

Wellspring Naturopathic Clinic PATIENT PROFILE

Date _____

NOTE: Naturopathic care is only possible when the physician has a complete picture of the patient physically, mentally, and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. Please print and mark questions you don't understand with a question mark (?).

Patient Name _____ Age _____ Date of Birth ____/____/____ Sex: _____

If patient is not of legal age (18): Parent or guardian name _____

Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening Phone _____ Cell Phone _____

Education _____ Occupation _____

Employer _____ Full or Part Time _____ Retired _____

SSN ____/____/____ Email Address : _____

Emergency Contact: _____ Relationship _____ Phone: _____

How did you hear about us? _____

Reason for visit today? _____

Primary Health Concerns: (In order of importance)

1. _____

2. _____

3. _____

4. _____

Medical History

The general state of your health has been: Excellent ___ Good ___ Fair ___ Poor ___

What childhood illnesses have you had?

Rubella (3-day measles) ___ Measles (2-week) ___ Whooping Cough ___ Asthma ___
 Rheumatic Fever ___ Mumps ___ Chickenpox ___ Scarlet Fever ___ Polio ___ Other _____

What immunizations have you had?

1. _____ 2. _____
 3. _____ 4. _____

When and where did you last receive medical or health care? _____
 Reason? _____

History of Illness

| Now | Past | Never | | Now | Past | Never | |
|-----|------|-------|--|-----|------|-------|---------------------|
| ___ | ___ | ___ | Anemia | ___ | ___ | ___ | High blood pressure |
| ___ | ___ | ___ | Arthritis | ___ | ___ | ___ | Serious injury |
| ___ | ___ | ___ | Asthma | ___ | ___ | ___ | Pneumonia |
| ___ | ___ | ___ | Bleeding (uncontrolled) | ___ | ___ | ___ | Rheumatism |
| ___ | ___ | ___ | Cancer | ___ | ___ | ___ | Thyroid trouble |
| ___ | ___ | ___ | Diabetes | ___ | ___ | ___ | Venereal disease |
| ___ | ___ | ___ | Gout | ___ | ___ | ___ | Mental disease |
| ___ | ___ | ___ | Heart murmur | ___ | ___ | ___ | Migraine headaches |
| ___ | ___ | ___ | Emphysema | ___ | ___ | ___ | Ulcers |
| ___ | ___ | ___ | Liver disease; yellow jaundice, Hepatitis | | | | |

Please list Past Surgeries and/or Hospitalizations:

1) _____ Date: _____

 2) _____ Date: _____

 3) _____ Date: _____

Have you had X-Rays taken?

1) _____ Date: _____

 2) _____ Date: _____

 3) _____ Date: _____

Allergies: (Medications, Food, Environmental)

What happens when you have an “allergy attack”?

Please List the Medications you are currently taking: (with dosage)

1)

2)

3)

4)

5)

Please list the supplements you are taking: (with dosage)

1)

2)

3)

4)

5)

Family & Social History

Please list any significant health concerns for the following relatives.

| | Age (if alive) | Age (at death) | Health Problems |
|-----------------|----------------|----------------|-----------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| <u>Maternal</u> | | | |
| Grandfather | _____ | _____ | _____ |
| Grandmother | _____ | _____ | _____ |
| <u>Paternal</u> | | | |
| Grandfather | _____ | _____ | _____ |
| Grandmother | _____ | _____ | _____ |

Has any **blood relative** had any of the following?

| Now | Past | Unknown | | Now | Past | Unknown | |
|-----|------|---------|-------------------------|-----|------|---------|---------------------|
| ___ | ___ | ___ | Anemia | ___ | ___ | ___ | Hay fever |
| ___ | ___ | ___ | Arthritis | ___ | ___ | ___ | Heart attack |
| ___ | ___ | ___ | Asthma | ___ | ___ | ___ | High blood pressure |
| ___ | ___ | ___ | Bleeding (uncontrolled) | ___ | ___ | ___ | Seizure or Epilepsy |
| ___ | ___ | ___ | Cancer | ___ | ___ | ___ | Sickle Cell Anemia |
| ___ | ___ | ___ | Diabetes | ___ | ___ | ___ | Stroke |
| ___ | ___ | ___ | Eczema | ___ | ___ | ___ | Mental illness |
| ___ | ___ | ___ | Glaucoma | ___ | ___ | ___ | Thyroid trouble |
| ___ | ___ | ___ | Gout | ___ | ___ | ___ | Tuberculosis |

Military Service:

When and where did you serve?

Type of discharge:

Have you traveled outside of the U.S.? When and Where?

