Maureen Becker ND LAcPC
5013 SE Hawthorne Blvd
Portland, OR 97215
(503) 736 - 9900

All information provided will be held confidential pursuant to the clinic's Notice of Privacy Practice

PERSONAL INFORMATION

NAME ________________________ BIRTHDATE ____________ AGE ______

GENDER IDENTIFICATION ________

ADDRESS ____

CITY/ STATE/ ZIP CODE ______________________________________

EMAIL ADDRESS ____

WORK PHONE ____________________ CELL PHONE ____________________

EVENING PHONE ____________________ EMERGENCY CONTACT ____________________

CONTACT PHONE ____________________ RELATION TO SELF ____________________

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Last Name ______ **First Name** ______ **M. Initial** ______ **Date of Birth** ______

What is the reason(s) for your visit to our Health Center today?

Primary concern: ______

Secondary concern: ______

Additional concern: ______

Additional concern: ______

*Please note that we may not be able to address all of your concerns as visit time allows in order of medical priority. Follow-up visits may be needed to address additional concerns.

When did the problem(s) begin? ______

Have these conditions been treated by another health care provider in the past?

If YES, How long ago? ______
Provider? ______
Where? ______

Is the problem(s) the result of an automobile accident and/or a work injury? ☐ Yes ☐ No

If YES, specify which concern was related to this accident/injury: ______

Allergies: Do you have any allergies to the following? *(please select all that apply)*

☐ Aspirin	☐ Bees	☐ Cats	☐ Codeine	☐ Contrast Dye	☐ Dogs
☐ Eggs	☐ Fish	☐ Latex	☐ Lidocaine	☐ Milk	☐ Mold
☐ Morphine	☐ NSAIDS	☐ Peanuts	☐ Penicillin	☐ Pollin	☐ Selfish
☐ Soy	☐ Sulfa	☐ Sulfites	☐ Tetracycline	☐ Wheat	

☐ Other ______

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Family History: Do you have a family history of any of the following? *(Please select all that apply)*

	Alcohol/ Drug Addiction	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness	Stroke	Vision Problems	Gastrointestinal	Other
Mom	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dad	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mom's Mom	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mom's Dad	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dad's Mom	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dad's Dad	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mom's Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mom's Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dad's Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dad's Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking:			
Name of Medication/ Supplement	Strength	Frequency Taken and Route (oral, topical, etc.)	How long have you been taking this?

Immunization History: *(Please select all that apply)*

Did you complete your childhood vaccinations? ☐ Yes ☐ No

Have you had a tetanus titer booster? ☐ Yes ☐ No

If YES, what was the date of this booster? ____________________

Have you received a flu shot this year? ☐ Yes ☐ No

Social History: Do you use any of the following tobacco products? *(Please select all that apply)*

Do you use tobacco products? ☐ Yes ☐ No

Smoking History:

☐ Current Smoker, Every Day ☐ Current Smoker, Some Days ☐ Former Smoker ☐ Heavy Tobacco Smoker

☐ Light Tobacco Smoker ☐ Never Smoker ☐ Passive Smoke Exposure - Never Smoker

☐ Other: ____________________

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Type of Tobacco Used: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chew ☐ Other:______

Start Date: ______________________ Quit Date: ______________________

Packs per day: ___ Years of smoking: ___ Are you interested in learning about options to quit smoking? ☐ Yes ☐ No

Alcohol Use: *(Please select all that apply)*

Do you drink alcohol? ☐ Yes ☐ No

If "YES", how many of the following per week? ___ glasses of wine
___ cans of beer
___ shots of liquor

Do you currently use any of the following recreational or street drugs? *(Please select all that apply)*

