



2735 20th Place, Suite A • Forest Grove, OR 97116
phone: (503) 357-2826 fax: (503) 357-4831
www.blossominghealth.com

(Please, fill in and bring it to your first appointment)

Comprehensive Patient Health History Questionnaire

Name: _____ Today's Date: _____ Age _____
Last First MI

SS# _____ Date of Birth: _____ Sex: Female _____ Male _____

Address: _____
Street/PO Box City State Zip Code

Email: _____ Phone: Home# _____

Work # _____ Cell # _____

Emergency Contact: _____
Name Relation to patient Phone #

Occupation: _____ Employer _____
Employer Location _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

How did you hear about us? _____ We want to thank them.

Health care and preventive medicine are only possible when the clinical staff has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

When did you last go to a Doctor's office, medical clinic, or hospital? What was the reason?

What are your most important health problems? List as many as you can in order of importance.

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Signature: _____ Date: _____



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RESPONSIBLE PARTY INFORMATION

Name of Insurance _____ ID# _____

Policy Holder (Guarantor) _____

Relationship to Patient _____ Last _____ First _____ Middle _____
Phone # _____

Address _____

Street _____ Apt# _____ City _____ State _____ Zip _____
Employer _____ Empl. Phone # _____

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

- 1. _____ I hereby authorize Blossoming Health Clinic to provide medical services for me.
- 2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Blossoming Health Clinic.
- 3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
- 4. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _____ day of _____ 20 _____

Patient Signature

Guarantor Signature

Guarantor's Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian I hereby authorize treatment for the following:

Parent's full name _____ DOB _____

To any medical treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

Signature _____



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SELF & FAMILY HISTORY

Check those applicable:

	Father	Mother	Siblings	Spouse	Child	Child
Age	_____	_____	_____	_____	_____	_____
Health G-Good P-Poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

For the following sections, please circle Yes or No

CHILDHOOD ILLNESSES

Scarlet Fever	Yes	No	Measles	Yes	No
Mumps	Yes	No	Rheumatic fever	Yes	No
Diphtheria	Yes	No	Rubella	Yes	No
Other _____					

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had, what date were they? _____	Mammogram	Yes	No
_____	DEXA Bone Scan	Yes	No
_____	Date _____		
_____	Electrocardiogram	Yes	No
_____	Electroencephalogram	Yes	No

ALLERGIES

Do you have any allergies to foods, drugs or other allergens in your environment (cats, mold, dust)? Yes No If yes, list and explain. _____



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CURRENT MEDICATIONS Please list prescription medications, over-the-counter drugs, vitamins or other supplements you are taking.

1) _____ mg	6) _____ mg
2) _____ mg	7) _____ mg
3) _____ mg	8) _____ mg
4) _____ mg	9) _____ mg
5) _____ mg	10) _____ mg

REVIEW OF SYSTEMS

C – a current condition, now or within 2 weeks.

P – a condition you have had in the past, beyond 2 weeks.

N – never

GENERAL

Weight _____ Weight 1 year ago _____
 Height _____

FATIGUE

C P N
 Energy level scale 1-10 (10 best) _____

SKIN

Rashes	C	P	N
Eczema, hives	C	P	N
Acne, boils	C	P	N
Itching	C	P	N
Color change	C	P	N
Dry skin	C	P	N
Night sweats	C	P	N
Hot flashes	C	P	N
Loss of scalp hair	C	P	N

HEAD

Headache	C	P	N
Migraine	C	P	N
Head injury	C	P	N

EYES

Impaired vision	C	P	N
Glasses or contacts	C	P	N
Eye pain	C	P	N
Eye Tearing/dryness	C	P	N
Double vision	C	P	N
Glaucoma	C	P	N
Cataracts	C	P	N

EARS

Impaired hearing	C	P	N
Ringing	C	P	N
Earache	C	P	N
Dizziness	C	P	N
Buzzing	C	P	N

NOSE and SINUSES

Frequent colds	C	P	N
Nose bleeds	C	P	N
Stuffiness	C	P	N
Hay fever	C	P	N
Sinus problems	C	P	N

MOUTH AND THROAT

Frequent sore throat	C	P	N
Sore tongue	C	P	N
Gum problems	C	P	N
Hoarseness	C	P	N
Frequent cold sores	C	P	N

NECK

Lumps	C	P	N
Swollen glands	C	P	N
Goiter	C	P	N
Pain or stiffness	C	P	N

RESPIRATORY

Cough	C	P	N
Sputum	C	P	N
Spitting up blood	C	P	N
Wheezing	C	P	N
Asthma	C	P	N
Bronchitis	C	P	N
Pneumonia	C	P	N



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Pleurisy C P N
 Emphysema C P N
 Difficulty breathing C P N
 Pain on breathing C P N
 Shortness of breath: C P N
 At night C P N
 Lying down C P N
 Tuberculosis C P N

