

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 _____

Referred by _____

COVID vaccine status: none partially fully and boosted

YOUR SOCIAL HISTORY

Fill in and check only what applies.

- | | |
|--|---|
| Marital status:
<input type="checkbox"/> Under 18
<input type="checkbox"/> Single
<input type="checkbox"/> Married
<input type="checkbox"/> Committed relationship
<input type="checkbox"/> Divorced
<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed | Living situation:
<input type="checkbox"/> Alone
<input type="checkbox"/> A family & children
<input type="checkbox"/> With your spouse
<input type="checkbox"/> Significant other
<input type="checkbox"/> Unrelated others
<input type="checkbox"/> With your children
<input type="checkbox"/> Full time
<input type="checkbox"/> 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.*

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

Others: _____

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

- | | | | | |
|-------------------------------------|-----------------------------------|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure or epilepsy | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Gout | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Venereal disease |

Others: _____

YOUR HEALTH HISTORY:

Allergies: _____

Hospitalizations, surgeries and their dates: _____

Medications currently using: _____

Supplements and natural medicines currently using: _____

FEMALE ONLY: <i>Fill in the blanks and check only what applies to you.</i>	
Painful menstruation? <input type="checkbox"/> Yes	Menopausal? <input type="checkbox"/> Yes
Excessive volume? <input type="checkbox"/> Yes	If yes, the last period was: _____
Prolonged flow? <input type="checkbox"/> Yes	Hysterectomy? <input type="checkbox"/> Yes
Premenstrual symptoms? <input type="checkbox"/> Yes	If yes: <input type="checkbox"/> Total <input type="checkbox"/> Partial When? _____
Irregular menstrual cycles? <input type="checkbox"/> 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? <input type="checkbox"/> 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"? <input type="checkbox"/> 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

5003 Burt Street, Omaha, NE 68132 (402) 391-6714

DISCLOSURE AND CONSENT STATEMENT (page 1 of 2)

With the onset of the COVID-19 pandemic we went to video conferencing for patient appointments. While many people still choose video conferencing for its convenience, in-office appointments are now available again. However, while the office has a separate entrance, it is in a home that shares the central heating and air condition system. Consequently, we are currently only seeing COVID vaccinated patients in person. A phone consultation may possible if video conferencing is not technically feasible.

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 you to confirm appointments?
(We do not provide medical advice via email - please call with medical questions.) | YES | NO |
| 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 a member of your family or someone close to you? If YES, please name the people allowed: | YES | NO |

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: _____