BELLTOWN
Spine & Wellness

Today's Date:_____

Patient Profile

Name:_____ Age:_____ Date of Birth:_____ Sex:_____
Address:_____ City:_____ State:_____ Zip:_____
Telephone: (Home)_____ (Work)_____ Email:_____
Occupation:_____ Full or Part Time:_____
Employer:_____
Address:_____ City:_____ State:_____ Zip:_____
Education:_____ Referred by:_____
Are you: _ Married _ Separated _ Divorced _ Single _ Cohabitating
Live with: _ Spouse _ Partner _ Parents _ Relatives _ Friends _ Pets _ Alone
Next of kin (or emergency name):_____ Relationship:_____
Address:_____ City:_____ State:_____ Zip:_____
Telephone: (Home)_____ (Work)_____

A NOTE TO OUR PATIENTS: Naturopathic, holistic, and preventive health care require the physician to have a complete picture of the patient physically, mentally and emotionally. Please take the time to complete this health history questionnaire carefully and thoroughly.

CURRENT HEALTH CONDITION

When, where and from whom did you last receive medical or health care? _____

_____

What are your most important health concerns?

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Which of the above problems are of most immediate concern? _____

Do you have any contagious diseases at this time: _ Yes _ No If yes, what?_____

CURRENT MEDICATIONS

_ Laxatives _ Pain relievers _ Antacids _ Cortisone
_ Tranquilizers _ Thyroid medication _ Sleeping pills _ Antibiotics
_ Appetite suppressants _ Nasal decongestants _ Birth control pills _ Hormones

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking and dosages:

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

FAMILY HISTORY

I am adopted (please check) _____

	Father	Mother	Brothers	Sisters	Children
Ages (if living)	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____
Check those applicable:					
Anemia	_	_	_	_	_
Arthritis	_	_	_	_	_
Asthma/Hayfever/Hives	_	_	_	_	_
Cancer	_	_	_	_	_
Diabetes	_	_	_	_	_
Glaucoma	_	_	_	_	_
Gout	_	_	_	_	_
Heart Disease	_	_	_	_	_
High Blood Pressure	_	_	_	_	_
Kidney Disease	_	_	_	_	_
Mental Illness	_	_	_	_	_
Seizures/Epilepsy	_	_	_	_	_
Stroke	_	_	_	_	_
Thyroid problems	_	_	_	_	_

FOR THE FOLLOWING, PLEASE MARK:

YES=a condition you now have **NEVER**=a condition you never had **PAST**=a condition you have had before

	YES	NEVER	PAST		YES	NEVER	PAST
Head							
Headaches/migraines	_	_	_	Head injury	_	_	_
Double vision	_	_	_	Jaw/TMJ problems	_	_	_
Dizziness	_	_	_	Fainting spells	_	_	_
Eyes							
Glasses or contacts	_	_	_	Impaired vision	_	_	_
Spots in eyes	_	_	_	Cataracts	_	_	_
Blurriness	_	_	_	Eye pain/strain	_	_	_
Color blindness	_	_	_	Tearing or dryness	_	_	_
Sensitivity to light	_	_	_	Glaucoma	_	_	_
Ears							
Discharge from ears	_	_	_	Pain in ears	_	_	_
Hearing problems	_	_	_	Ringing in ears	_	_	_
Sensitivity to noise	_	_	_	Many ear infections	_	_	_
Nose and Sinuses							
Frequent colds	_	_	_	Nose bleeds	_	_	_
Stuffiness	_	_	_	Hayfever	_	_	_
Sinus problems	_	_	_	Loss of smell	_	_	_
Mouth and Throat							
Frequent sore throat	_	_	_	Copious saliva	_	_	_
Teeth grinding	_	_	_	Mouth ulcers	_	_	_
Bleeding gums	_	_	_	Hoarseness	_	_	_
Speech difficulties	_	_	_	Loss of voice	_	_	_
Neck							
Lumps	_	_	_	Swollen glands	_	_	_
Goiter	_	_	_	Pain or stiffness	_	_	_