☐ E-cigs ☐ Nicotine Vaping ☐ Marijuana ☐ Opioids ☐ Heroin

☐ Meth ☐ Amphetamines ☐ PCP ☐ Ecstasy ☐ LSD

☐ Ketamine ☐ Mescaline ☐ Psilocybin/Psychedelics ☐ Cocaine ☐ Crack

☐ Nitrous Oxide ☐ Solvent Inhalants ☐ Barbiturates ☐ Benzodiazepines ☐ IV

☐ Other ______________________________________

Sexual Orientation and Gender Identity: *(Please select all that apply)*

Do you identify as: ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual

☐ *(self describe):* ___________ ☐ Don't know ☐ Choose not to disclose

What is your gender identity? *(please select all that apply)*

☐ Cisgender Female ☐ Cisgender Male

☐ Trangender Female/ Trans Woman/ Male-to-Female (MTF) ☐ Transgender Male/ Trans Man/ Female-to-Male (FTM)

☐ Additional Gender Category or Other Not Listed ☐ Choose not to disclose

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Are you sexually active? ☐ Yes ☐ No ☐ Not Currently

Partners? *(Please select all that apply)* ☐ Female ☐ Male ☐ *(Self describe):* ____________

Medical Conditions: Do you currently have or have a history of the following? *(Please select all that apply)*

☐ Adrenal Disorder	☐ Depression	☐ Inflammatory Bowel Disease
☐ Anemia	☐ Diabetes Mellitus	☐ Irritable Bowel Syndrome
☐ Anxiety	☐ Digestive Problem	☐ Kidney Disease
☐ Arthritis/Joint Disorder	☐ Heart Disease	☐ Liver Disease
☐ Asthma	☐ Hyperlipidemia	☐ Stroke
☐ Cancer	☐ Hypertension	☐ Thyroid Disease
☐ COPD	☐ Other: ____________	

Surgeries/ Hospitalizations: Have you had any of the following surgeries? *(Please select all that apply and indicate the month and year, MM/YY)*

☐ Appendectomy, Date: ______	☐ C-Section, Date: ______	☐ Small Intestine Surgery, Date: ______
☐ Brain Surgery, Date: ______	☐ Eye Surgery, Date: ______	☐ Spine Surgery, Date: ______
☐ Breast Surgery, Date: ______	☐ Fracture Surgery, Date: ______	☐ Tonsillectomy, Date: ______
☐ Coronary, Date: ______	☐ Hernia Repair, Date: ______	☐ Tubal Ligation, Full, Date: ______
☐ Cholecystectomy, Date: ______	☐ Hysterectomy, Full, Date: ______	☐ Valve Replacement, Date: ______
☐ Colon Surgery, Date: ______	☐ Joint Replacement, Date: ______	☐ Vasectomy, Date: ______
☐ Cosmetic Surgery, Date: ______	☐ Prostate Surgery, Date: ______	☐ Other: ______

Do you have any implants, artificial joints or discs, metal or anything that could impact therapy or imaging? ☐ Yes ☐ No

If YES, please describe: ____________________

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What is your current birth control method? *(Please select all that apply)*

☐ Abstinence ☐ Cervical Cap ☐ Condom ☐ Diaphragm
☐ Hormonal Patch ☐ Implant ☐ Injection ☐ Inserts
☐ IUD ☐ IUS ☐ Pill ☐ Rhythm
☐ Spermicide ☐ Sponge ☐ Surgical ☐ Vaginal Ring
☐ Withdrawal ☐ Vasectomy ☐ Menopause ☐ None
☐ Other: ______________________________

PHQ-2: Over the past 2 weeks, how often have you been bothered by any of the following problems?		
1. Little interest or pleasure in doing things	☐ nearly every day ☐ more than half the days	☐ several days ☐ not at all
2. Feeling down, depressed, or hopeless	☐ nearly every day ☐ more than half the days	☐ several days ☐ not at all

Food Security: *(Please answer the following questions regarding your social history)*		
In the past year, we worried whether our food would run out before we could get more	☐ often true ☐ sometimes true	☐ never ☐ don't know/ refused
In the past year, the food we bought just didn't last and we didn't have money to get more	☐ often true ☐ sometimes true	☐ never ☐ don't know/ refused

