HEARTLAND NATUROPATHIC CLINIC
PATIENT PROFILE

Date_____

Name _____ Birth date _____ Age _____

Address _____ Sex _____ Height ____ Weight ____

_____
city state zip

Phones: Home _____ Wk/Cell _____

Email address (to be used by this office only – please print clearly)

_____

Occupation _____ □ Full-time □ Part-time □ Retired

If under 18, parents' names _____

Emergency contact _____

Phone _____ Relationship _____

Family physician _____ Phone _____

Address _____

Referred by _____

YOUR SOCIAL HISTORY
Fill in and check only what applies.

Marital status:
□ Under 18
□ Single
□ Married
□ Committed relationship
□ Divorced
□ Separated
□ Widowed

Living situation:
□ Alone
□ A family & children
□ With your spouse
□ Significant other
□ Unrelated others
□ With your children
□ Full time
□ Part time

How many children have you had? ___

Education (number of years):
HS ____ Coll ____ Voc ____ Prof ____

CURRENT HEALTH PROBLEMS: *List your most important health problems in the order of importance.*

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

YOUR PERSONAL HEALTH HISTORY: *Check the health problems you have had and relevant organ systems.*

□ Alcohol/drug abuse
□ Allergies
□ Anemia
□ Arthritis
□ Asthma
□ Cancer
□ Diabetes
□ Gout
□ Hepatitis A/B/C
□ Herpes genitalis
□ Heart disease
□ High cholesterol
□ High blood pressure
□ Hypoglycemia
□ Injury (serious)
□ Liver disease
□ Reoccurring infections
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Venereal disease
□ Cardiovascular disorders
□ Endocrine (gland) disorders
□ Genital/sexual disorders
□ G.I. (digestive) disorders
□ Immune/blood system
□ Musculoskeletal disorders
□ Nervous system disorders
□ Psychological problems
□ Pulmonary (lung) disorders
□ Skin disorders
□ Urinary/kidney disorders

Others: _____

_____

_____

_____

FAMILY HEALTH HISTORY: *Check for blood relatives and state your relationship to them.*

□ Alcoholism
□ Anemia
□ Asthma
□ Hemophilia
□ Cancer
□ Diabetes
□ Glaucoma
□ Gout
□ Hay fever
□ Heart disease
□ High blood pressure
□ Hypoglycemia
□ Mental illness
□ Seizure or epilepsy
□ Sickle cell anemia
□ Skin disorders
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Venereal disease

Others: _____

_____

YOUR HEALTH HISTORY:

Allergies: _____

Hospitalizations, surgeries and their dates: _____

_____

Medications currently using: _____

_____

Supplements and natural medicines currently using: _____

_____

FEMALE ONLY: *Fill in the blanks and check only what applies to you.*

Painful menstruation? □ Yes Menopausal? □ Yes

Excessive volume? □ Yes If yes, the last period was: _____

Prolonged flow? □ Yes Hysterectomy? □ Yes

Premenstrual symptoms? □ Yes If yes: □ Total □ Partial When? _____

Irregular menstrual cycles? □ Yes _____ _____

Length of menstrual cycles (from the first day of a period to the first day of the next period)? _____

Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Have you ever taken estrogen, progesterone or hormone replacement therapy? □ Yes

If yes, when, what kind and for how long? _____

Have you used hormones for birth control, such as the birth control pill or the "shot"? □ Yes

If yes, when, what kind and for how long? _____

HEALTH HABITS:

Primary interests, hobbies or activities: _____

How much and what form of regular exercise to you get? _____

_____

If you answer YES to the following questions, please report what form, how much and how often you use them.

Do you use alcohol? □ Yes _____

Tobacco products? □ Yes _____

Recreational drugs? □ Yes _____

Drink coffee or soda? □ Yes _____

DIET: *Please describe your current typical diet.*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What kinds of food make up your usual diet or are you on any special diets? _____

_____

What kinds of foods do you usually avoid? _____

How much and the form of fluids you drink? _____

***Please read and then sign the second page*.**

Heartland Naturopathic Clinic

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DISCLOSURE AND CONSENT STATEMENT (page 1 of 2)

Please note that due to the COVID pandemic the clinic has converted to telehealth and "contactless" service. Consequently, all scheduled health consultations with patients/clients are conducted via internet video conferencing. If there are technical limitations preventing video conferencing it may be possible to do a phone consultation. Supplements and remedies can be mailed or picked up.

Disclosure Statement

The purpose of the natural health counseling services offered by Rachelle S. Bradley, N.D. is to help the whole person reestablish balance through removing obstacles to health and encouraging the body/mind's natural healing processes.

While Dr. Bradley has been licensed as a naturopathic physician in several states, the State of Nebraska does not yet offer licensure for naturopathic physicians. Consequently, in this practice Dr. Bradley does not function as a physician, offer diagnostic services or primary care, and these services do not replace the necessary services of a licensed physician or primary care provider. You will be expected to maintain your relationship with your current primary care provider. However, Dr. Bradley is licensed in Nebraska as a mental health practitioner (LMHP) and a medical nutrition therapist (LMNT).

Privacy Consent (HIPAA Compliance)

This Notice of Privacy Practices provides information about how we may use or disclose protected health information. It contains a patient/client's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

DISCLOSURE AND CONSENT STATEMENT (page 2 of 2)

May we phone or email to you to confirm appointments? YES NO
(We do not provide medical advice via email - please call with medical questions.)

May we leave a voice message at home or on your cell phone? YES NO

May we conduct video consultations/conferencing (telehealth)? YES NO

May we conduct phone consultations (telehealth)? YES NO

May we discuss your health condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

I, _____, as a mature adult have read this disclosure
(Please print your name)

and consent statement and understand the limitations of these services.

I assume full responsibility for the decision to seek these services for: (check one)

___ Myself, or

___ My legal ward: _____.
(Please print your child or ward's name)

Signature: _____

Date: _____