	YES	NEVER	PAST		YES	NEVER	PAST
Cardiovascular							
Heart disease	_	_	_	Angina	_	_	_
High blood pressure	_	_	_	Low blood pressure	_	_	_
Blood clots	_	_	_	Fainting	_	_	_
Phlebitis	_	_	_	Palpitations	_	_	_
Rheumatic fever	_	_	_	Chest pain	_	_	_
Swelling in ankles	_	_	_	Heart murmurs	_	_	_
Respiratory							
Cough	_	_	_	Sputum production	_	_	_
Spitting up blood	_	_	_	Wheezing	_	_	_
Asthma	_	_	_	Bronchitis	_	_	_
Pneumonia	_	_	_	Pleurisy	_	_	_
Emphysema	_	_	_	Difficulty breathing	_	_	_
Pain on breathing	_	_	_	Shortness of breath	_	_	_
Tuberculosis	_	_	_	" " lying down	_	_	_
Night sweats	_	_	_	" " at night	_	_	_
Gastrointestinal							
Trouble swallowing	_	_	_	Heartburn	_	_	_
Bad breath	_	_	_	Bad taste in mouth	_	_	_
Change in thirst	_	_	_	Change in appetite	_	_	_
Nausea	_	_	_	Vomiting	_	_	_
Vomiting blood	_	_	_	Constipation	_	_	_
Blood in stool	_	_	_	Diarrhea	_	_	_
Pain or cramps	_	_	_	Gall bladder disease	_	_	_
Belching	_	_	_	Ulcers	_	_	_
Passing gas	_	_	_	Hemorrhoids	_	_	_
Eating disorder	_	_	_	Distress from eating fats	_	_	
Black stools	_	_	_	Jaundice	_	_	_
Liver disease	_	_	_	Bad body odor	_	_	_
Bowel movements: How often_____				Is this a change?	_ Yes	_ No	
Male reproduction							
Hernias	_	_	_	Testicular mass	_	_	_
Testicular pain	_	_	_	Prostate disease	_	_	_
Discharge or sores	_	_	_	Herpes	_	_	_
Syphilis	_	_	_	Chlamydia	_	_	_
Gonorrhea	_	_	_	Condyloma	_	_	_
Premature ejaculation	_	_	_	Impotence	_	_	_
Vasectomy	_	_		Painful erections	_	_	_
Sexual orientation: _ Heterosexual _ Bisexual _ Homosexual				Sexually active	_	_	_
Female reproduction/breasts							
Age of first menses_____				Cycles irregular	_	_	_
Length of cycle_____				Bleeding between cycles	_	_	_
Duration of menses_____				Pain during intercourse	_	_	_
Painful menses	_	_	_	Clotting	_	_	_
PMS	_	_	_	Birth control	_	_	_
If yes, please list your symptoms:				Type_____			
_____				Number of pregnancies_____			
_____				Number of live births_____			
Endometriosis	_	_	_	Number of miscarriages_____			
Ovarian cysts	_	_	_	Number of abortions_____			
Difficulty conceiving	_	_	_	Menopausal symptoms	_	_	_
Cervical dysplasia	_	_	_	Abnormal PAP	_	_	_
Sexual difficulties	_	_	_	Vaginal discharge	_	_	_

	YES	NEVER	PAST		YES	NEVER	PAST
Female reproduction/breasts (continued)							
Pelvic pain	_	_	_	Chlamydia	_	_	_
Gonorrhea	_	_	_	Condyloma	_	_	_
Herpes	_	_	_	Syphilis	_	_	_
Do you do breast exams	_	_	_	Breast pain/tenderness	_	_	_
Breast lumps	_	_	_	Nipple discharge	_	_	_
Sexual orientation: _ Heterosexual _ Bisexual _ Homosexual				Sexually active	_	_	_
Urinary							
Pain on urination	_	_	_	Increased frequency	_	_	_
Frequency at night	_	_	_	Inability to hold urine	_	_	_
Many urinary infections	_	_	_	Problems starting urine	_	_	_
Blood in urine	_	_	_	Kidney stones	_	_	_
Musculoskeletal							
Joint pain or stiffness	_	_	_	Arthritis	_	_	_
Broken bones	_	_	_	Weakness	_	_	_
Muscle spasms or cramps	_	_	_	Back pain	_	_	_
Blood/peripheral vascular							
Easy bleeding/bruising	_	_	_	Anemia	_	_	_
Deep leg pain	_	_	_	Cold hands/feet	_	_	_
Varicose veins	_	_	_	Thrombophlebitis	_	_	_
Fluid retention	_	_	_	Bleeding from unusual places	_	_	_
Emotional							
Treated for emotional problems	_	_	_	Anxiety/nervousness	_	_	_
Mood swings	_	_	_	Depression	_	_	_
Considered/attempted suicide	_	_	_	Tension	_	_	_
Excessive worry	_	_	_	Panic attacks	_	_	_
Neurological							
Seizures/epilepsy	_	_	_	Paralysis	_	_	_
Muscle weakness	_	_	_	Numbness or tingling	_	_	_
Loss of memory	_	_	_	Easily stressed	_	_	_
Vertigo or dizziness	_	_	_	Loss of balance	_	_	_
Endocrine							
Hypothyroid	_	_	_	Heat/cold intolerance	_	_	_
Hypoglycemia	_	_	_	Diabetes	_	_	_
Excessive thirst	_	_	_	Excessive hunger	_	_	_
Fatigue	_	_	_	Seasonal depression	_	_	_
Unexplained weight loss/gain	_	_	_	Change in sexual desire	_	_	_
Immune							
Vaccinations	_	_	_	Reactions to vaccinations	_	_	_
Chronic fatigue syndrome	_	_	_	Chronic infections	_	_	_
Chronically swollen glands	_	_	_	Slow wound healing	_	_	_
Skin							
Rashes	_	_	_	Eczema/hives	_	_	_
Acne/boils	_	_	_	Itching	_	_	_
Color changes	_	_	_	Hair loss	_	_	_
Lumps	_	_	_	Warts	_	_	_

