Purity Integrative Health & Wellness Center, PLLC

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Date & Time of Initial Visit: _____

Name *Full Legal Name:*			
Date of Birth:			
Gender Identification: ☐ M ☐ F ☐ Other:			
Address:			
CITY:	**STATE:**	**ZIP:**	
Mailing Address if different from above:			
Email address:		**Required	
Home Phone:	**Cell Phone:**		
Preferred method of contact: home phone / cell phone / other:			
Employment status: ☐ Full-time ☐ Part-Time ☐ Student ☐ Retired ☐ Stay at Home Parent			
Employer:	**Job Title:**		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Primary Care doctor:	**Date of last physical exam:**		
Clinic your PCP is associated with:			

How did you hear about us:
Referred by someone specific? : _____
Internet Search: Google/Bing / Insurance Website / Newspaper Ad / Brochure in community / Website www.purityhealth.net / AANP Website/ WANP Website / Saw Signs or Drove by / Other (please list):

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio					
Immunizations?	☐ Tetanus ☐ MMR	☐ Chickenpox	☐ Pneumonia ☐ Influenza	☐ Hepatitis	☐ COVID: J&J or mRNA? #___
Where were you born?		**Any known exposures? (farm, radiation, etc)**			
Current Height:		**Current Weight:**			
Colonoscopy?		**Mammogram?**			

WHAT HAVE YOU BEEN SEEN FOR OR TREATED FOR IN THE PAST? PLEASE INCLUDE APPROXIMATE DATES: (Past Medical History)
Ex: blood pressure, cholesterol, thyroid, sinus, depression, anxiety, diabetes, arthritis, asthma, allergies, anything you have sought medical help for or taken medication for in the PAST or present.

Name *Full Legal Name:*		**DOB:**

WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY?
What is the focus of today's visit—what prompted you to make the appointment?

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

ADOPTED: YES / NO
L=LIVING; D=DECEASED (INCLUDE AGE)

	CURRENT AGE OR AGE AT DEATH		SIGNIFICANT HEALTH PROBLEMS & CAUSE OF DEATH IF DECEASED		CURRENT AGE OR AGE AT DEATH		SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH IF DECEASED
Father		L / D		**Children**	☐ M ☐ F		
Mother		L / D			☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grand-mother** *Maternal*		L / D	
	☐ M ☐ F			**Grand-father** *Maternal*		L / D	
	☐ M ☐ F			**Grand-mother** *Paternal*		L / D	
	☐ M ☐ F			**Grand-father** *Paternal*		L / D	

Name		**DOB:**

Full Legal Name:		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers	
Name of the Drug, Strength & Frequency	Vitamins, Herbs, Supplements, etc
Allergies:	
DRUGS ALLERGIES:	ENVIRONMENTAL OR FOOD ALLERGIES:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise (Outside of work)	☐ Sedentary (No exercise)	☐ Mild exercise (golf, take stairs, yoga, etc)	☐ **Occasional** vigorous exercise (cardio 4x/wk for 30 minutes, active occupation)		
	☐ **Regular** vigorous exercise (i.e., work or recreation 5x/week for 30+ minutes, HR above 70% MaxHR)				
	HOW MANY DAYS DO YOU EXERCISE PER WEEK:		**HOW MANY MINUTES:**		
	WHAT DO YOU DO FOR EXERCISE (run, walk, weights, etc):				
Diet	Do you follow a specific diet? Vegan Vegetarian Paleo Keto Whole 30 Other:				
	Typical Breakfast:				
	Typical Lunch:				
	Typical Dinner:				
	Typical Snacks/Treats:				
	How Much PURE water do you drink: _____ ounces or liters		JUICE: _____ ounces	MILK: _____ ounces	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	☐ Energy Drinks
	# of cups/cans per day?		What kind? (Diet, regular, drip, espresso)		
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?	☐ Beer	☐ Wine	☐ Liquor/Mixed Drinks	
	How many drinks per day?			☐ Rarely or occasional/holidays	
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Have you ever been in treatment for alcohol or drugs?			☐ Yes	☐ No

Name *Full Legal Name:*		**DOB:**

Tobacco	Do you **currently** use tobacco products:				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years used:	Have you **ever** used tobacco?	☐ Year quit:			
Drugs	Do you **currently** use recreational or street drugs?				☐ Yes	☐ No
	Have you **ever** used or tried recreational/street drugs? If yes, list:				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you feel safe in your home physically, emotionally, sexually?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

