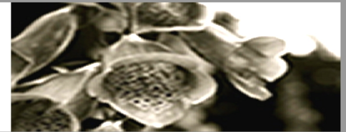
Radiant
Naturopathic Wellness Clinic



Patient Profile

Please complete the following forms throughly to assist us in our diagnosis and treatment. This will become a part of your confidential medical record and will not be shared unless you expressly authorize its release. Please print clearly.

Todays Date:________________________________
Last Name:_________________________________First Name:______________________________MI:______
Date of Birth:_______________________________Age:______ ( ) M ( ) F SSN:________-______-_________
Address:_______________________________________City:__________________State:______Zip:___________
Home Ph:__________________________Cell Ph:___________________________Work Ph:____________________
May we contact you by Phone? ( ) Home ( ) Cell ( ) Work
May we leave confidential voicemail? ( ) No ( ) Yes
Email address:____
May we contact you with confidential information by email? ( ) No ( ) Yes
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Partnered ( ) Dependent ( ) Widowed ( ) Other
Emergency Contact:_______________________________Phone:____________________Relation:_____________
How did you find out about Radiant Naturopathic?____

Insurance Information

Insurance Information: We are currently in-network providers for REGENCE, PREMERA, and LIFEWISE. If you do not have medical insurance, please skip this section:

Name of Insurance Co:
Name of Insured Person:
ID / Policy#:
Group ID#:
Insurance Address:
Relation to Insured person: Self ( ) Spouse ( ) Child ( ) Other ( )
Status: ( ) Employed ( ) Full-time student ( ) Part-time student ( ) Retired ( ) Other

Current Health Concerns

Date of onset Description Possible cause

1.____
2.____
3.____
4.____

Current Medications

Itemize all medications you are currently using or have used recently. Please include all over-the-counter medications / hormones.

Name of drug	Reason for use	Dose	Start date / end date	Prescribing doctor / self

Do you have a known drug allergy? ( ) No ( ) Yes (Specify)____
Have you ever had a non-allergy reaction to a drug? ( ) No ( ) Yes (Specify):___________________________
Have you ever been on chemotherapy? ( ) No ( ) Yes (Specify):_______________________________________

Radiant Naturopathic Wellness Clinic, PLLC

Sheetal Shah, ND • Jean Lowe Carlson, ND • Matt Carlson, ND, LAc
16455 NE 85th Street, Suite 103, Redmond WA, 98052
Ph: (425) 405-4546 Email: info@radiantnaturopathic.com Web: www.radiantnaturopathic.com
Updated 10/11/13

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Current Supplements

Please list all vitamins, minerals, herbs, and other natural products that you are currently using or have used recently.

Name of supplement	Reason for use	Dose	Start date / end date	Prescribing doctor / self

Have you ever had an adverse reaction to a supplement? ( ) No ( ) Yes (Please explain):____________________

____

Previous Treatment for Current Health Concerns

( ) No previous treatment
Condition or diagnosis:____
Name of Doctor/Hospital:____
Address:____
Date first seen:________________ Date last seen:_______________
Tests/imaging done, including x-rays?____
Test results:____
Was the condition treated?____
Results of treatment: ( ) Good ( ) Fair ( ) Poor
Please list other doctors seen for this/these condition(s): ( ) None
Name ____________________ Date __________________________ Testing/treatment ________________________
1.____
2.____
3.____
4.____

Health Maintenance Update

Current Primary Care Physician:_____________________________________Phone:_____________________
Clinic name:____Last visit:________________________
Address:______________________________________City:________________State:____Zip:____________

Additional Providers (Doctors and clinic name):
Doctor:________________________________ **Clinic:** ____
Doctor:________________________________ **Clinic:** ____
Doctor:________________________________ **Clinic:** ____

Pregnancy / Gynecological History

Pregnancies # ______
Children # ______
Miscarriages# ______
Terminations# ______
Age periods began ______
Age at Menopause ______

Menstrual problems: ______________________________________
Pregnancy Problems: ______________________________________
Current birth control: ______________________________________
Hysterectomy: ( ) Partial ( ) Complete
Last pap smear (date): ______________________________________
Last mammogram: ______________________________________

