping? .... ☐ Yes ☐ No Are you prone to "binge" drinking? .... ☐ Yes ☐ No Do you drive after drinking? .... ☐ Yes ☐ No		
Tobacco:	Do you use tobacco? .... ☐ Yes ☐ No ☐ Cigarettes - Pks/day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day ☐ # of Years ☐ or Year Quit		
Drugs:	Do you currently use recreational or street drugs? .... ☐ Yes ☐ No Have you ever given yourself street drugs with a needle? .... ☐ Yes ☐ No		
Caffeine:	Coffee............................ ☐ Yes ☐ No Amount: Soda............................ ☐ Yes ☐ No Amount: Caffeinated tea............................ ☐ Yes ☐ No Amount: Other..Amount:		
TOXIC EXPOSURES	☐ Pottery ☐ Glass blowing ☐ Painting ☐ Model building ☐ Cleaning chemicals ☐ Anesthesia	☐ Nuclear power plant ☐ Frequent air travel ☐ Electric power lines ☐ Mercury fillings ☐ Other mercury exposure ☐ Lead paint	☐ Asbestos ☐ Second hand smoke ☐ Other solvents ☐ Other heavy metals ☐ Pesticides ☐

REVIEW OF SYSTEMS		
Check if you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.		
CONSTITUTIONAL		
☐ Weight ☐ Energy level ☐ Sleep	☐ Appetite ☐ Strength ☐ Night sweats	☐ Sense of wellbeing ☐ Libido
EYES, EARS, NOSE, MOUTH, THROAT		
☐ Vision loss ☐ Double vision ☐ Excessive tearing ☐ Dry eyes ☐ Blind spots ☐ Eye pain ☐ Eye discharge	☐ Hearing loss ☐ Ringing in the ears ☐ Vertigo/ dizziness ☐ Nose bleeds ☐ Chronic stuffy nose ☐ Post nasal drip ☐ Recurrent sinus infections	☐ Headaches ☐ Missing teeth ☐ Gingivitis ☐ Bad breath ☐ Neck stiffness or swelling
HEART AND BLOOD VESSELS		
☐ Chest wall pain ☐ Palpitations ☐ Short of breath w/ mild exercise ☐ Short of breath lying flat	☐ Heart murmur ☐ Varicose veins ☐ Clotting disorder ☐ Vessel inflammation	☐ Fainting ☐ Swelling ☐ Leg pain when walking ☐ Anemia
LUNGS		
☐ Painful breathing ☐ Shortness of breath	☐ Wheezing ☐ Cough ☐ Chronic bronchitis	☐ Coughing sputum ☐ Coughing blood
MUSCULOSKELETAL		
☐ Back pain ☐ Scoliosis ☐ Bone loss/ fractures	☐ Muscle weakness ☐ Muscle cramps ☐ Muscle pain	☐ Joint pain ☐ Morning stiffness ☐ Hot/red muscles or joints ☐ Limited range of motion
NEUROLOGIC AND PSYCHOLOGICAL		
☐ Seizures, convulsions ☐ Paralysis ☐ Numbness/ tingling ☐ Tremor	☐ Lack of coordination ☐ Speech difficulties ☐ Anxiety ☐ Depression	☐ Bipolar disorder ☐ Suicidal history

ELIMINATION	
Gastro-Intestinal:	How often do you have a bowel movement? Is your stool: ☐ Formed ☐ Loose ☐ Hard ☐ Dry ☐ Greasy ☐ Brown ☐ Tan ☐Black ☐Green ☐ Yellow In your stool, do you ever notice: ☐ Undigested food ☐ Bright red blood ☐ Mucous Do you strain to pass stool? ....☐ Yes ☐ No Do you have hemorrhoids? ....☐ Yes ☐ No Do you experience gas, bloating or belching daily? ....☐ Yes ☐ No Do you ever unintentionally pass stool? ....☐ Yes ☐ No
	☐ Abdominal pain ☐ Heartburn/ indigestion ☐ Nausea/ vomiting ☐ Recent change in bowel movements ☐ Constipation ☐ Diarrhea

