Tilia
NATURAL HEALTH

206.257.5817 PH
206.257.5819 FAX
105 NE 56th Street
Seattle, Washington 98105
www.tilianaturalhealth.com

NATUROPATHIC MEDICINE FOR THE WHOLE FAMILY

Patient Information

Today's Date: _____

Legal Name: _____ Nickname: _____

Parent/Guardian Name(s) (if patient is a minor): _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Trans ☐ Intersex SSN: _____

Relationship Status: ☐ single ☐ married/partnered ☐ divorced ☐ widowed Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____ (Type: C/H/W) 2nd: _____ (Type: C/H/W)

May we leave confidential messages at either number? ☐ Yes ☐ No If so, please put a star next to the number(s)

Email (only used to contact for official purposes): _____

Employer (patient or parent[s]): _____ Position: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about us? _____

Billing Information – Patients paying at time of service are not required to fill out billing section but must sign Authorization

Insurance Company: _____ Plan Name: _____

Insurance Address: _____ Phone: _____

ID Number: _____ Group Number: _____

Whose policy is this? ☐ Self ☐ Spouse ☐ Other Name: _____ DOB: _____

Secondary Insurance: _____

Is your visit due to a recent accident? ☐ Yes ☐ No - If yes, please consult reception for the correct forms

Authorization and Agreement of Payment

I hereby authorize direct insurance payment to my physician for services rendered. I understand that I am responsible for knowing and understanding my insurance policy and Naturopathic benefits and that I am responsible for any co-pays, co-insurances, deductibles or services not covered by my insurance.
I also authorize release of any medical records that may be necessary for either medical care or processing of claims.

_____ _____

Patient/Parent/Guardian Signature Date

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Tilia Natural Health Policies and Fees

We plan for your experience at Tilia Natural Health to be an excellent one and wish to fully inform you of our fees and payment policies.

PAYMENT

Initials

- We accept payment by cash, check, or MasterCard / Visa / debit card.
- Checks denied for lack of funds will incur a fee of $35.00.
- All balances must be paid within 30 days of the invoice date. Balances over 30-days past due will be charged to your card on file. If that charge is denied, you will be invoiced at the end of the month.
- A minimum billing fee of $10.00 or 2%, whichever is greater, will be added to any unpaid balance that is over 30 days past invoice.
- Payment plans are available upon request, though balances over $500 will continue to incur interest.

We reserve the right to make changes to our fees and/or policies without advance notice.

INSURANCE

All charges incurred at our office are your responsibility, regardless of insurance coverage. You are responsible for knowing the terms of your insurance coverage.

- Dr. Eastman's practice requires full payment at time of service. If you have out-of-network insurance coverage for naturopathic care and you wish to submit a bill to request reimbursement for services, please ask for a **superbill** at each visit.
- Dr. Wells is an in-network provider for Regence, Premera, First Choice Network, and FedMed. She is happy to see patients as an out-of-network provider. She provides courtesy billing for patients with out-of-network insurance; payment for the first appointment is taken at the time of service.
- **L&I and PIP Accident Claims:** In the event that your PIP coverage does not fully cover service received at Tilia Natural Health, you are responsible for payment. PIP coverage generally does not cover medications. These must be paid for at the time of purchase.
  Tilia Natural Health accepts L&I payments as payment in full for a claim that has been authorized by the Department of Labor and Industries. If payment is denied, you will be responsible for payment of all charges for service received.

Initials

COMMUNICATION

- **Off hours** – An off-hours number is available for contacting each doctor when they are not in-office. If your provider plans to be unavailable, the office voicemail will alert you to who should be contacted instead. **There is a $75 fee for this service**. Phone calls are not billable to insurance.
- **Texting** – Texts are not received or reviewed on the clinic phone. Texts to your provider are never an appropriate form of communication, regarding either your own or another's healthcare.
- **EMAIL** – ***Email correspondence is not appropriate for urgent medical needs!***
  Short emails regarding follow-up on treatment plans or *as requested by your provider* are acceptable.