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Preferred Pharmacy:____

Occupation:____

Who do you turn to for support:__________________________________

Sources of stress:____

I share my home with:______________________________________

Smoking Status (circle): Never/Past/Current - Number of cigarettes/packs per day:________________

I DO / DO NOT have a living will (please circle which applies)

I DO / DO NOT have advanced healthcare directives (please circle which applies)

Please indicate approximate dates and results of most recent exams and imaging:

Exam	Date	Physician	Results
Full Physical Exam			
Dental Exam			
Cholesterol Profile			
Urine Sample			
Blood Work			
Prostate Exam (M)			
PAP/Pelvic Exam (F)			
Mammogram (F, 40+)			
Bone Density (DEXA)			
Eye Exam			
Colonoscopy or Flexible Sigmoidoscopy			
Other			

Imaging	Date	Physician	Reason for Imaging	Results
CT				
MRI				
X-Ray				
ECG (EKG)				
EEG				

Surgeries and Hospitalizations

Type of Surgery	Date	Physician	Reason	Result(s)

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Medical History (check all that apply)

Cardiovascular

- ☐ Abnormal heart rhythm
- ☐ Blood clot
- ☐ Carotid artery disease
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Deep vein thrombosis (DVT)
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Heart attack (MI)
- ☐ Peripheral vascular disease
- ☐ Phlebitis
- ☐ Heart valve disease

Pulmonary

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Croup
- ☐ Cystic fibrosis
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Pulmonary hypertension
- ☐ Respiratory syncytial virus
- ☐ Sarcoidosis
- ☐ Sleep apnea
- ☐ Tuberculosis (TB)

Gastrointestinal

- ☐ Gall stones
- ☐ Cirrhosis
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Incontinence of feces
- ☐ GERD (heartburn)
- ☐ Hepatitis
- ☐ Irritable bowel syndrome (IBS)
- ☐ Pancreatitis
- ☐ Peptic ulcer disease
- ☐ Ulcerative colitis

Renal / Urinary

- ☐ Benign prostatic hypertrophy
- ☐ Urinary incontinence
- ☐ Infertility
- ☐ Chronic renal failure
- ☐ Endometriosis
- ☐ Bed wetting
- ☐ Erectile dysfunction (impotence)
- ☐ Glomerulonephritis
- ☐ Kidney stones
- ☐ Frequent bladder infections

Musculoskeletal

- ☐ Degenerative disc disease
- ☐ Chondromalacia patella
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ Bone fractures
- ☐ Endometriosis
- ☐ Gout
- ☐ Juvenile rheumatoid arthritis
- ☐ Osgood-Shlatter disease
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosis (SLE)
- ☐ Other:___________________

Endocrine

- ☐ Diabetes
- ☐ Hypothyroid (low)
- ☐ Hyperthyroid (high)
- ☐ Grave's disease
- ☐ Hashimotos
- ☐ Other:___________________

Other

- ☐ Cataract
- ☐ Glaucoma
- ☐ Over weight

Neurological

- ☐ Alzheimer's disease
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Stroke
- ☐ Dementia
- ☐ Headaches
- ☐ Migraines
- ☐ Multiple sclerosis (MS)
- ☐ Myasthenia gravis
- ☐ Parkinson's
- ☐ Sensory neuropathy
- ☐ Seizures
- ☐ TIA's
- ☐ Other:___________________

Hematologic / Dermatology

- ☐ Iron deficiency anemia
- ☐ Hemolytic anemia
- ☐ Pernicious anemia
- ☐ Sickle cell disease
- ☐ Thalassemia
- ☐ Allergy / Immune / Skin
- ☐ Allergies (seasonal)
- ☐ Chicken pox
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Immune deficiency
- ☐ Ear infections (frequent)
- ☐ Sinusitis (frequent)

Psychiatric

- ☐ Anxiety
- ☐ Anorexia nervosa
- ☐ Bipolar
- ☐ Bulimia
- ☐ Depression
- ☐ Obsessive compulsive
- ☐ Schizophrenia
- ☐ Other:___________________

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Informed Consent for Treatment