Economic Status:

Income Sources _____ Does your income cover your expenses? _____

How often do you drink - wine? _____ beer _____ other alcohol _____

Do you use tobacco _____ If yes, how much per day? _____ How many years have you smoked _____

Do you use marijuana or other drugs? _____ If yes, which and how often _____

How many meals do you generally eat per day _____, Irregular meals? _____ Number of snacks _____

Where do you usually buy your food? _____

Who cooks the food you eat? _____

List any foods you exclude from your diet _____

List the primary foods included in your diet _____

List any foods to which you have had a bad reaction _____

List foods you crave _____

Are you satisfied with your diet as it is now? _____ If no, why not? _____

What are your hobbies or primary interests? _____

Do you exercise _____ What form(s) _____ How often _____

Symptoms

Please mark **1-** mild, **2-** moderate or **3-** severe, and if any of the following apply **N**ow or in the **P**ast
 Example: 3N indicates symptom is severe-now

Head

- ___ headaches
- ___ dizziness
- ___ blurry vision
- ___ fainting/blackouts
- ___ loss of balance
- ___ eye pain/red eye
- ___ near or far sighted
- ___ eyes are light sensitive
- ___ cataracts/glaucoma
- ___ earaches
- ___ ringing in ears
- ___ discharge from ears
- ___ difficulty hearing
- ___ nosebleeds
- ___ sinus problems
- ___ loss of smell
- ___ persistent hoarseness
- ___ grinding teeth
- ___ neck lumps/swelling
- ___ dental problems
- ___ sore throat
- ___ loss of voice
- ___ sore/bleeding gums
- ___ difficult swallowing
- ___ cold or canker sore
- ___ speech difficulties

Respiratory

- ___ wheezing
- ___ cough up blood
- ___ cough up phlegm
- ___ shortness of breath
- ___ chest colds
- ___ chronic cough
- ___ nighttime breathing problems
- How many pillows_____

Cardiovascular

- ___ palpitations
- ___ chest pain
- ___ night sweats
- ___ unexplained fever

- ___ rapid/skipped beats
- ___ high blood pressure
- ___ swollen feet/ankles
- ___ leg pain when walking
- ___ leg vein trouble
- Have you ever had
rheumatic fever or syphilis?

When? _____
 How far can you walk or how
 many stairs can you climb
 before having to stop?

What makes you stop?

Gastrointestinal

- ___ stomach pain
- ___ indigestion
- ___ trouble swallowing
- ___ heartburn/acid reflux
- ___ frequent or severe
nausea
- ___ blood in vomit
- ___ jaundice
- ___ constipation
- ___ diarrhea
- ___ vomiting
- ___ hemorrhoids
- ___ loss of appetite
- ___ excessive appetite
- ___ blood in stool
- ___ light colored stool
- ___ black stools
- ___ rectal pain/itching
- ___ change in bowel
movements
- ___ excessive gas / bloating
- ___ excessive belching
- ___ distress from fats or
greasy food

- ___ stools yellow or clay
colored, foul-odor, shows
undigested food
- ___ indigestion 2-3 hours
after meals, fullness,
bloating, sourness, etc.
- ___ heavy full feeling after
meals
- ___ excessive lower bowel
gas
- ___ bad breath, bad taste in
mouth, body or foot odor
- ___ constipation alternating
with diarrhea
- ___ stomach pain 5-6 hrs
after eating, usually at night,
relieved by drinking milk
- ___ above symptoms
aggravated by stress
- ___ indigestion immediately
after eating
- ___ difficulty belching,
stomach cramps, colicky
sensations in stomach
- ___ nervousness,
shakiness, headaches,
relieved by eating sweets
- ___ irritable if late for meals,
miss meal, or before
breakfast
- ___ sudden cravings for
sweets or alcohol
- ___ wake up at night feeling
hungry
- ___ overweight
- ___ gain weight or fail to
lose on diets
- ___ feel better mornings,
worse afternoons
- ___ loss of appetite
- ___ good appetite, but fail to
gain or lose weight
- ___ sleepy during the day
- ___ strain at stool

___ change of appetite
Is it increased or decreased?

How often do you have
bowel movements?

Genitourinary

- ___ frequent urination
- ___ night urination
- ___ incontinence
- ___ trouble starting urine
- ___ blood in urine
- ___ kidney stones
- ___ trouble holding urine
- ___ pain with urination
- ___ bladder infections

Musculoskeletal

- ___ aching muscles
- ___ numbness/tingling
- ___ restless legs
- ___ broken bones
- ___ weakness
- ___ swollen joints
- ___ sore joints
- ___ leg cramps
- ___ tender points
- ___ backaches
- ___ burning on soles of feet
- ___ Unusual redness on palms of hands
- ___ arthritis, if yes,
When?