  Emails are reviewed and responded to in the order in which they were received. Due to the high volume of emails, it may take *up to 1 week* for your doctor to be able to respond.

  Email is not appropriate for new healthcare symptoms or concerns. If you have a medical concern or question, please call to make an appointment.

  Email consults, as appropriate, are available for a fee. They are not billable to insurance.
- **Phone Consults** – Phone consults are available for established clients. There is a minimum $45/15min fee for this service, unless covered by your insurance as an in-network service.

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CLINIC POLICIES

CANCELLATION

Tilia Natural Health requires **24 hours notice, received during normal business hours,** for any established patients to cancel or change an appointment. Appointments cancelled with less than 24 hours notice or those missed entirely will be charged the appropriate fee. This applies regardless of whether or when you received an email reminder. **48 hours notice is required for new patient appointment.**

Initials

Normal Business Hours

The voicemail message will alert you to any change in our hours and provide you with doctor contact numbers. Urgent messages left during our stated business hours for the day will be responded to within that day. If you need to speak with your doctor outside her regular hours, you may choose to call your doctor.

Purchase & Return of Dispensary Items/ Products

All pharmacy items must be paid for at the time of purchase. Credit on account will be given for unopened items in perfect condition if returned within 30 days. No credit will be given for items returned after 30 days.
Refunds cannot be made.
Medical supplies, products packaged in the clinic, refrigerated products, homeopathic remedies (including UNDA), and birth control devices cannot be returned.

Mailing of Dispensary Items

We will mail you items that were out of stock when requested, pre-paid, free of shipping cost.

We will mail requested refill items after payment is received, including a minimum handling-fee of $5.00 plus postage. Unfortunately, we cannot be responsible for your reception of these items. We cannot re-send or refund if the shipment fails to reach you.

I agree to make payment according to the policies of Tilia Natural Health. I understand that payment is due according to the terms of provider's practice and my insurance coverage. By receiving products and services from Tilia Natural Health, I am agreeing to pay for those products and services regardless of insurance coverage.

Patient Name (Please Print) _____ Patient / Representative / Guardian Signature _____ Date _____

CREDIT CARD INFORMATION

Cardholder Name: _____ Date: _____

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Exp: ____/____ CCV: _____

Billing Address: _____

I authorize Tilia Natural Health, LLC to charge the portion of my bill that is my financial responsibility to this credit or debit card.

Cardholder Signature: _____

This information is stored securely on your chart and will only be used in the event of unpaid balances over 30-days past due, per the terms of our payment policy. Patients with no card on file will be billed monthly; over-due balances will incur a late fee.

☐ **I decline keeping a card on file**

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ADULT INTAKE

NAME: _____ **DOB:** _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in assisting with your health care needs.

Why did you choose to come to this clinic; what do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

1.
2.
3.

What *long-term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to addressing any underlying issues that relate to your lifestyle?

Rate from 0 to 10 - 10 being 100% committed

0% 1 2 3 4 5 6 7 8 9 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

What potential obstacles do you foresee in addressing any lifestyle factors undermining your health?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

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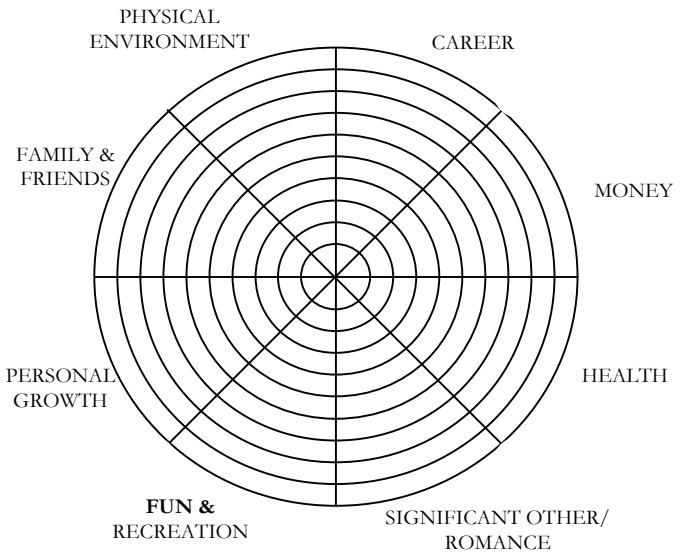
WHEEL OF BALANCE