PERSONAL HEALTH HISTORY

****GYNECOLOGICAL HISTORY--WOMEN ONLY****				
How old were you when you started your period:				
Are you currently in Menopause? If yes, approximately when was your last menstrual cycle?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Date of last menstruation (this is the date you began your period):				
Period every _____ days and they last for _____ days				
Do you have any of the following: Heavy periods, irregularity, spotting, pain, or discharge? (*Circle*)	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? (circle)	☐	Yes	☐	No
Gestational History: Number of pregnancies _____ Number of live births _____ Number of Abortions _____ Number of Miscarriages _____Approx how many mos at time of loss: _____ Any complications during pregnancy such as pre-eclampsia, gestational diabetes, bed-rest, pre-mature labor?				

Name *Full Legal Name:*		**DOB:**

****GYNECOLOGICAL HISTORY--WOMEN ONLY CONTINUED****

Are you CURRENTLY pregnant or breastfeeding?	☐ Yes	☐ No
Did you breastfeed your children? If yes, for how many months? _____	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections **within the last year**?	☐ Yes	☐ No
Any blood in your urine currently?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge? (circle)	☐ Yes	☐ No
Have you ever had an abnormal pap? If you've had an abnormal pap, did you have HPV? Did you receive treatment? If yes, what was done?	☐ Yes	☐ No
Date of last pap? Have you ever had a rectal exam? If yes, when?		

****UROLOGY—MEN ONLY****

Do you usually get up to urinate during the night? If yes, # of times _____	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Have you had a prostate and rectal exam? If yes, date of most recent:	☐ Yes	☐ No
Last PSA test and value?		

MENTAL HEALTH

Is stress a major problem for you? If yes, what is your stress level on a scale of 1-10? What are your primary stressors:	☐ Yes	☐ No
Do you ***currently*** feel depressed?	☐ Yes	☐ No
Do you deal with anxiety on a regular basis?	☐ Yes	☐ No
Do you have problems with eating or your appetite? (Either overeating or under eating--***circle***)	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself? If yes, when or how recent?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor, either individually or family/marriage? If yes, when & why?	☐ Yes	☐ No

Name *Full Legal Name:*		**DOB:**

OTHER CURRENT ISSUES

Check if you ***currently*** have any symptoms in the following areas to a significant degree and briefly explain.

☐	Skin	☐	Joint Pain
☐	Head/Neck	☐	Muscle pain
☐	Eyes	☐	Dizziness/Loss of Balance
☐	Ears	☐	Numbness/Tingling
☐	Nose	☐	Depression
☐	Throat	☐	Anxiety
☐	Chest/Heart	☐	Blood Sugar Problems
☐	Lungs/Breathing	☐	Thyroid Issues
☐	Intestinal/Bowel	☐	Weight Change
☐	Genital	☐	Changes in Energy
☐	Bladder	☐	Problems with sleep
☐	Circulation/Veins	☐	Other:

Additional Information—Anything else you want the doctor to know? Describe below:

CONSENT FOR NATUROPATHIC TREATMENT

I, _____ (patient) hereby authorize any Naturopathic Physician employed by Purity Health, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions; Herbs and Natural Medicines (prescribing of various therapeutic substance including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Pharmaceutical Prescriptions (prescribing of various pharmaceutical drugs within the scope of practice for Naturopathic Physicians which includes all Legend Drugs and specific Schedule III, IIIN, 4, & 5 in WA and a specified formulary list in MT per MT State Law)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans, or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.)

Electromagnetic and Thermal Therapies (includes the use of therapeutic ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and hydrotherapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

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, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used.

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Printed Name Relationship if not the patient

HIPAA ACKNOWLEDGEMENT

I, _____(patient name), give my permission to share any medical information, appointment information, or pick-up supplements on my behalf to the following person or persons.

SHARING OF CONFIDENTIAL INFORMATION

I authorize the following people to share my health history, labs and/or records on my behalf.