I, ____, hereby authorize the Naturopathic Doctors at Radiant Naturopathic PLLC (Sheetal Shah ND, Jean Lowe Carlson ND, Matt Carlson ND LAc) to perform or refer for the following specific procedures as necessary to facilitate my diagnosis and treatment (as stated under WA state RCW 18.36A.040):

- **Common Diagnostic procedures:** e.g., venipuncture, Pap smears, radiology, laboratory, X-ray.
- **Minor office procedures:** e.g., dressing a wound, ear cleansing, suturing, nasal specific, nasal sympatico.
- **Medicinal use of nutrition and food science:** e.g., therapeutic nutrition, nutritional supplementation, and intramuscular vitamin & herbal injections.
- **Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's own innate healing responses.
- **Hydrotherapy:** e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths.
- **Physical medicine:** e.g., ultrasound, naturopathic adjustments, Craniosacral therapy, Visceral Manipulation, Low Level Laser treatment, magnet therapy.
- **Pharmaceutical medicine:** e.g., prescription of drugs listed on the Washington State naturopathic formulary.
- **Lifestyle counseling and hygiene:** e.g., diet therapy, Ayurvedic diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- **Psychological counseling techniques:** Emotional Freedom Technique (EFT), SomatoEmotional Release, Emotion Code Therapy, Motivational Interviewing, CBT, Biofeedback
- **Contraception and Contraceptive Devices:** recommendation, prescription, and management.
- **Immunizations:** age-appropriate immunizations for children and adults.
- **IV therapy:** IV nutrition, IV chelation, and IV remineralization
- **Ayurvedic Medicine:**
  - **Marma point therapy:** Pressure points used to stimulate the body's healing processes
  - **Ayurvedic Massage:** Deep or light tissue massage using Ayurvedic pressure points and possibly Ayurvedic herbs to stimulate healing processes.
- **Acupuncture and Oriental Medicine:**
  - **Acupuncture:** insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.
  - **Cupping:** a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.
  - **Gua Sha:** a rubbing on an area of the body with a blunt, round instrument.
  - **Herbs:** may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.
  - **Moxa:** indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.
  - **Tui-Na:** an ancient massage used to treat a wide variety of common disharmonies.
  - **Dietary Advice:** based on traditional Chinese Medical Theory.

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I recognize the potential risks and benefits of these procedures as described below:

- **Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture, IV therapy or procedures.
- **Potential benefits:** restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- **Notice to pregnant women:** All female patients **must alert the doctor** if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

I recognize that if I withhold information specifically requested by Radiant Naturopathic PLLC I will be impeding their ability to provide me with the best possible care.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Radiant Naturopathic PLLC regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that any doctor at Radiant Naturopathic PLLC retains the right and authority to terminate this therapeutic relationship at any time for any reason according to Radiant Naturopathic PLLC patient termination guidelines.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years, after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my physician to the best of his/her ability.

My signature confirms that I am informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I may request a written definition of WA state RCW 18.36A rules and how these rules define the way in which my private information is used or disclosed to carry out treatment, payment, or health care operations.

Name: ______________________________ Signature: ______________________ Date: ________
(Patient)

Name: ______________________________ Signature: ______________________ Date: ________
(Parent/Guardian/Personal Representative)