Wellness is a balance of many factors.
Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



HEALTH & LIFESTYLE

Age: _____ Marital Status: ☐ single ☐ married/partnered ☐ divorced ☐ widowed # of Children: _____

Ht: ____ ‘ ____ “ Wt: _____lbs Weight 1yr ago: _____lbs Maximum Weight: _____lbs When: _____

You consider yourself: ☐ Underweight ☐ Overweight ☐ Just Right

Have you had *unintentional* weight gain or loss of 10 or more pounds in the last month? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No Drug Allergies: ☐ Yes ☐ No

Please list any allergies: _____

Do you have: ☐ Corrective Lenses ☐ Dentures ☐ Hearing Aid ☐ Other Medical Device _____

Occupation: _____ Hours worked per week: _____

Major causes of stress: _____

When during the day is your energy the best?_____ Worst? _____

Main interests and hobbies: _____

Exercise: ☐ Yes ☐ No If so, what kind and how often: _____

Watch TV: ☐ Yes ☐ No If so, how many hours? _____

Read: ☐ Yes ☐ No If so, how many hours? _____

Do you have a religious or spiritual practice? ☐ Yes ☐ No If so, what kind? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

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HEALTHCARE STATUS

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom? _____

_____

If no, when and where did you last receive medical or health care? _____

_____

For what reason were you seen? _____

_____

Have you had any recent labwork done (within last 6mo)? ☐ Yes ☐ No

If so, where? _____

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

- _____
- _____
- _____
- _____
- _____
- _____
- _____

What types of therapies have you tried for these problems? *Put a * next those that have helped*

☐ Diet Modification ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐ Homeopathy

☐ Chiropractic ☐ Acupuncture ☐ Conventional Rx ☐ Other: _____

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what? _____

HOSPITALIZATIONS, SURGERY & IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

Procedure:_____Year:_____ Procedure:_____Year:_____

Procedure:_____Year:_____ Procedure:_____Year:_____

Procedure:_____Year:_____ Procedure:_____Year:_____

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FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (*please check and write who*)

□ Cancer	□ Diabetes	□ Heart Disease	□ High Blood Pressure
□ Kidney disease	□ Epilepsy	□ Arthritis	□ Glaucoma
□ Tuberculosis	□ Stroke	□ Anemia	□ Mental Illness
□ Asthma	□ Hay fever	□ Hives	□ Depression or Suicide
□ Eating Disorder	□ Genetic Disorder	□ Dementia	□ Alcoholism / Addiction
□ Learning Disabilities	□ Osteoporosis	□ Migraines	□ Obesity
□ Parkinson's	□ Multiple Sclerosis	□ Alzheimer's	□ Other: _____

Other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESNESS

Birth location: _____ Time: _____ Weight: _____

Please mark any diseases you had as a child:

□ Rheumatic Fever	□ Scarlet Fever	□ German Measles	□ Mumps
□ Diptheria	□ Chicken Pox	□ Measles	□ Other: _____

CURRENT MEDICATIONS

Do you regularly take or use any of the following?