Where?

What kind?

SKIN

- ___ acne
- ___ itching
- ___ rashes
- ___ lesions
- ___ easy bruising
- ___ hives

Endocrine

- ___ always cold

- ___ always hot
- ___ chronic fatigue
- ___ weakness
- ___ increased hunger
- ___ increased thirst
- ___ Unexplained weight loss/gain
- ___ prefer hot weather
- ___ prefer cold weather
- ___ can't stand cold
- ___ cold hands & feet
- ___ increased hunger

Nervous

- ___ anxiety
- ___ numbness
- ___ tremor
- ___ foggy thinking
- ___ lack of strength
- ___ convulsions
- ___ loss of memory
- ___ lack of concentration
- ___ paralysis

Blood, Immune

- ___ painful lymph nodes
- ___ frequent bleeding
- ___ anemia
- ___ fluid retention
- ___ swollen glands
- ___ wounds heal slowly

Male Reproductive

- ___ prostrate problems
- ___ painful erections
- ___ infertility
- ___ discharge from penis
- ___ difficulty with or premature ejaculation
- ___ lump or swelling in testicles
- ___ painful testicles
- ___ trouble maintaining or achieving erection
- What contraception do you use? _____

Female Reproductive

- ___ lumps in breast(s)

- ___ breast pain
- ___ missed periods
- ___ lack of sexual desire
- ___ no lubrication when aroused
- ___ sex is painful
- ___ pelvic pain
- ___ vaginal discharge
- ___ heavy periods
- ___ genital eruptions
- ___ vaginal itching/burning
- ___ bleeding or spotting between periods
- ___ difficulty having orgasms
- ___ premenstrual symptoms: cramps, water retention, breast tenderness, headaches, etc.
- ___ infertility
- ___ lump(s) in breast
- ___ nipple discharge
- Period every _____ days, Regular? Yes or No

Period usually lasts
___ days

Number of pads or tampons
used per day

Date of last
period _____

What form of contraception
do you use?

Number of
pregnancies _____

Number of
births _____

Number of
miscarriages _____

Number of
abortions _____

Any complications of
pregnancy? if yes please
list _____

Age at first menstrual
period _____

Did you have a "normal" puberty? _____

Have you ever had a venereal disease?

Mental / Emotional

- ___ depression
- ___ suicidal thoughts
- ___ angered easily
- ___ afraid of being alone
- ___ shy/timid
- ___ restlessness
- ___ excessive worry
- ___ loneliness
- ___ trouble getting along with people

- ___ frequent nightmares
- ___ mental confusion
- ___ mood swings
- ___ crying spells
- ___ suspicious/jealous
- ___ loss of a loved one
- ___ feel pick-up from exercise
- ___ feeling of worthlessness
- ___ memory trouble
- ___ hard to express anger
- ___ place other's interests before mine
- ___ hear voices
- ___ excess stress
- ___ don't remember dreams
- ___ trouble sleeping

- ___ don't know how to relieve stress
- ___ see things others don't
- ___ think others want to hurt me
- ___ chronic lateness or procrastination



Also: Please record your diet for three days prior to your appointment.

Thank You!

Policy Statement
2009

We welcome you as a patient and appreciate the opportunity to provide you with our professional services. The information that follows is designed to answer most of the questions that our patients ask, and to serve as a policy statement.

OFFICE HOURS: Monday through Friday, 8:30 AM – 5:00 PM (Subject to variability)

APPOINTMENTS: We try to see all patients on an appointment basis. Appointments should be made as far in advance as possible. On occasion, emergencies may prevent us from keeping an appointment; in this event you will be notified as soon as possible. If you miss an appointment or fail to cancel at least 24 hours before the scheduled time of the appointment, you will be charged at one half the hourly rate.

TELEPHONE CONSULTATIONS AND E-MAIL: A telephone call or E-mail should not replace a visit, and any call or correspondence that requires new instruction, case analysis, or prescription will be subject to a consultation charge. The fee is prorated according to the consultation time.

RESEARCH: Whenever possible the clinic manager will assist you on research requests. However, requests for more involved research by Helen Healy, N.D. may also be subject to consultation fees.

| FEES | Same Day Pay Discount | |
|---------------------------|-----------------------|-----------|
| Initial Visit (1.5 hours) | \$ 180.00 | \$ 171.00 |
| Return Visit (1 hour) | \$ 120.00 | \$ 114.00 |
| Return Visit (per minute) | \$ 2.00 | \$ 1.90 |
| Dispensary | by item | |
| Lab | by test | |
| Shipping & handling | by order | |
| Delivery | \$ 20.00 | |
| NSF Checks | \$ 29.00 | |

DISCOUNT: When payment is received at the time of the visit, the fee is discounted 5%. Otherwise charges are based upon \$115.00 per hour which is prorated according to the consultation time. Also, to promote recycling a discount is offered on glass bottles that are refilled in the office.

