bnc
bend naturopathic clinic

Dr. Azure Karli, N.D.
715 nw hill street
bend/oregon/97701
541/389/9750
541/389/2250 fx

New Patient Information Form

Welcome to Bend Naturopathic Clinic for your health care needs. I appreciate your interest in Naturopathic medicine and I am here to help you obtain your greatest health potential by the safest medical methods possible.

As a licensed Primary Care Health Practitioner, I can take care of your general health care needs, which may include anxiety, arthritis, allergies, physical exams, common colds, ear infections, digestive problems, detoxification, male and female hormone imbalances, nutritional counseling, Well-woman exams including pap smears and other conditions. If I can assist you with any other concerns, please ask.

Payment Information: Full payment in the form of cash, check or credit card is due at the time of service. *We are willing to bill your insurance company if we get a pre-verification over the phone indicating the extent and type of coverage you have before your visit. Otherwise you will be responsible for payment at the time of service and we will provide you will a service summary that you can submit for reimbursement.*

Missed Appointment: A 24-hour cancellation policy is necessary, so that I may have the opportunity to accommodate other patients. Canceled office visits or phone consults without a 24-hour notice will result in a $40 charge to you for the missed appointment.

Phone Calls: As a courtesy, I am happy to answer questions by the phone at any time that I am available. However, telephone calls that extend more than five minutes will be billed at the usual rate.

When you wish to refill your medicinary items, please call at least 24 hours in advance so that your waiting time will be minimized. If your medicinary item is specially ordered for you please call 1 week in advance.

SCHEDULE OF FEES: (*prices reflect fees that are paid in full at time of service*)

NEW PATIENTS

Initial Office Visit	$120-$160*
Female Exam	$160.00
Physical Exam (complete)	$160.00

ESTABLISHED PATIENTS

Office visit or Phone consultation	$40.00-$120.00*
Female Exam	$140.00
Physical Exam (complete)	$140.00
After hours emergency care	$225.00*

***Price can vary depending on complexity of care and time spent with Dr. Karli. Expect your first visit to be approximately one hour and follow up visits to be about 1/2 hour.**

ALL MEDICINARY AND MOST LAB FEES ARE DUE AT THE TIME OF SERVICE AND ARE NOT INCLUDED IN THE OFFICE VISIT OR TREATMENT PRICES.

Dr. Karli is cost conscious and will do her best to keep fees reasonable while offering you the finest health care possible. Due to circumstances beyond her control, prices are subject to change without notice.

STATEMENT AND SIGNATURE: I have read and fully understand the above information. I agree to the financial policy of Dr. Karli and understand that I am responsible for paying for all services received. If my insurance company is billed, I am responsible for payment of whatever portion, in part or whole, which my insurance company does not cover. I will be liable for all financial and legal collection fees.

_____

Signature of Patient or Guardian Date

New Patient Information

Please fill out the short form below:

Name _____ Date _____

Age _____ Date of Birth (mo/day/yy) ____/____/_____ Sex: F M

Address _____ City _____

State _____ Zip _____ Email Address _____

Telephone (home) _____ (work) _____ ext. _____

Occupation _____ Hours per week _____ Retired _____

Employer _____ Address _____

Social Security # _____ Education _____

How did you hear about us _____

Are you:

Married ___ Separated ___ Divorced ___ Widowed ___ Significant Partner ___ Single ___

Live with:

Spouse ___ Partner ___ Relatives ___ Friends ___ Parents ___ Alone ___

Do you give Dr. Karli or her staff permission to leave messages stating Dr. Karli's or the clinic's name and reason for calling at the phone numbers listed above? *(Please circle your answer below to the corresponding phone numbers)*

Home: *yes / no* Work: *yes / no*

Specific instructions for message leaving: _____

_____

_____

Next of kin or other to reach in an emergency:

Name _____ Relationship _____

Phone _____ Address _____

Health Care Questionnaire

Holistic health care and preventive medicine are only possible when the physician 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 and where did you last receive medical or health care? _____
_____

What was the reason?

_____

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

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

Family History

Check those applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good / P=poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hay fever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

For the following sections, please circle Y=yes or N=no

Childhood Illnesses

Scarlet Fever	Y / N	Diphtheria	Y / N	Rheumatic Fever	Y / N
Mumps	Y / N	Measles	Y / N	German measles	Y / N

Other_____

Hospitalization and Surgery

*What Hospitalizations or surgeries have you had?*_____

_____

X-rays and Special Studies

X-rays, CAT scans, or MRI's you have had: _____

_____

Electrocardiogram: Y / N Electroencephalogram: Y / N

Immunizations

Polio	Y / N	Pertussis	Y / N
Tetanus shot (not antitoxin)	Y / N	Diphtheria	Y / N
Measles/Mumps/Rubella	Y / N	Other _____	

Allergies

Please list any foods, drugs or other allergens: _____

_____

Current Medications

Do you take or use?