Review of Systems: Please mark 'C' for any current symptoms (in the past 2 weeks). Please mark 'P' if you are not currently experiencing symptoms. *If you have had any one of these symptoms in the past, it will be captured in the history section above.*

Constitution

Fever	☐ C ☐ P	Chills	☐ C ☐ P	Weight Loss	☐ C ☐ P
Fatigue	☐ C ☐ P	Sweating	☐ C ☐ P	Weakness	☐ C ☐ P

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Review of Systems (*Continued*): Please mark 'C' for any current symptoms (in the past 2 weeks). Please mark 'P' if you are not currently experiencing symptoms. *If you have had any one of these symptoms in the past, it will be captured in the history section above.*

Endocrine/ Heme/ Allergies

Easy Bruising/ Bleeding	☐ C	☐ P	Environmental Allergies	☐ C	☐ P	Excessive Thirst	☐ C	☐ P

Neurological

Dizziness	☐ C	☐ P	Headaches	☐ C	☐ P	Tingling	☐ C	☐ P
Tremor	☐ C	☐ P	Sensory Change	☐ C	☐ P	Speech Change	☐ C	☐ P
Focal Weakness	☐ C	☐ P	Seizures	☐ C	☐ P	Fainting	☐ C	☐ P

Psychiatric

Depression	☐ C	☐ P	Suicidal Ideas	☐ C	☐ P	Excessive Thirst	☐ C	☐ P
Hallucinations	☐ C	☐ P	Nervous/ Anxious	☐ C	☐ P	Substance Abuse	☐ C	☐ P
Memory Loss	☐ C	☐ P	Insomnia	☐ C	☐ P			

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Review of Systems (*Continued*): Please mark 'C' for any current symptoms (in the past 2 weeks). Please mark 'P' if you are not currently experiencing symptoms. *If you have had any one of these symptoms in the past, it will be captured in the history section above.*

Skin

Rash	☐ C	☐ P	Itching	☐ C	☐ P	Other: ______		

Head, Ears, Nose, Throat

Hearing Loss	☐ C	☐ P	Ringing in Ears	☐ C	☐ P	Ear Pain	☐ C	☐ P
Ear Discharge	☐ C	☐ P	Nosebleeds	☐ C	☐ P	Congestion	☐ C	☐ P
Sinus Pain	☐ C	☐ P	Noisy Breathing	☐ C	☐ P	Sore Throat	☐ C	☐ P

Eyes

Blurred Vision	☐ C	☐ P	Double Vision	☐ C	☐ P	Light Sensitivity	☐ C	☐ P
Eye Pain	☐ C	☐ P	Eye Discharge	☐ C	☐ P	Eye Redness	☐ C	☐ P

Cardiovascular

Chest Pain	☐ C	☐ P	Palpitations	☐ C	☐ P	Shortness of breath	☐ C	☐ P
Leg Cramping/ Claudication	☐ C	☐ P	Leg Swelling	☐ C	☐ P			

Respiratory

Cough	☐ C	☐ P	Coughing up Blood	☐ C	☐ P	Sputum Production	☐ C	☐ P
Shortness of breath	☐ C	☐ P	Wheezing	☐ C	☐ P			

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Review of Systems (*Continued*): Please mark 'C' for any current symptoms (in the past 2 weeks). Please mark 'P' if you are not currently experiencing symptoms. *If you have had any one of these symptoms in the past, it will be captured in the history section above.*

Gastrointestinal

Symptom	C	P	Symptom	C	P	Symptom	C	P
Heartburn	☐ C	☐ P	Nausea	☐ C	☐ P	Vomiting	☐ C	☐ P
Abdominal Pain	☐ C	☐ P	Diarrhea	☐ C	☐ P	Constipation	☐ C	☐ P
Blood in Stool	☐ C	☐ P	Black/Tarry Stools	☐ C	☐ P			

