Basic Office Questionnaire

The Healing Arts Partnership
511 2nd Ave W, Seattle, WA 98119
Office: 800-470-7217   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:___ CNTRY_________

Do you reside in the United States ( ) yes ( ) no ( ) Part time CNTRY: ________________

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:___ CNTRY_________

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: ____