411 N Mission St
Wenatchee, WA 98801
phone 509.387.0336

New Patient Information

Name: _____ Date: _____
Address: _____
City: _____State:_____ Zip Code: _____
Telephone # (home): _____(cell):_____
E-mail address: _____
Would you like to receive our periodic e-newsletter with health articles and special offers? Y N
Age:_____ Date of Birth: _____
Gender assigned at birth: Female ___ Male ___ Gender Identity_____
Sexual Orientation_____Occupation:_____
Next of Kin or other to reach in an emergency: _____
Relationship:_____Phone:_____
How did you hear about our clinic_____
Do you have a Primary Care Provider? Y N
If yes, when and whom:_____
Preferred Pharmacy_____

What are your most important health concerns and what treatments have you used in the past?
1) _____
past treatment_____
2) _____
past treatment_____
3) _____
past treatment_____
4) _____
past treatment_____
5) _____
past treatment_____

Do you have any known contagious diseases at this time? Y N
Explain_____

ALLERGIES

Are you hypersensitive or allergic to any drugs, foods or environmentals?
_____

Name:_____ **Y (Yes) N (No) P (Past)**

PAST MEDICAL HISTORY

CHILDHOOD AND MAJOR ILLNESSES

_____ year: _____
_____ year: _____

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____ year: _____
_____ year: _____
_____ year: _____

FAMILY HISTORY (parents, grandparents, siblings) Indicate whom below:

Cancer__ Diabetes__ Heart Disease/High BP__ Arthritis/Osteoporosis__ Stroke__ Anemia__
Mental Illness/Depression/Anxiety__ Asthma/Allergies/Hives (circle)__

_____

CURRENT MEDICATIONS

List Meds, OTCs, Vitamins and any supplements. If more please finish on the back.

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

GENERAL

Height:_____ Weight: lbs. _____ Weight 1 year ago: lbs. _____
Maximum Weight : _____When: _____
Energy Scale (0 worst 10 best) _____/10
When during the day is your energy the best?_____ worst? _____
How many hours of sleep a night? _____ Awaken rested? Y N Sleep Well? Y N

HABITS

Main interests and hobbies_____
Have a history of abuse? Y N Any major traumas? Y N
Use recreational drugs? Y N _____
Do you drink coffee/caffeine/soda?(circle) Diet Often? Y N
Treated for alcoholism? Y N Do you currently use tobacco? Y N P
Do you drink alcohol? Y N If yes, how many years? _____ quit_____
How many drinks a week?_____ If yes would you like to quit? Y N
Do you have a religious or spiritual practice? Y N _____

TYPICAL FOOD INTAKE

Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____
Exercise? Y N If yes, what kind and how often_____

Name:_____ **Y (Yes) N (No) P (Past)**

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Mood Swings?	Y N P
Anxiety or hx anxiety attacks?	Y N P	Depression?	Y N P
Considered/Attempted suicide?	Y N P	Poor concentration/brain fog?	Y N P
Memory problems?	Y N	Seasonal depression?	Y N P

Rate your stress level on a scale of 1-10:_____

What are your sources of stress?_____

What practices do you have for stress management (ex exercise, meditation, yoga, eating)

_____

Immune/Endocrine/Neurologic

Chronic infections?	Y N P	Swollen glands?	Y N P
Hypothyroid/Hyperthyroid	Y N P	Hypoglycemia?	Y N P
Excessive thirst?	Y N P	Diabetes?	Y N P
Excessive hunger?	Y N P	Heat or cold intolerance?	Y N P
Seizures?	Y N P	Muscle weakness?	Y N P
Loss of memory?	Y N P	Chronic Fatigue Syndrome/EBV?	Y N P
Slow wound healing?	Y N P	Numbness or tingling?	Y N P

Skin

Rashes?	Y N P	Acne?	Y N P
Lesions/Color Change?	Y N P	History of Skin Cancer?	Y N P
Eczema or Psoriasis?	Y N P	Perpetual Hair Loss?	Y N P

Upper Body

Headaches/Migraines (circle)?	Y N P	Head Injury?	Y N P
Cataracts?	Y N P	Impaired vision?	Y N P
Tearing or dryness?	Y N P	Glasses or contacts?	Y N P
Impaired hearing?	Y N P	Earaches?	Y N P
Ringing?	Y N P	Dizziness?	Y N P
Frequent colds?	Y N P	Sinus Issues/Stuffiness?	Y N P
Seasonal Allergies	Y N P	Nose Bleeds?	Y N P
Frequent sore throat?	Y N P	Gum problems?	Y N P
Teeth grinding?	Y N P	Hoarseness?	Y N P

Musculoskeletal

Joint Pain/Stiffness	Y N P	Whiplash/Injury	Y N P
Chronic Neck Pain?	Y N P	Chronic Back Pain?	Y N P
Arthritis?	Y N P	Muscle spasms or cramps?	Y N P

Auto Accident?_____

Jaw/TMJ problems Y N P

Lungs/Heart/GI

Name:_____ **Y (Yes) N (No) P (Past)**

Cough? chronic/acute(circle)	Y N P	Bronchitis/Pneumonia?	Y N P
Asthma?	Y N P	Shortness of breath?	Y N P
High/Low Blood Pressure? (circle)	Y N P	Blood clots?	Y N P
Chest pain?	Y N P	Murmurs/Palpitations/Fluttering?	Y N P
Swelling in ankles?	Y N P	Cold hands/feet?	Y N P
Heartburn/acid reflux?	Y N P	Abdominal pain or cramps?	Y N P
Nausea/vomiting	Y N P	Blood in stool?	Y N P
Gall Bladder removed?	Y N P	Change in thirst/appetite? (circle)	Y N P
Gas/Bloating (circle)	Y N P	Constipation/Diarrhea (circle)	