Laxatives	Y / N	Pain Relievers	Y / N	Antacids	Y / N
Cortisone	Y / N	Appetite Suppressants	Y / N	Sleeping Pills	Y / N
Tranquilizers	Y / N	Thyroid Medication	Y / N		

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

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

Review of Symptoms

For the following please circle the correct answer:
Y= a condition you have now **N=** never had **P=** a condition you have had in the past

General
Weight _____
Weight 1 yr. Ago _____
Maximum Weight _____
(when was this) _____
Height _____
Fatigue Y P N

Skin
Rashes Y P N
Eczema, hives Y P N
Acne, boils Y P N
Itching Y P N
Color change Y P N
Lumps Y P N
Night Sweats Y P N

Head
Headache Y P N
Head Injury Y P N

Eyes
Impaired Vision Y P N
Glasses or contacts Y P N
Eye Pain Y P N
Tearing or dryness Y P N
Double vision Y P N
Glaucoma Y P N
Cataracts Y P N

Ears
Impaired hearing Y P N
Ringing Y P N
Earache Y P N
Dizziness Y P N

Nose and Sinuses
Frequent colds Y P N
Nose bleeds Y P N
Stuffiness Y P N
Hay fever Y P N
Sinus Problems Y P N

Mouth and Throat
Frequent sore throat Y P N
Sore Tongue Y P N
Gum Problems Y P N
Hoarseness Y P N
Dental cavities Y P N

Neck
Lumps Y P N
Swollen glands Y P N
Goiter Y P N
Pain or stiffness Y P N

Respiratory
Cough Y P N
Sputum Y P N
Spitting up blood Y P N
Bronchitis Y P N
Wheezing Y P N
Asthma Y P N
Pleurisy Y P N
Emphysema Y P N
Difficulty breathing Y P N
Pain on breathing Y P N
Shortness of breath Y P N
- at night Y P N
- lying down Y P N
Tuberculosis Y P N

Cardiovascular
Heart Disease Y P N
Angina Y P N
High Blood Pressure Y P N
Murmurs Y P N
Rheumatic fever Y P N
Chest Pain Y P N
Swelling in ankles Y P N
Palpitations, fluttering Y P N

Gastrointestinal
Trouble swallowing Y P N
Heartburn Y P N
Change in thirst Y P N
Change in appetite Y P N
Nausea Y P N
Vomiting Y P N
Vomiting blood Y P N
Bowel movements
How often? _____
Is this a change? _____
Blood in stool Y P N
Belching or passing gas Y P N
Jaundice (yellow skin) Y P N
Liver Disease Y P N
Gall Bladder disease Y P N
Ulcer Y P N
Hemorrhoids Y P N

Urinary
Pain on urination Y P N
Increase frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Frequent infections Y P N
Kidney stones Y P N

Continued on next page…

Review of Symptoms *(Continued…)*

Y= a condition you have now **N=** never had **P=** a condition you have had in the past

Female Reproductive

Age menses began _____
Average number of days _____
Length of cycle _____
Bleeding between periods Y P N
Are cycles regular Y P
Pain during intercourse Y P N
Painful menses Y P N
Excessive flow Y P N
Birth Control Y N
What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Difficulty conceiving Y P N
Menopausal symptoms Y P N
Are you sexually active Y N
Sexual difficulties Y P N
Venereal disease Y P N
Sexual preference:
Heterosexual _____
Bisexual _____
Homosexual _____

Breasts

Do you do self exams Y P N
Lumps Y P N
Pain (or tenderness) Y P N
Nipple Discharge Y P N

Male Reproductive

Hernias Y P N
Testicular masses Y P N
Testicular pain Y P N
Are you sexually active? Y N
Sexual difficulties Y P N
Prostate disease Y P N
Venereal disease Y P N
Discharge or sores Y P N
Sexual Preference:
Heterosexual _____
Bisexual _____
Homosexual _____

Musculoskeletal

Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasm/cramps Y P N
Weakness Y P N

Peripheral Vascular

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

Neurologic

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle weakness Y P N
Numbness or tingling Y P N
Loss of memory Y P N

Emotional

Depression Y P N
Mood Swings Y P N
Anxiety or nervousness Y P N
Tension Y P N

Endocrine

Hypothyroid Y P N
Heat or cold intolerance Y P N
Excessive thirst Y P N
Excessive hunger Y P N

Blood

Anemia Y P N
Easy bleeding or bruising Y P N

Habits

What are your main interests and hobbies?
_____
_____
_____
_____
_____
Do you exercise? Y N
What forms? _____
_____
_____
_____
_____
How often? _____
_____

Do you eat three meals daily? Y N
Awaken rested Y N
Sleep well Y N
Average 6-8 hours sleep Y N
Enjoy work Y N
Spend time outside Y N
Watch television Y N
How many hours a day ____
Read Y N
How many hours a day ____
Take Vacations Y N
Been treated for drug dependence Y N
Use recreational drugs Y N
Use alcoholic beverages Y N
Been treated for alcoholism Y N
Use tobacco Y N