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

Others: _____

_____

_____

_____

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

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

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

DISCLOSURE AND CONSENT STATEMENT (page 1 of 2)

Video conference appointments are available for convenience but initial visits are preferred to be in-person. While the office has a separate entrance, it is in a home with a common heating and air conditioning system. Consequently if, on a day a patient is scheduled to come into the office, they have an active contagious illness (e.g., a cold, the influenza, COVID, etc.) or have recently been exposed to one, we ask them to reschedule to a video conference. A phone consultation may be also possible.

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 is licensed as a naturopathic physician in Washington state, 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 her services do not replace the necessary services of a licensed physician or primary care provider (PCP). She also does not offer emergency care. For emergencies please contact your PCP or visit the emergency room. You will be expected to maintain your relationship with your current PCP. However, Dr. Bradley is licensed in Nebraska as a mental health practitioner (LMHP) and a medical nutrition therapist (LMNT).

Privacy Consent (Notice of Privacy Practices - HIPAA Compliance)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 establishes federal standards protecting Protected Health Information (PHI) from disclosure without the patient's or their guardian’s consent. Every healthcare provider of any practice size is required to comply with these rules.

This Notice of Privacy Practices provides information about how we may use or disclose PHI. 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 PHI is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do agree, we shall honor this agreement. The HIPAA law allows for the use of PHI for treatment, payment, or healthcare operations.

Protecting PHI is complicated by modern communication methods. With proper identification of the patient, landline and cell phone calls between the patient and their healthcare practitioner are HIPAA compliant. However, several common communication technologies are *only* HIPAA compliant *if* the patient or their guardian has also given documented informed consent for that particular technology. This additional consent criteria must be met for:

- Regular email
- Standard texting
- Video conferencing (e.g., Zoom)
- VoIP (Voice over Internet Protocol) and other internet based communication methods

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DISCLOSURE AND CONSENT STATEMENT (page 2 of 2)

By signing this form, you acknowledge that you have read the Disclosure Statement and understand the limitations of this practice. In compliance with HIPAA requirements, by signing this form you also consent to our use and disclosure of your *Protected Healthcare Information* (PHI) for the following purposes.

By signing this form, I understand that:

- PHI 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.

Additionally:

May we phone, email, or text you to confirm appointments?	YES	NO
May we leave a voice message at home or on your cell phone?	YES	NO
Unless authorized below, we can only treat or provide PHI in person, by landline, or cell phone (we never use texting for these purposes):		
Do you want us to use email for communicating PHI?	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: _____