NAME	RELATIONSHIP	CONTACT PHONE

SUPPLEMENTS

I authorize the following people to pick up supplements on my behalf. If SAME AS ABOVE, initial: ____

NAME	RELATIONSHIP	CONTACT PHONE

IN CASE OF EMERGENCY

Please contact the following person(s); If SAME AS ABOVE, initial: ____

NAME	RELATIONSHIP	CONTACT PHONE

HIPAA

I hereby certify that I have received & reviewed the *Notice of Privacy Practices* for **Purity Integrative Health & Wellness Center, PLLC**. I understand that if I have objections or concerns with this policy, I must notify **Purity Integrative Health & Wellness Center, PLLC** per the instructions in the *Notice of Privacy Practices*. I also understand that I may revoke the above permissions at any time via written request.

_____ _____

Patient Name (Print) **Date**

_____ _____

Signature (Patient/Parent/Guardian) **Relationship**

Financial Agreement – Updated 10/10/23

Thank you for choosing Purity Integrative Health & Wellness Center for your Naturopathic care. We know you have many choices in providers and we appreciate your business. We look forward to a relationship with mutual trust and an

opportunity to help you obtain optimal health. As you know, payment for services is part of your care and part of our professional relationship. We have developed a financial agreement to make these obligations clear from the beginning.

NEW PATIENT DEPOSIT

We require a deposit of $50 for all new patient appointments scheduled. This deposit will be used for patient responsibility if any after your insurance processes your date of service or used for the Late Cancellation/No Show fee. If your insurance pays 100% of the allowed amount for each visit, you may request a refund of the deposit This deposit is not be used for supplement purchases. Initials _____

UNINSURED PATIENTS/TIME OF SERVICE/SELF-PAY

Payment is due at the time of service. Purity Health accepts checks and most major credit cards; we DO NOT accept cash. There is a discount for those paying for services in full at the time of service. If payment is not paid at the time of service, the price will revert to the uninsured price AND a $10 billing/late fee **per month** of non-payment will be assessed. Initials _____

INSURANCE COVERAGE AND PAYMENTS

We will gladly bill your insurance. It is **your responsibility to obtain and verify coverage** for the services provided at Purity prior to your scheduled appointment, we will provide you with a form that will show you the questions and codes to verify. **If you have a co-pay, this will be due at the time of service, should you choose not to pay at the time of service, a $10 fee will be added**. If your insurance denies coverage, you will become a self-pay patient (refer to section above). If they cover only a portion or your visit is subject to your deductible, it is your responsibility to pay the remaining balance (co-insurance and/or deductible). In the event that your insurance coverage has changed, it is **your responsibility to provide us with the new insurance company/card**, member ID number, and group number. If these are not received within the timeframe assigned by your insurance, you will be responsible for the full cost of the office visit that is not covered by your insurance company. At that time, we will provide you with a superbill and you may personally re-submit the bill to your insurance company for reimbursement. Initials _____(please initial even if you do not have insurance)

TELEMEDICINE (VIRTUAL VISITS)

Virtual Visits/TeleMedicine visits are allowed by insurances AT THIS TIME. These Virtual Visits/TeleMedicine will be subject to a copay or other patient responsibility as determined by your insurance. Please verify your benefits for this type of service. Initials _____

THIRD PARTY PAYORS

If you are involved in an accident of any type, Purity will submit to third party payors such as PIP (Personal Injury Protection) for a Motor Vehicle Accident, or L&I (Labor & Industry)/WC (Worker's Compensation) for an injury that occurred while at work. **It is your responsibility to provide ALL information, claim numbers, attorney information, etc., PRIOR to being seen**. If you do not have this information, we will have you pay for the visit up front and YOU can request reimbursement from your insurance company, we will supply a superbill. ***If you do not have PIP coverage or your L&I/WC claim is denied, you will revert to an uninsured patient required to provide payment at the time of service.*** *Please note that issues or conditions that are outside the parameters of your PIP or L&I/WC coverage will need to be scheduled for a different visit on a different day as we have to create a totally separate chart for accidents.* Initials _____

PHONE CONSULTATIONS

Phone visits will be scheduled by physician authorization only and will be charged **a flat rate of $55 for each 1-15 minutes on the phone, $110 for 16-30 minutes, $165 for 30-45 minutes & $220 for 45-60 minutes**. **We will not bill your insurance for phone calls**. The fee will be waived if it is determined that an in person office visit is required. The fee will also be waived if it is a question limited to a current and documented treatment plan and does not require a new chart note. Initials _____

EMAIL CORRESPONDENCE

Due to HIPAA regulations, email consultations are not permitted. If there is an extenuating circumstance, we may make exceptions and these will be discussed ahead of time. There will be a $15 charge for **each email** received and responded to. Initials _____