Genitourinary

Symptom	C	P	Symptom	C	P	Symptom	C	P
Painful Urination	☐ C	☐ P	Urgency	☐ C	☐ P	Frequency	☐ C	☐ P
Blood in Urine	☐ C	☐ P	Flank/Side Pain	☐ C	☐ P			

Male Sexed

Symptom	C	P	Symptom	C	P	Symptom	C	P
Hernias	☐ C	☐ P	Testicular Masses	☐ C	☐ P	Sexual Difficulty	☐ C	☐ P

Female sexed

Age of first menses	________	Age of last menses	________	Duration of menses	________
Date of last annual exam	________	Number of pregnancies	________	Number of live births	________
Number of miscarriages	________	Number of abortions	________		

Musculoskeletal

Symptom	C	P	Symptom	C	P	Symptom	C	P
Muscle Pain	☐ C	☐ P	Neck Pain	☐ C	☐ P	Back Pain	☐ C	☐ P
Joint Pain	☐ C	☐ P	Falls	☐ C	☐ P			

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NATUROPATHIC MEDICINE, CLASSICAL CHINESE MEDICINE, AND NUTRITION INFORMED CONSENT AND REQUEST TO ESTABLISH CARE

Informed consent is a process, not a form, and involves an ongoing, interactive dialog between you and your provider. The process of informed consent occurs when communication between you and your provider results in your authorization or agreement to undergo a specific medical intervention.

I do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of Dr. Maureen Becker. I consent to services rendered to me under the instructions of Dr. Muareen Becker.

I understand I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/or students:

- My suspected diagnosis(s) or condition(s)
- The nature, purpose, goals, and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, and/or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

I understand that evaluation and treatment may include, but is not limited to:

- **Common diagnostic procedures** (including by not limited to physical examination, laboratory testing of blood and other bodily fluids, and referrals for: electrocardiogram, lung function testing, and ultrasound).
- **Dietary and therapeutic nutrition recommendations and counseling** (including but not limited to the use of foods, individualized diet plans, and nutritional supplements).
- **Natural substance prescriptions** (including but not limited to plant/herbal, mineral or animal-based substances). Substance may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, pastes, plasters, washes, or other forms.
- **Counseling** (including but not limited to mindfulness techniques, behavioral change, stress management techniques, and tobacco/substance use cessation).
- **Over-the-counter and prescription medications** (including only those medications listed on the Oregon Board of Naturopathic Medicine formulary).

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INFORMED CONSENT AND REQUEST TO ESTABLISH CARE (CONTINUED)

- **Classical Chinese medicine** procedures including, but not limited to, acupuncture, cupping, electro-acupuncture, and herbology. Possible risks and complications associated with these procedures may include:
  - Nausea
  - Infections and blisters
  - Fainting
  - Scarring
  - Bruising
  - Bleeding
  - Tingling/soreness near needling sites that may last a few days

AUTHORIZATION: *(Please sign and date below)*

I understand that some medicines, supplements and procedures may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform my provider or student so taht my treatment plan may be re-evaluated.

I have fully read and understand the above and hereby consent to services.

X____ ________________

Signature of Patient OR Parent/Legal Guardian Signature *(if patient is under 15)* **Date**

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HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENT

I hereby consent to the use and disclosure of my Protected Health Information by Dr. Maureen Becker for the purposes of **treatment, payment and healthcare operations**, or as otherwise required by law.

- Dr. Maureen Becker has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosures of my Protected Health Information. I have a right to review the Notice prior to signing this consent and receive a printed copy of the notice.
- I have the right to request restrictions to the usage and disclosure of my Protected Health Information.
- I have the right to request an alternative to the standard method of communication of my Protected Health Information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Dr. Maureen Becker at the following address: 5013 SE Hawthorne Blvd Portland, OR 97215.
- I understand that while Dr. Maureen Becker may honor these requests, they are not required by law to do so.
- I am aware that Dr. Maurren Becker has the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices affected for all Protected Health Information that they maintain. In the event of amendments, Dr. Maureen Becker will make available a revised Notice of Privacy Practice for my review.

