HEALTH QUESTIONNAIRE

Welcome to ***Alaska Natural Health Solutions!*** *Our intention here is to get a complete picture of your health history and lifestyle choices. We understand that this form is time consuming and appreciate your patience. Be as accurate and honest as you can. Some of these questions are of a personal nature; please be assured this information will be protected with the strictest confidentiality. Please let us know if you find any of the questions need clarification. When you finish, please let the reception staff know.*

Health Concerns

1. What is your primary health concern?

2. How long has this problem been present? How frequent? How severe?

3. Where in you body do you experience this problem? Any change of location since it began?

4. Has the problem gotten better or worse or changed with time? In what way?

5. Are ther any associated symptoms or problems?

6. What treatments have been tried so far (either your own efforts or those of a health care professional)? Any response?

7. What do you hope to accomplish with this evaluation/consultation?

Other current health problems: ____

____

Your Past Medical History (please include dates)
Significant illnesses: __Addiction __Cancer __Depression __Diabetes __Fatigue
__Fibromyalgia __High Blood Pressure __Heart __Hepatitis __Rheumatic Fever
__Seizure __Thyroid Disease __Other
Details: ____

____

Other Serious Health Problems:

____

____

Surgeries: ____

____

Current Medications: (please include name, dose, how often you take it, how long, who prescribed it)

____

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____

Allergies: (include name of drug and type of reaction). ________________________

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.**Family Medical History:** __Addiction __Cancer __Depression __Diabetes __Fatigue __Fibromyalgia __High Blood Pressure __Heart __Hepatitis __Rheumatic Fever __Seizure __Thyroid Disease __Other

Details: ____

More about you: __ tobacco how much for how long ________________

Alcohol: how much how often/types ________________________________

Recreational drugs: as above ________________________________

Use seat belts? ______ Smoke alarm in working order? ______ Bike helmet? ______

Typical Diet: Breakfast -

Snack -

Lunch -

Snack -

Dinner -

Supplements: ____

Sleep: ____

Exercise: ____

Caffeine: ____

Relationships: Marital status: ________________________________

Children? Names ages, quality of relationship: ________________________

____

Family of origin. As above: ________________________________

____

Intimate relationship positive overall? ________________________

Sexual relationship satisfying? ________________________________

Community: ____

Hobbies: ____

Employment: ____

Relaxation, Meditation ____

Spiritual Pursuits: ____

Current symptom review: Please circle all that apply to you currently:

GEN: fatigue, weight changes, appetite changes, unusual weakness, bleeding, fever, chills, recent trauma or infections.

HEENT: vision changes, hearing changes, nose bleeds, unusual sneezing, nasal congestion, runny nose, sore throat, swallowing difficulties, ear pain, facial pain.

NECK: neck pain, swellings, or stiffness.

LUNGS: cough, short of breath, need to sit upright to breath, or coughing up blood.

HEART: palpitations, extra or skipped beats, chest pain, high blood pressure.

GI: abdomen pain, excessive burping, heart burn, nausea, vomiting, vomiting blood, diarrhea, constipation, greasy stools, bloody stools, black stools, or passing excess gas.

GENT: recent pain with urination, urine frequency, urine hesitancy, urine urgency, urine flow-slow, urine retention, getting up at night to urinate, dark urine, or losing urine when you don't mean to, low sex drive, erectile dysfunction.

BJE: joint pain, joint stiffness, back pain, muscle cramps, or muscle pain.

SKIN: rash, lesions, unable to sweat, bruising, itching, changes in moles or freckles.

NEURO: memory loss, disorientation, fainting, double vision, dizziness, vertigo, clumsiness, numbness, tingling or burning sensations, head pain, headache.

MOOD: anxiety, depression, panic attacks

BILLING INFORMATION

Patient Name: ______________________ Date ______________________

A. Patient Information

Address: ______________________
City: ____________ State: ___ Zip: ________
Home Ph: ______________________
Work Ph: ____________ Cell: ____________
Date of Birth: ______________________
Soc. Sec. No.: ______________________
☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married
☐ Widowed ☐ Divorced ☐ Employed ☐ Student

B. Guarantor if other than Patient

Name: ______________________
Address: ______________________
City: ____________ State: ___ Zip: ________
Phone: ______________________

C. Referring Physician Name

____

D. Primary Health Care Provider

Name: ______________________
Address: ______________________
City: ____________ State: ___ Zip: ________
Phone: ______________________

E. Primary Insurance Coverage

Insurance Carrier: ______________________
Insured's Name: ______________________
Group Number: ______________________
Ins. ID#: ______________________
Insurance Address: ______________________
City: ____________ State: ____ Zip: ________
Phone: ______________________
Relationship of Patient to Insured:
☐ Self ☐ Spouse ☐ Child

F. Secondary Insurance Coverage

Insurance Carrier: ______________________
Insured's Name: ______________________
Group Number: ______________________
Ins. ID#: ______________________
Insurance Address: ______________________
City: ____________ State ___ Zip: ________
Phone: ______________________
Relationship of Patient to Insured:
☐ Self ☐ Spouse ☐ Child

G. Tertiary Insurance Coverage

Insurance Carrier: ______________________
Insured's Name: ______________________
Group Number: ______________________
Ins. ID#: ______________________
Insurance Address: ______________________
City: ____________ State___ Zip: ________
Phone: ______________________
Relationship of Patient to Insured:
☐ Self ☐ Spouse ☐ Child

H. Assignment of Benefits - My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

I. Release of Medical Records - My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorney, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

J. Financial Responsibility - It is my responsibility to pay for all services provided in the event that my insurance company denies payment or makes a partial payment, I am responsible for the balance. If you have contracted with my insurance company at a discount rate and the agreed upon fee has been satisfied, the balance will be waived.

Patient Signature: ______________________ Date: ____________