MISSED OR LATE CANCELLED APPOINTMENTS

It is a professional courtesy and our policy to provide 48 hours' notice if you cannot keep an appointment. You will receive a text message or phone call/email 7 days (and 2 days) prior to your appointment which gives you plenty of time to respond in the time frame. There will be a $50 charge for your first appointment cancelled less than 48-hours in advance or missed all together, the second late cancellation or no-show will have a fee of $75, the third is $100, and the fourth visit will have a fee of $150 and a deposit of $50 required prior to scheduling your next appointment. If you are late to an appointment, please understand that you have a scheduled time, and this may result in your appointment being cut short to remain within the parameters of your scheduled appointment time or you may be turned away and rescheduled resulting in a late cancel/no show fee. Initials _____

RETURNED CHECKS

There will be a $50 fee for returned checks in addition to the NSF fee from our bank. Please note that you will still be responsible for charges and asked to pay with a credit or debit card. Initials _____

COLLECTIONS

Should we be required to send your account to collections due to failure to pay, there will be a $50 collection fee. Initials _____

LABORATORY SERVICES

As a courtesy, we have a LabCorp phlebotomist on-site, however, at the WA location, she is not an employee of Purity. If labs are ordered, you will be given a requisition to bring to the lab, either in house or to another LabCorp location. You are responsible for ensuring coverage of these labs and your financial obligation will be between you and the lab. Please direct financial questions regarding lab fees to the original lab you had your services performed. If you do not have coverage and our clinic offers you an uninsured prepay patient discount, you are then in contract with Purity to pay your bill and this is due the SAME DAY you have your blood drawn. If a test is ordered that initiated additional testing (called "reflex"), you will be billed the additional costs incurred. Initials _____

SUPPLEMENTS, HERBS AND SKINCARE

Supplements and herbs are recommended by your provider for general health and most conditions. Patients may choose to purchase them from **Purity Integrative Health & Wellness Center, PLLC OR** at recommended health food stores or via our online partners, FullScripts (Wellevate),WholeScripts (Xymogen), and Epionce. There is a 30-day return policy for **unopened** supplements purchased in our office. Initials _____

CREDIT CARD AUTHORIZATION & PAYMENT

Due to changes in Healthcare Policy and increasing high-deductible Health Insurance plans, we have unfortunately experienced higher numbers of patients with unpaid medical bills. Therefore, we have implemented a new policy in which all patients are required to provide a credit card to be kept securely on file for future account balances. Please note that this does not change your existing rights with respect to the use of your card. You are still able to ask for investigation into your insurance company's decision on a claim. Card numbers are stored securely off-site with our bank. Card numbers are not kept in our office. If you choose to not keep your card on file, there is a deposit required of $100 for **each visit**. This deposit will be used for any patient responsibility as per your insurance.

Co-pays will remain due at time of service as part of the contract between patient and insurance company. We will bill your insurance company(s) following your visit. They are required to send us and you a copy of the Explanation of Benefits letter detailing what amount was covered/paid by your insurance and what, if any, amount is owed by you, the patient. The card on your account will be charged as payment in full for any remaining balance not paid by insurance. You will receive receipts via email as long as we are provided with your email address (required). Transactions are run as credit, not debit, and are listed as "Purity Integrative Health and Wellness Center" or "Purity Health" on your statement. If you have any questions about this agreement, please contact our Billing office by phone at (425)338-2357. Initials _____

PATIENT AUTHORIZATION AND UNDERSTANDING

I have read and understand the financial policies of Purity Integrative Health & Wellness Center, PLLC. I agree to abide by the terms of the financial agreement. I request that payment of benefits be made to Purity Integrative Health & Wellness Center, PLLC and hereby authorize the release of any information necessary to determine the liability of payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing and there has been a termination of services with Purity Integrative Health & Wellness Center, PLLC.

Thank you for your understanding and cooperation in our financial policies. As stated before, payment for services is part of your treatment and part of our professional relationship. This creates mutual respect and trust between physician and patient. Should you default on any of the above financial terms and obligations, we will no longer be able to see you at the clinic. We appreciated your support in helping us to continue to serve you and others.

Patient's Legal Name: _____

Name of Legal Guardian if applicable: _____

Patient's or Legal Guardian's Signature: _____ Date: _____