AUTHORIZATION: *(Please sign and date below)*

I have fully read and understand the above agreements and authorizations.

X____ ____________________

Signature of Patient OR Parent/Legal Guardian Signature *(if patient is under 15)* **Date**

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STATEMENT OF FINANCIAL RESPONSIBILITY

Patients are required to pay for all medical services rendered.

FOR ALL PATIENTS:

- There will be a flat fee of $30 for any appointment that is either missed or not canceled within 24 hours of the appointment time.
- You acknowledge that you are financially responsible for all charges. Any account over 120 days old will be sent to collections. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. You hereby authorize Dr. Maureen Becker to release information necessary to secure payment.
- You are responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including Medicinary, lab work, and tests, as well as any physician ordered add-on lab work and tests.

TIME OF SERVICES AND OTHER DISCOUNTS:

- A discount will be applied for payment at the time of service.
- As a courtesy of paying in full at the time of service, you will receive medical services at a discounted rate. If you do not pay at the time of service your account will not reflect a time of service discount.

IF YOU ARE INSURED:

- You authorize release of information in your medical history to your insurance carrier and assign all benefits for unpaid services to Dr. Maureen Becker. This release applies to support of the insurance billing process only.
- You are responsible for providing all accurate and thorough documentation required to verify your insurance coverage and/or bill your insurance carrier.
- You understand that Dr. Maureen Becker requires proof of insurance at any time and that your insurance may need to be re-verified for specific coverage details as often as every 6 months, if there is a denial of a claim, or if you have a change in coverage.
- You are responsible for full payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by your insurance carrier at the time of service.
- You are responsible for payment even if your insurance company makes a determination that the care received was not medically necessary.

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STATEMENT OF FINANCIAL RESPONSIBILITY (CONTINUED)

- You may forfeit the privilege of billing your insurance carrier if you do not comply with any of your financial responsibilities or documentation requirements.

AUTHORIZATION: *(Please sign and date below)*

I have fully read, understand, and agree to these financial policies.

X______________________________________ ______________

Signature of Patient OR Parent/Legal Guardian Signature *(if patient is under 15)* **Date**

MINORS SEEKING TREATMENT WITHOUT A PARENT/GUARDIAN (AGES 15-17):

I ______________________, certify that I am ________ years old. I am seeking outpatient health services from Dr. Maureen Becker. I have been fully informed of the services to be rendered and consent to those services.

Payment Method *(choose one and initial)*

1. _______ I agree to allow Dr. Maureen Becker to notify my parent(s) to the extent necessary to obtain insurance coverage for the services provided.
2. _______ I do NOT want Dr. Maureen Becker to notify my parent(s) regarding any of these services unless required by (initial if yes) law to do so. I do not wish that Dr. Maurren Becker obtain my parent(s)' consent to bill insurance. I fully understand that Dr. Maureen Becker requires me to pay for all services in advance and that my failure to do so may result in termination of services. In the event that I am unable to pay for these services, Dr. Maureen Becker may, at her sole discretion, terminate this relationship and refer me to appropriate health providers.

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STATEMENT OF FINANCIAL RESPONSIBILITY (CONTINUED)

- You may forfeit the privilege of billing your insurance carrier if you do not comply with any of your financial responsibilities or documentation requirements.

AUTHORIZATION: *(Please sign and date below)*

I have fully read, understand, and agree to these financial policies.

X____ ______________

Signature of Patient OR Parent/Legal Guardian Signature *(if patient is under 15)* **Date**

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I ________________________, certify that I am _________ years old. I am seeking outpatient health services from Dr. Maureen Becker. I have been fully informed of the services to be rendered and consent to those services.

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