CHILDHOOD ILLNESSES

_ Rubella (German 3-day measles) _ Measles (2 week) _ Mumps _ Chickenpox
_ Whooping cough _ Rheumatic fever _ Polio _ Scarlet fever
_ Roseola _ Asthma _ Others _____

IMMUNIZATIONS

_ Pertussis _ Tetanus _ Polio _ Diptheria
_ Measles/Mumps/Rubella _ Hepatitis _ Others _____

X-RAYS AND SPECIAL STUDIES

_ Electrocardiogram (EKG) _ Electroencephalogram (EEG) _ Intravenous Pyelogram (IVP)

What x-rays, CAT scans, or other studies have you had?_____

_____

_____

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had?_____

_____

_____

ALLERGIES

Are you hypersensitive or allergic to?
Any drugs:_____

_____

Any foods:_____

_____

Any chemicals or environmental toxins:_____

_____

What happens to you when you have an "allergy attack?"_____

_____

What prior types of allergy testing have you had?
_ Intradermal _ Scratch _ Blood IgG food _ Blood IgE inhalant/food _ Electroacupuncture
_ Kinesiology _ Cytotoxic _ Food Intolerance _ None

GENERAL INFORMATION

Weight:_____ lbs. Weight 1 year ago:_____ lbs.
Maximum weight:_____ lbs. When:_____
Height:_____ ft. _____ in.
When is your energy the best during the day?_____Worst?_____

Use alcoholic beverages	_	_	_	Ever treated for alcoholism	_	_	_
If yes, list types and amounts:_____							
Use recreational drugs	_	_	_	Ever treated for drug dependence	_	_	_
If yes, list types and amounts:_____							
Smoke tobacco products	_	_	_	Chew tobacco products	_	_	_
If yes, list types and amounts:_____							
Drink coffee	_	_	_				
If yes, amount:_____							
Drink black tea	_	_	_	Drink cola	_	_	_
Eat out often	_	_	_	Go on diets often	_	_	_
Eat excessive sugar	_	_	_	Eat excessive salt	_	_	_

TYPICAL FOOD INTAKE

Breakfast:_____

_____

Lunch:_____

_____

Dinner:_____

_____

Snacks:_____

_____

Where do you generally grocery shop?_____

Are you currently on a specific diet (eg., vegetarian, macrobiotic, ova-lacto, kosher, detox)?

_____

What is your greatest barrier to healthy/optimal nutrition?_____

How much water do you drink/day?_____

What type of foods do you crave the most?_____

Who does most of the cooking in the household?_____

LIFE STYLE

Main interests and hobbies:_____

_____

Do you exercise? _ Yes _ No

If yes, what kind and how often?_____

_____

Do you have a religious or spiritual practice? _ Yes _ No

If yes, what kind?_____

Do you average 6-8 hours sleep? _ Yes _ No If no, how many?_____

Do you sleep well? _ Yes _ No If no, what is the problem?_____

Do you awaken rested? _ Yes _ No If no, what is the problem?_____

Do you enjoy your work? _ Yes _ No If no, why not?_____

What is your current stress level? Scale of 1-10 (10 is highest)_____

*If yes, from what (ie., job, family, social, etc)?_____

How do you relax from stress?_____

Do you have a supportive relationship? _ Yes _ No If no, what do you think the problem is?_____

