

# Basic Office Questionnaire

## The Healing Arts Partnership

4744 41<sup>st</sup> Ave. SW #102; Seattle, WA 98116

Office: 206-932-0880 FAX: 206-932-3738

Thank you for choosing our clinic! In order to serve you properly, we need the following information. All information is confidential.

\*\*We require proof of identification for patient and if applicable patient guardian. For minors the permission to treat patient is required from both parents. Consent for treatment, below, must be signed by both parents. Guardians please provide official proof of guardianship.

In the event we need to assist you with insurance issues, please provide us with an insurance card and a prescription drug plan card, if applicable. Thank you

Office Use Only

Patient \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Identification provided

### Authorization for Treatment of Minors

I authorize treatment by the providers of Healing Arts Partnership/Holistic Health West for my child or the minor under my guardianship. I am legally entitled to do so and have provided identification for said child and myself. I have also provided proof of guardianship if applicable.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

### Demographics

Date \_\_\_\_\_ Patient Name (first, last, MI) \_\_\_\_\_

Soc. Sec # \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Birth date \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ State: \_\_\_ CENTRY \_\_\_\_\_

Do you reside in the United States ( ) yes ( ) no ( ) Part time CENTRY: \_\_\_\_\_

Check appropriate box: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

### Responsible Party (if not patient)

Minor Parent or Guardian('s) \_\_\_\_\_

Guardian Circumstance ( ) Parent ( ) Foster Parent ( ) Other \_\_\_\_\_

Parent or Guardian Employer: \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ State: \_\_\_ CENTRY \_\_\_\_\_

**Primary Care Physician**

If you would like us to forward your records to your primary care physician, please request this at each visit and provide us with the FAX number.

Name \_\_\_\_\_ ( )M.D. ( )N.D. ( )Other

Phone: (\_\_\_\_)\_\_\_\_\_ FAX: (\_\_\_\_)\_\_\_\_\_

Address:\_\_\_\_\_ City/Zip: \_\_\_\_\_ State:\_\_\_ CNTRY\_\_\_\_\_

**Release of Information**

I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

**Health History**

**Drug allergies:** \_\_\_\_\_

Please state your **main health concern:** \_\_\_\_\_

Describe your **diet:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ Are you concerned about your weight \_\_\_\_\_

**Smoking:** ( )Yes ( )No \_\_\_ # per day \_\_\_# of years \_\_\_Years Quit \_Pipe \_Cigar \_Chew

**Alcohol Use:** ( )Never ( )Daily ( )Weekly Other \_\_\_\_\_

**Exercise:** ( )Never ( )Daily ( )Weekly Other \_\_\_\_\_

**Caffeine:** ( )Never ( )Occasional ( )Daily \_\_\_# of servings ( )Coffee ( )Pop ( )\_\_\_\_\_

**Chemical/Occupational Exposures:** ( )Asbestos ( )Amalgam fillings – How Many \_\_\_\_\_

**Other:** \_\_\_\_\_

**Food Sensitivities:** \_\_\_\_\_

**Environmental Sensitivities:** \_\_\_\_\_

**Drugs:** (Please check all of the following that apply)

Allergy Medications	Blood Pressure Med	Estrogen Hormone	Nasal Sprays	Thyroid
Antacids	Blood Thinners	Heart Medication	Nitroglycerine	Tranquilizers
Anti Depressant	Cortisone	Insulin	Shots_____	Water Pill (diuretic)
Antibiotics	Decongestant	Laxative	Sleeping Pills	Weight Loss
Asthma Medicine	Diabetes Med.	Marijuana	Steroids	Vitamins
Birth Control	Digitalis	Mood Stabilizer		

**Family History:** Check all of the following in your immediate family (parents, siblings, children)

Alcoholism	Diabetes	High Blood Pressure	Parkinson's	Thyroid
Cancer	Heart Disease	Multiple Sclerosis	Stroke	

**Dates Of Last Exams:**

Physical Exam \_\_\_\_\_  
Eye Exam \_\_\_\_\_  
Dental Exam \_\_\_\_\_  
Chest X-Ray \_\_\_\_\_  
Electrocardiogram \_\_\_\_\_

**Men Only:**

( ) Discharge from Penis                      ( ) Prostrate Trouble              ( ) Stream Weak or Slow  
( ) Swelling or Pain in Testes              ( ) Date of Vasectomy

**Women Only:**

Age menstruation began \_\_\_\_\_ Last menstrual period date \_\_\_\_\_  
Menstruation    \_\_\_ Irregular  
                          \_\_\_ Regular  
                          \_\_\_ Painful  
                          \_\_\_ Heavy    \_\_\_ Light    ( ) Yes    ( ) No; is there any recent change?  
Number of pregnancies: \_\_\_\_\_    Number of births: \_\_\_\_\_  
Type of birth control: \_\_\_\_\_    How long: \_\_\_\_\_  
IUD ( ) Yes    ( ) No    Years inserted: \_\_\_\_\_    Date of last mammogram: \_\_\_\_\_  
History of breast disease: \_\_\_\_\_