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Fee Schedule

OFFICE SERVICES					
New - Primary Care			**Established - Primary Care**		
CPT	**DX#**	**Fee**	**CPT**	**DX#**	**Fee**
99201 (E+M, problem focus)		$80	99211 (E+M, problem focus)		$40
99202 (E+M, exp. problem focus)		$120	99212 (E+M, exp. problem focus)		$80
99203 (E+M, detail problem)		$160	99213 (E+M, detail problem)		$120
99204 (E+M, Comprehensive, mod.)		$200	99214 (E+M, Comprehensive, mod.)		$160
99205 (E+M, Comprehensive, high)		$240	99215 (E+M, Comprehensive, high)		$200
PREVENTATIVE MEDICINE SERVICES					
99381 (Child < 1yr)		$160	99391 (Child < 1yr)		$160
99382 (Child 1-4 yrs)		$160	99392 (Child 1-4 yrs)		$160
99383 (Child 5-11 yrs)		$160	99393 (Child 5-11 yrs)		$160
99384 (Child 12-17 yrs)		$160	99394 (Child 12-17 yrs)		$160
99385 (Adult 18-39 yrs)		$160	99395 (Adult 18-39 yrs)		$160
99386 (Adult 40-64 yrs)		$200	99396 (Adult 40-64 yrs)		$160
99387 (Adult 65+ yrs)		$200	99397 (Adult 65+ yrs)		$160
PREVENTATIVE MEDICINE, COUNSELING					
99401 (Prevent Med, Counsel 15 mins)		$80	99403 (Prevent Med, Counsel 45 mins)		$120
99402 (Prevent Med, Counsel 30 mins)		$100	99404 (Prevent Med, Counsel 60 mins)		$160
PHYSICAL MEDICINE					
97140 (Manual therapy, 15 mins)		$40	97810 (Acup., initial 15 mins)		$40
97110 (Ther. exercises, 15 mins)		$40	97811 (Acup., next 15 mins)		$40
97112 (N/M Reeducation, 15 mins)		$40	97813 (Acup., w/E-stim, initial 15 mins)		$50
97014 (Elect. Stimulation, 15 mins)		$40	97814 (Acup., w/E-stim, next 15 mins)		$50
97035 (Ultrasound, 15 mins)		$40	98925 (OMT, 1-2 regions)		$40
97034 (Cont. Baths, 15 mins)		$40	98926 (OMT, 3-4 regions)		$50
SPORT (Sports Physical, non-ins covered)		$50	98927 (OMT, 5-6 regions)		$60
OTHER SERVICES					
Consultations			**Prolonged Services, email, phone calls**		
INTM (Introductory Meeting, 15 mins)		**Free**	99354 (Prolonged 30-74 mins)		$150
99241 (Problem focused)		$80	99355 (Each addl. 30 mins)		$150
99242 (Exp. Problem focus)		$120	PH15 (Phone/email/skype, 5-15 mins)		$40
99243 (Detailed prob.)		$160	PH30 (Phone/email/skype, 16-30 mins)		$80
99244 (Complex, mod.)		$200	PH45 (Phone/email/skype, 31-45 mins)		$120
99245 (Complex, high)		$240	PH60 (Phone/email/skype, 46-60 mins)		$160
Office Procedures			**Office Lab Tests**		
36415 (Venip, routine)		$10	81002 (Urine, dipstick only)		$10
96372 (Ther/proph/diag inj, sc/im)		$35	87430 (Strep a screening)		$25
96374 (Ther/proph/diag inj, iv push)		$80	82947QW (Blood glucose)		$20
J3420 (B-12, B-complex, Iron, each)		$5	81025 (Urine Pregnancy test)		$10

I understand the fees of Radiant Naturopathic. Premera, Regence, or LifeWise insurance will be billed upon the above schedule. If I have a different insurance or no insurance, I will pay at the time of service, and may request a superbill to submit to my own insurance plan if I seek coverage. Phone/email management is not covered by insurance and will be billed to me personally.

Name: (or Parent/Guardian Name) **Signature:** **Date:**

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Appointment Contract

I agree to be here on time for all of my scheduled appointments. If I am unable to keep my appointment, I will give *Radiant Naturopathic* at least 24 hours advance notice. If I fail to show for my appointment or am more than 15 minutes late without contacting the clinic, I understand that I will be charged a $50 appointment non-compliance fee. Payment for this fee will be my responsibility and will not be filed with any third party. I agree to pay this fee in full before rescheduling any type of appointment at *Radiant Naturopathic*. I understand that appointment times are given as estimated times that patients will be seen by the doctor. I understand the length of an office visit is based on the needs of each individual patient in the clinic and that there may be minimal or extended delays.

Please Note

The first visit with our office will take 1 to 1.5 hours. If you do not have this much time, you may want to reschedule your appointment.

Name: ______________________________________ Signature: ____________________________ Date: __________
(Patient)

Name: ______________________________________ Signature: ____________________________ Date: __________
(Parent/Guardian/Personal Representative)

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