Bowel Movements: How often? _____ Is this a change? Y N

Urinary/Vascular

Pain on urination?	Y N P	Inability to hold urine?	Y N P
Kidney stones?	Y N P	Frequent infections?	Y N P
Easy bleeding or bruising?	Y N P	Deep leg pain or Varicose Veins?	Y N P
Hemorrhoids?	Y N P	Anemia?	Y N P

MALE Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
STD? _____		Are you sexually active?	Y N
Prostate disease?	Y N P	Decreased libido?	Y N

FEMALE Reproduction

Age of first menses? _____		Length of cycle? _____ days	
Are cycles regular?	Y N	Duration of menses? _____ days.	
Painful?	Y N P	Heavy or excessive flow?	Y N P
PMS?	Y N P	-If yes, symptoms? _____	

MENOPAUSE? Age of last menses? (if menopausal) _____

-If menopausal any symptoms?_____

Are you sexually active?	Y N	Date of last annual exam/ PAP _____	
Abnormal PAP?	Y N P	(If yes clarify and date_____)	
Pain during intercourse?	Y N P	Endometriosis?	Y N P
Ovarian cysts?	Y N P	Breast pain/tenderness?	Y N P
STD(s)?_____		Decreased libido	Y N
Birth control?	Y N P	(If yes what type? _____)	
Difficulty conceiving?	Y N P		

-Number of pregnancies: _____ -Number of miscarriages: _____

-Number of live births: _____ -Number of abortions: _____

Is there anything else you would like to add or comment on?

_____

_____

_____

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Probability and Accountability Act and the state of Washington. This personal health information will never be otherwise given to anyone- even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality care, implement payment activities, conduct normal practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, ECT. Origin Holistic retains full ownership of all documentation collected, and reserves the right to duplicate it for treatment purposes. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail/answering machine messages, postcards, newsletters and special events.

Patient Rights

You have the right to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for used other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services. We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr Rian Herscher. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Dr Herscher reserves the right to change the privacy practices that are describes in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

NAME of Patient or Personal Representative_____

SIGNATURE of Patient or Personal Representative_____

Additional Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. (Please circle)

ANY MEMBER OF THE IMMEDIATE FAMILY: Y N_____

SPOUSE: Y N _____

OTHER (please Specify)

ANYONE SPECIFICALLY NOT ALLOWED ACCESS:_____

FINANCIAL POLICY

Insurance - According to your insurance plan, you are responsible for any and all non-payment, co-payments, deductibles, and co-insurances. If is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments prior balances must be paid prior to the visit. If you have no insurance, payment for an office visit is to be paid at the time of the visit. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card to remain on file.

Cancellations - WE REQUIRE A 24-HOUR NOTICE FOR CANCELING ANY APPOINTMENTS. There is a **$125 for all new appointments and a $75 charge** for repeat appointments if they are not canceled OR if 24-hour notice is not given.

A **$25 fee** will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

Agreement

I have read and understood this office financial policy and and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

NAME of Patient or Personal Representative_____

SIGNATURE of Patient or Personal Representative_____

Consent for Treatment Form

I, _____, hereby authorize the Doctors at Wenatchee Holistic Medicine to use the following to facilitate my diagnosis and treatment:

COMMON DIAGNOSTIC PROCEDURES: (ex. blood draw, laboratory, physical exam). **USE OF NUTRITION:** (Therapeutic nutrition, nutritional supplements, intramuscular vitamin injections & IV Therapy). **BOTANICAL MEDICINE:** (Teas, alcohol and glycerin extracts, solid extracts, capsules, tablets, creams, ointments and suppositories). **PRESCRIPTION MEDICATIONS:** (All prescriptions within scope of practice). **PHYSICAL MEDICINE:** (Massage therapy, muscle energy stretching, trigger point release, manipulation, hydrotherapy, or similar hands-on therapies). **LIFESTYLE COUNSELING AND HYGIENE:** (Diet therapy, exercise, and general wellness recommendations). **IV THERAPY:** I understand that intravenous nutrient therapy is not standard, widely approved or accepted for the purpose(s) of treatment of prevention of disease and the view that it is of benefit in the treatment of such disorders is considered "experimental" by most physicians. I am advised that other treatment approaches have been used in these conditions, including but not limited to prescription medications, over-the-counter drugs and nutritional supplements and these alternatives have been explained to my full satisfaction.

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

Potential Benefits: Restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures, tenderness/soreness or bruising from physical treatments. I recognize the potential risks of vitamin intramuscular injections include: irritation, swelling, redness, pain, bruising and/or bleeding at the injection site and anaphylaxis. For IV therapy I have been informed of possible risks and side effects including but not limited to discomfort at the infection site, thrombophlebitis, fatigue, allergic reaction, lowering of blood sugar levels, fever, and chills and generalized complaints. I understand the nature of the proposed therapy and the risks and dangers have been explained to me to my full satisfaction.

If I'm prescribed HCG I realize it is presently relied upon as a medication for fertility and it is also used to safely promote the production of testosterone in males. It is not approved by the FDA for weight loss.

Notice to all pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to pregnancy.

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 directed by myself, my representative, or unless law requires. I understand that I may look at my medical record and can request a copy of my record by my paying the appropriate fee. I understand that my medical record will be kept no more than ten years after the date of my last treatment. I understand that the doctor will answer any questions that I might have.

With this knowledge, I voluntarily consent to the above procedures. I realize that neither the doctor nor any personnel has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health condition by signing this agreement.

Signature_____ Date_____

Signature of Patient Representative or Guardian_____