Do you have a history of abuse or trauma? _ Yes _ No If yes, please describe:_____

CURRENT ILLNESS OR CONDITION

If you have a condition, how does your condition affect you?_____

_____

_____

What do you think is happening and Why? _____

What do you feel needs to happen for you to get better?_____

_____

_____

What do you enjoy most in life?_____

How much change are you willing to make at this time for improving your health?_____

_____

_____

BELLTOWN
Spine & Wellness

HIPPA PATIENT PRIVACY PRACTICE SUMMARY

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of your medical information and to provide you with notice describing the following:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your healthcare information for purposed of providing or arranging for your healthcare, the payment for, or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or permission.
As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentiality, requesting that we restrict certain uses and disclosures of your health insurance, and complaining if you thing your rights have been violated.
We have available a detailed Notice of Privacy Practices which fully explain your rights and our obligations under the law. We may revise this Notice from time to time. The effective date at the top right hand side of this page indicates the most current date in effect.
You have the right to receive the most current copy of this Notice. If you have not yet read or received this, please ask at the front desk for a copy, and it will be provided to you.
If you have any questions, concerns or complaints about the Notice or your medical information, please contact Dr. Scott Mindel or Dr. Julie Sutton at our office number, (206) 441-7984.

Thank you,

Belltown Spine and Wellness Center

Scott Mindel, DC Julie Sutton, ND Lac

_____ _____
Patient's Name (PRINT) Guardian/Personal Representative's Name (PRINT)

_____ _____
Patient's Signature Guardian/Personal Representative's Signature

_____ _____
Date Relationship/Representative's Authority

BELLTOWN
Spine & Wellness

INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I hereby authorize **Julie L. Sutton ND, LAc., CSCS** to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:
General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories
or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy).
Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, micro-current stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

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, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.
I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by **Julie L. Sutton**. I understand that a record will be 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 me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon
request and that obtaining a copy of my record may require payment of a fee.

_____	_____
Patient's Name (PRINT)	Guardian/Personal Representative's Name (PRINT)
_____	_____
Patient's Signature	Guardian/Personal Representative's Signature
_____	_____
Date	Relationship/Representative's Authority

BELLTOWN
Spine & Wellness

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby authorize Julie L. Sutton ND, LAc., CSCS to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

Gua Sha: a rubbing on an area of the body with a blunt, round instrument.

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Dietary Advice: based on traditional Chinese Medical Theory.

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

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: Labor-stimulating acupuncture points are not used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the intern or doctor if they know or suspect they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Julie L. Sutton 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 a record will be 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 myself or my representative or if it is required or permitted by applicable 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. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

_____	_____
Patient's Name (PRINT)	Guardian/Personal Representative's Name (PRINT)
_____	_____
Patient's Signature	Guardian/Personal Representative's Signature
_____	_____
Date	Relationship/Representative's Authority

BELLTOWN
Spine & Wellness

Appointment and Fee Policy

At Belltown Spine & Wellness Center, appointment times are reserved especially for you.

Cancellation Policy:
We require *a minimum of 24 hours* notice of cancellation or a reschedule for an appointment. A cancellation or a rescheduled appointment within 24 hours of the original scheduled appointment is subject to a $75 fee. Late arrivals are subject to a $75 rescheduling fee, or a shortened visit.

Missed Appointment Policy:
There will be a missed appointment fee of $75 for any missed appointments not cancelled or rescheduled in accordance with the cancellation policy.

Phone and Email Consultation Policy:
Phone and/or email consultations are available under special circumstances. This includes any treatment and/or advice the doctor might give via phone or email regarding your care. The fee for phone consultations is $50 per first 30 minutes, and $25 each additional 15 minutes. The fee for email consultations is $25. These fees do not apply to consults which clarify ongoing therapy or if the doctor initiates the call. Insurance does not cover these services; they are 100% patient responsibility.

Cash Patients:
Payment of services is required at time of service.

Insurance Patients:
Payment of services is ultimately the responsibility of the patient/guarantor. If a particular service is not covered or denied by your insurance, you will be responsible for the *full* service fee.

Supplement Policy:
Supplements purchased are non-refundable (due to health codes), however, a credit may be applied to your account when returned within 10 days of purchase date.

I have read the above policy and agree to the terms. I understand that I am responsible for all charges incurred.

Patient Name (Please Print) _____

Signature _____ Date _____

A COPY OF THIS AGREEMENT WILL BE PROVIDED UPON REQUEST