URINARY:	How often do you urinate?
	Do you have any of the following:
	☐ Pain with urination
	☐ Urinate too frequently/ too much
	☐ Urgency to urinate
	☐ Urinary flow obstruction
	☐ Dribbling at end of urination
	☐ Recurrent urinary tract infections
	☐ Must get up at night to urinate
	☐ Leaking urine
	    ☐ when laughing or coughing
	    ☐ at other times
	☐ Kidney stones

SKIN:	Do you sweat easily? What makes you sweat? Do you regularly apply lotion or oils to your skin? If so, what type Do you scrub or dry brush your skin regularly? Note if you have or have had any of the following: ☐ Acne ☐ Eczema ☐ Rash ☐ Chronic itching ☐ Dry skin ☐ Contact dermatitis ☐ Moles ☐ Hives ☐ Pigment changes ☐ Skin cancer ☐ Hair loss or unusual growth ☐ Yellowing of the skin

SEXUAL AND REPRODUCTIVE HEALTH

All questions contained in this questionnaire are optional and will be kept strictly confidential.

FOR MALE & FEMALE PATIENTS

Reproductive Conditions- check if you had any of the following:

Male & Female Patients

- ☐ Genital herpes
- ☐ Genital warts
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Syphilis
- ☐ Hepatitis
- ☐ HIV
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Pain with intercourse
- ☐ Itching, odor, discharge
- ☐ None

Female Patients

- ☐ PCOS
- ☐ Endometriosis
- ☐ Uterine fibroid
- ☐ Ovarian Cyst
- ☐ PID
- ☐ DES exposure
- ☐ Fibrocystic breasts
- ☐ Yeast infection
- ☐ Bacterial vaginosis
- ☐ Trichimonas
- ☐ Other
- ☐ Ever had an Abnormal Pap?

Sexual History

Are you sexually active? ☐ Currently ☐ Past ☐ Never
Age you were first consensually sexually active
Partners? ☐ Male ☐ Female ☐ Both
Are you in a monogamous relationship? ☐ Yes ☐ No
Do you have difficulty having an orgasm? ☐ Yes ☐ No
Feel knowledgeable about safer sex? ☐ Yes ☐ No
Do you practice safer sex? ☐ Yes ☐ No
Any other concerns? ☐ Yes ☐ No
Have you ever had an STD screening? ☐ Yes ☐ No
If so, when?

If so, when?

FOR FEMALE PATIENTS

Date of last annual gyn exam/Pap?_________________________

If you are post menopausal, please do your best to answer the questions below. They will help us understand your current health

Menstrual History

At what age did you first bleed? …………………..
What was the first day of your most recent period?
How long is your cycle, month to month?.............
Is your cycle length regular?....................... ☐ Yes ☐ No
How many days do you bleed? ……………………
Is your flow …………. ☐ Light ☐ Moderate ☐ Heavy
PMS? ………………….. ☐ Yes ☐ No Describe:
Do you skip periods?...
Any mid cycle spotting?........................... ☐ Yes ☐ No
If post menopausal, since when?.........

Menstrual Symptoms

Check if you experience any of the following

- ☐ Cramps
- ☐ Swelling
- ☐ Breast tenderness
- ☐ Mood swings
- ☐ Anxiety, Irritability
- ☐ Cravings Describe:
- ☐ Fatigue
- ☐ Confusion
- ☐ Acne
- ☐ None

Pregnancy History:

Date:	Outcome:	Breastfed? How long?

Are you currently trying to get pregnant?.. ☐ Yes ☐ No
Do you plan to become pregnant in the future?.. ☐ Yes ☐ No If so, when?
Have you ever had difficulty getting or staying pregnant?......................... ☐ Yes ☐ No

Contraceptive History: *What birth control methods have you used? (Fertility awareness, condoms, sponge, cap, diaphragm, IUD, oral contraceptives, Norplant, Depo-provera…)*

Type:	How long?	Any problems?	Current use?

Date: ________________

Patient Name:		Secure message phone:
Date of birth:	M / F	Prefer reminders via: call ☐ text ☐ email ☐
Address:		Home phone: Cell phone: Work phone:
Email:		Will you be billing your insurance: Yes ☐ No ☐ (we do not provide billing services, only codes for your personal use)
Occupation (if applicable):		Employer (optional):
Guardian or Emergency Contact:		Family members (optional):
Other Physicians/ health providers:		Referred by / How did you hear about us?

Naturopathic Primary Care & Apothecary

www.WildFernNaturalHealth.com