CARDIOVASCULAR

Heart disease C P N
 Angina C P N
 High blood pressure C P N
 Murmurs C P N
 Rheumatic fever C P N
 Chest pain C P N
 Swelling in ankles C P N
 Palpitations, fluttering C P N

GASTROINTESTINAL

Trouble swallowing C P N
 Heartburn C P N
 Change in thirst C P N
 Change in appetite C P N
 Nausea C P N
 Vomiting C P N

Bowel movements: Per day? _____
 Is this a change? _____

Blood in stool C P N
 Belching or passing gas C P N
 Jaundice (yellow skin) C P N
 Liver disease C P N
 Gall bladder disease C P N
 Ulcer C P N
 Hemorrhoids C P N

URINARY

Pain on urination C P N
 Increased frequency C P N
 Frequency at night C P N
 Inability to hold urine C P N
 Frequent infections C P N
 Kidney stones C P N
 Water intake daily (ounces) _____
 Coffee (caffeine) (ounces) _____

FEMALE REPRODUCTIVE

Birth control? Yes No
 What type? _____

Number of pregnancies _____

Number of live births _____

Number of miscarriages _____

Difficulty conceiving Yes No

Are you sexually active? Yes No

Low Libido C P N

Sexual difficulties C P N

Pain during intercourse C P N

Sexually transmitted illness C P N

Vaginal dryness C P N

Pain or tenderness C P N

Nipple discharge C P N

Nipple changes C P N

PMS/Painful menses C P N

Excessive flow C P N

Bleeding between periods C P N

Are cycles regular Yes No

Length of cycle (0-31) _____

Bleeding number of days _____

Last Pelvic exam _____

Natural menopause since _____

Hysterectomy ___Total Partial Ovary

MALE REPRODUCTIVE

Hernias C P N

Testicular masses C P N

Testicular pain C P N

Are you sexually active? Yes No

Low libido C P N

Sexual difficulties C P N

Sexually transmitted illness C P N

Last prostate exam _____

Prostate disease C P N

Excessive sweating C P N

MUSCULOSKELETAL

Joint pain or stiffness C P N

Arthritis C P N

Broken bones C P N

Muscle spasms or cramps C P N

Muscle weakness C P N

Decreased muscle mass C P N



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PERIPHERAL VASCULAR

Deep leg pain	C	P	N
Cold hands/feet	C	P	N
Varicose veins	C	P	N
Thrombophlebitis	C	P	N

NEUROLOGIC

Fainting	C	P	N
Seizures	C	P	N
Paralysis	C	P	N
Twitching	C	P	N
Tremors	C	P	N
Numbness or tingling	C	P	N
Memory lapses	C	P	N
Foggy thinking	C	P	N

EMOTIONAL

Irritable	C	P	N
Depression	C	P	N
Mood Swings	C	P	N
Anxiety or nervousness	C	P	N
Tension	C	P	N

ENDOCRINE

Low body temp	C	P	N
Hyperthyroid (high)	C	P	N
Diabetes	C	P	N
Heat intolerance	C	P	N
Cold intolerance	C	P	N
Excessive thirst	C	P	N
Excessive hunger	C	P	N
Chronic Fatigue	C	P	N
Water retention	C	P	N

BLOOD

Anemia	C	P	N
Easy bleeding or bruising	C	P	N

MISCELANEOUS

Bone Loss	C	P	N
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Chemical Sensitivities _____

Last physical exam _____

Last cholesterol testing _____

Crave sugar C P N

Crave salty foods C P N

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

HABITS

What are your main interest and hobbies?

Do you exercise? Yes No

What type of exercise do you do?

How many days per week do you exercise?

1 2 3 4 5 6 7

Trouble getting to sleep Yes No

Waken in middle of night? Yes No

Urinate during the night? Yes No

Awaken rested? Yes No

Sleep well? Yes No

Average 6-8 hours sleep? Yes No

Use recreational drugs? Yes No

Use alcoholic beverages? Yes No

Have you been treated for alcoholism? Yes No

Use tobacco? C P N

How many per day? _____

Interested in a physician assisted smoking cessation program? Yes No



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Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **January 17, 2007.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature _____ Date: / /



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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required B y Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Initials _____



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Cancellation Policy for Medical Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Scheduled Appointments

To schedule an appointment please call 503-357-2826. We encourage that you schedule appointments for preventative health visits, physicals, pap exams, chronic medical conditions, and prescription renewals.

Cancellation of an Appointment

In order to be respectful of the medical needs of the Blossoming Health community, please be courteous and call our staff promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our valued patients.

If it is necessary to cancel your scheduled appointment we require that you call 48 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments please call 503-357-2826. If you do not reach the receptionist you may leave a detailed message on the voice mail. You may not cancel via email.

Late Cancellations

Late cancellations will be considered as a "no show".

No Show Policy

A "no show" is someone who misses an appointment without canceling it by 10 a.m. one (1) working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". The first time there is a "no show", the patient will be reminded of the no show policy. If there is a second "no show" a fee of \$50.00 will be billed to the patient's account.

Print Name: _____ Signature _____ Date: / /