PAYMENTS: Payment is due at the time of the visit unless other arrangements are made prior to the visit with the doctor. Dispensary and lab fees must be paid at the time of the visit. The credit limit per person is \$100.00 (\$200.00/family), subject to approval.

INSURANCE: If you have insurance that covers naturopathic out-patient services, we prefer that you make payment at the time of the visit and handle your own reimbursement with your insurance company. There is a \$14.00 charge for time spent on insurance documentation.

PAST DUE ACCOUNTS: A monthly finance charge of 1.5% is assessed to all balances 30 days past the due date (60 days). Past due accounts with no payment activity for 90 days are subject to possible third party collection efforts.

DELIVERY: Afterhours delivery within the metro area is available for a flat charge of \$20.00, weather permitting.

CHANGE OF ADDRESS: We request that you keep your file current by informing us of any change of address or telephone numbers. We look forward to working with you.

I have read this policy statement and understand its contents.

Signature_____

905 JEFFERSON AVE., SUITE 202 • ST. PAUL, MN • 55102

PHONE: 651-222-4111 • FAX: 651-222-8758

EMAIL: WELLSPRINGCLINIC@MSN.COM

WEBSITE: HELENHEALYND.COM

MEMBER A.A.N.P.

PATIENT INFORMED CONSENT

This Informed Consent is required by Minnesota Statute 147E in order that you, the patient, are aware of the nature of Helen C. Healy, ND's practice in naturopathic medicine. The Minnesota Board of Medical Practice has required that each individual seeing Helen C. Healy, ND read this form and sign it prior to initial consultation or treatment.

I, (print name) _____, UNDERSTAND THAT:

1. Helen C. Healy, ND is fully credentialed and registered to practice naturopathic medicine in the State of Minnesota, pursuant to Minnesota Statute 147E. Her active registration number is 1007.
2. Dr. Healy received her four-year naturopathic medical training at the National College of Naturopathic Medicine in Portland, Oregon, and graduated in 1983.
3. Dr. Healy passed all the Oregon Board examinations and received her Oregon license in 1983 to practice as a naturopathic doctor. She maintains this license as well.
4. Dr. Healy, to the best of her ability, will present treatment facts and options accurately, and will make recommendations according to standards of good naturopathic medical practice.
5. The scope of practice of a registered naturopathic doctor in the State of Minnesota includes, but is not limited to, the following services: (a) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, glandular, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease; (b) performing or ordering physical examinations and physiological functions tests; (c) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);(d) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results; (e) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; (f) prescribing or performing naturopathic physical medicine; and, (g) admitting patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.
6. A registered naturopathic doctor is **not** allowed to: (a) administer therapeutic ionizing radiation or radioactive substances; (b) administer general or spinal anesthesia; (c) prescribe, dispense, or administer legend drugs or controlled substances including chemotherapeutic substances; (d) perform or induce abortions; or (e) perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue.
7. A registered naturopathic doctor is **not** allowed to practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietitian, nutritionist, or any other health care professional, unless the registered naturopathic doctor also holds the appropriate license or registration for the health care practice profession.
8. Potential risks include allergic reactions to prescribed herbs and supplements, side effects of natural medications, and/or the inconvenience of lifestyle changes.
9. All female patients must alert Dr. Healy if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.
10. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Helen C. Healy, ND or any of her personnel 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 have read and understand the statements above. Dated: _____

Signature: _____

**Driving Directions to
Wellspring Naturopathic Clinic
905 Jefferson Ave, Suite 202,
St Paul, MN 55102
651-222-4111**

From the East, take 94 West:

Take 94 West to 35E South

Take the Victoria Exit, turn left. The next street is Jefferson Ave, turn right.

Office building is approximately ½ block on the right-905 Jefferson, Ste 202

From the West, take 94 East:

Take the Lexington exit; turn right (South);

Travel South crossing over Summit, Grand and St. Clair (theses are all stoplights);

The next stoplight is Jefferson, turn left.

Go down the hill under the 35E overpass;

Office building is on the left – 905 Jefferson, Suite 202

From the South, take 35E North:

Take the Randolph exit, turn right;

Go 2 blocks to Milton, turn left;

Go 4 blocks to Jefferson, turn right; office building is on the left, 905 Jefferson, Ste 202

From the North, take 35E South:

Take 35E into St Paul, take the Victoria exit, turn left;

At the first stop sign, turn right (Jefferson); office building is on the right;

905 Jefferson, Suite 202