□ Laxatives	□ Cortisone	□ Sleeping Pills
□ Pain relievers	□ Antibiotics	□ Thyroid Medication
□ Antacids	□ Tranquilizers	□ Birth Control Pills

Please list any other prescription medications, over the counter medications, vitamins or other supplements you are taking, *including the dosage*:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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FOR THE FOLLOWING, PLEASE CIRCLE:

Y - yes/condition you have now **N** - no/never had **P** - problem in the past **S** - sometimes a problem now

GENERAL

Do you sleep well?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S
Awake rested?	Y	N	P	S
Have a supportive relationship?	Y	N	P	S
Have a history of abuse?	Y	N	P	S
Experienced a major trauma?	Y	N	P	S
Use recreational drugs?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
Treated for alcoholism?	Y	N	P	S
Use tobacco?	Y	N	P	S
If in the past, how many years? _____				
How many packs per day? _____				
Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Eat three meals a day?	Y	N	P	S
Do you go on diets often?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Do you drink coffee?	Y	N	P	S
Drink black/green tea?	Y	N	P	S
Drink soda?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S
Do you add salt to your food?	Y	N	P	S
Do you have an eating disorder?	Y	N	P	S

NEUROLOGIC

Seizures?	Y	N	P	S
Muscle weakness?	Y	N	P	S
Loss of memory?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S
Paralysis?	Y	N	P	S
Numbness or tingling?	Y	N	P	S
Easily stressed?	Y	N	P	S
Loss of balance?	Y	N	P	S
Learning disability?	Y	N	P	S

NECK

Lumps in neck?	Y	N	P	S
Goiter?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S

ENDOCRINE

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S
Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

IMMUNE

Reactions to immunizations?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S
Slow wound healing?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S
Chronic infections?	Y	N	P	S
Night sweats?	Y	N	P	S
Autoimmune disorder?	Y	N	P	S

EARS

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Ear aches?	Y	N	P	S

EYES

Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Glaucoma?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S

NOSE AND SINUS

Frequent colds?	Y	N	P	S
Stuffiness?	Y	N	P	S
Sinus problems?	Y	N	P	S
Nose bleeds?	Y	N	P	S
Hayfever?	Y	N	P	S
Loss of smell?	Y	N	P	S

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HEAD

Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw problems or TMJ?	Y	N	P	S

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

SKIN

Rashes?	Y	N	P	S
Acne/boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Psoriasis?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S

ENVIRONMENTAL

Chemical exposure?	Y	N	P	S
Pesticide exposure?	Y	N	P	S
Radiation exposure?	Y	N	P	S
Environmental sensitivity?	Y	N	P	S

Sensitivities: _____

URINARY

Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Fibromyalgia?	Y	N	P	S
Osteoporosis/Osteopenia?	Y	N	P	S

RESPIRATORY

Cough?	Y	N	P	S
Mucus?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
- when lying down?	Y	N	P	S
Pain when breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S
Bowel movements: how often?	_____			
Is this a change?	Y	N		
Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S
IBS or Crohn's diagnosis?	Y	N	P	S
Known food intolerances?	Y	N	P	S

MENTAL/EMOTIONAL

Treated for emotional problem?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S
Seasonal Affective Disorder?	Y	N	P	S

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CARDIOVASCULAR

Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S
Heart palpitations?	Y	N	P	S
Chest Pain?	Y	N	P	S
Hypertension?	Y	N	P	S
High cholesterol?	Y	N	P	S

Other heart disease: _____

SEXUAL HEALTH

Are you sexually active?	Y	N	P	S

Sexual orientation: _____

Birth control? Y N

Type: _____

Low libido?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Herpes?	Y	N	P	S
Chlamydia?	Y	N	P	S
Genital warts?	Y	N	P	S
Syphilis?	Y	N	P	S

Please fill out the following questions corresponding to your physical sex

* MALE REPRODUCTIVE *

Discharge or sores?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S

* FEMALE REPRODUCTIVE *

Age of first menses: _____

Age of last menses (if menopausal): _____

Days between cycles: _____ days

Duration of menses: _____ days

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

Symptoms: _____

_____

Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Fibroid tumors?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S

Date of last pap smear: _____

Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Pain during intercourse?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Number of abortions: _____

Do you do self breast exams?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

Symptoms: _____

_____

Had a mammogram?	Y	N	P	S

If so, when: _____

Atypical/Abnormal? Y N

Thank you for completing this health history.
Your answers help us direct your care.