PSR _____

PSR _____

BASTYR UNIVERSITY

Patient Registration

PLEASE WRITE LEGIBLY

Patient Name: _____
Last Name First Name Middle Initial

What is your preferred first name? (Nickname, Chosen name, etc.) _____

Other name(s) that records may be kept under:_____

DOB (required)_____ SSN:_____

Address:_____

City:_____State:_____Zip Code: _____

Email address:_____

Phone: *Appointment reminders will be sent to 1st preference.*

1. □ Cell □ Home □ Work: (_____)_____ **Confidential voicemail OK?** Yes No

2. □ Cell □ Home □ Work: (_____)_____ **Confidential voicemail OK?** Yes No

The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Your answers are both voluntary and private.

What is your birth sex? □ Male □ Female □ Unknown □ Another: _____

What gender do you identify as? □ Male □ Female □ Trans □ Another: _____

What is your pronoun? □ He □ She □ They □ Another: _____

Primary Language:_____

Ethnic Group (Select One): □ Latino/Latina/Hispanic □ Non-Hispanic

Race (Select all that apply): □ Alaskan Native □ American Indian □ Asian □ Black □ Native Hawaiian □ Pacific Islander □ White □ Other/Unknown_____

Are you active Military or a US Veteran? □ Yes □ No

Employment Status (Check one): □ Full Time □ Not Employed □ Part Time □ Retired □ Seasonal □ Self-Employed □ Student (Full Time) □ Student (Part Time) □ BCNH Student □ BCNH Staff/Spouse

Occupation:_____Hours per Week: _____

Employer:_____Address:_____

Marital Status: □ Single □ Married □ Significant other □ Widowed

Primary Care Provider (PCP) Information (Please select one of the following):

□ I wish to establish Primary Care with BCNH.

□ I see BCNH for ancillary/adjunctive care only. My Primary Care Physician (PCP) is: _____

□ If seeking adjunctive cancer support, who is your oncologist? _____

- Last physical: _____ Date of Last bloodwork: _____

□ Other providers: _____

PATIENT REGISTRATION FORM CONTINUED

Guarantor (Person who is financially responsible for the account):

Name:_____ Relationship to the patient: _____

Address (if different from patient): _____

City:_____ State:_____ Zip:_____

Social Security Number: _____ Gender: □ M □ F DOB:_____

Emergency Contact/Other Guardian Name: _____

Relationship: _____ Legal Guardian? □ Yes □ No

Primary Phone:_____Work Phone: _____

Please provide your insurance information below:

Primary Insurance Company: _____ Group # _____

Member ID #_____ Relationship to Subscriber:_____

Claims Address: _____

Subscriber Name (if other than patient):_____ DOB: _____

Secondary Insurance Company: _____ Group # _____

Member ID #_____ Relationship to Subscriber:_____

Claims Address: _____

Subscriber Name (if other than patient):_____ DOB: _____

Check if applicable: □ Auto Accident □ Workers compensation Date of Accident: _____ Claim#:_____

****Please be prepared to present your insurance card at check-in at each visit****

How did you hear about us?

□ Friend/patient □ Event/health fair □ Shuttle/Bus □ Staff/student □ Physician: _____

□ Radio/TV □ Walk by □ Social media □ Yelp □ Website: _____

□ Please sign me up for the Clinic newsletter so I can stay up to date regarding clinic hours, events and discounts.

Research is vital to the advancement of natural medicine. If Bastyr has a research study, I can help with:

□ Yes! Please contact me for future research participation

I certify the above information is true and correct to the best of my knowledge. I acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

_____ _____

Patient/Guardian Signature **Date**

BASTYR UNIVERSITY

PERSONAL HEALTH HISTORY for YOUR CLINICAL TEAM

Patient:_____Date of Birth:_____
Last Name First Name Middle Initial

What is the main reason, or goal, for your visit today? _____

_____

Allergies: Do you have a severe allergy to any of the following? (**Please select all that apply)**

☐ Sulfa ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Latex ☐ Sulfites
☐ Cats ☐ Dogs ☐ Mold ☐ Dust ☐ Bees ☐ Pollen
☐ Wheat ☐ Shellfish ☐ Peanuts ☐ Eggs ☐ Milk ☐ Soy
☐ Other _____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking.
If you need additional space to list medications/supplements, please use page 6 or the back of page 7.

Name of Medication/Supplement	Dose	Frequency Taken

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

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

Surgeries / Hospitalizations: (Please select all that apply and write in date.)

- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ C-Section (If applicable)
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy (If applicable)
- ☐ Joint Replacement
- ☐ Prostate Surgery (If applicable)
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation (If applicable)
- ☐ Valve Replacement
- ☐ Vasectomy (If applicable)
- ☐ Other:

Family History: Do you have a family history of any of the following?
(Please "X" the boxes that apply to you)

	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems	Other
Mother															
Father															
Sister															
Brother															
Maternal Grandma															
Maternal Grandpa															
Paternal Grandma															
Paternal Grandpa															
Maternal Aunt															
Maternal Uncle															
Paternal Aunt															
Paternal Uncle															
Other															

☐ Adopted ☐ Family History Unknown

Social History: Please answer the following questions regarding your social history:

Tobacco Use

Tobacco Use: ☐ Never Smoker ☐ Former Smoker ☐ Passive Smoke Exposure (Second Hand) ☐ Current Smoker
☐ Other
Start Date:_____ End Date:_____
Type of tobacco used: ☐ Cigarettes ☐ Cigars ☐ Pipe
Packs/Day:_____ Years:_____
Smokeless Tobacco: ☐ Current User ☐ Former User ☐ Never Used ☐ Unknown
Types: ☐ Snuff ☐ Chew
Quit Date (if applicable):_____
If you are a current tobacco user: Are you ready to quit? ☐ Yes ☐ No

Do you drink alcohol?	☐ Yes	☐ No

If Yes, how many of the following do you have per week?
Drinks/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	☐ Marijuana	☐ Opioids	☐ Heroin
☐ Methamphetamine	☐ Amphetamines	☐ PCP	☐ Ecstasy
☐ LSD	☐ Ketamine	☐ Mescaline	☐ Psilocybin
☐ Cocaine	☐ Crack	☐ Nitrous Oxide	☐ Solvent Inhalants
☐ Barbiturates	☐ Benzodiazepines	☐ IV	☐ Other

If yes to Marijuana: □ Medicinal? □ Recreational? □ Both?
If yes to any of the drugs above how many times per week estimate do you use them? _____

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

Sexually Active: ☐ Yes ☐ No

Birth Control/Protection:

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

Partners? ☐ Male ☐ Female ☐ Both ☐ Another

Sexual Orientation/Gender Identity (this helps our clinicians give you the best care possible)**:**

What is your birth sex?	☐ Male	☐ Female	☐ Unknown	☐ Another:_____
What gender do you identify as?	☐ Male	☐ Female	☐ Trans	☐ Another:_____
What is your pronoun?	☐ He	☐ She	☐ They	☐ Another:_____

Do you have any children? Yes No If so, what are their ages:

Do you exercise regularly? Yes No If so, how often and what type of exercise?

Do you have any dietary restrictions or food intolerances? Yes No If so, what?

Additional Medications/Supplements?

Name of Medication/Supplement	Dose	Frequency Taken

CONTINUED ON NEXT PAGE

Review of Systems: **Please circle below if you've experienced in the last six months:** **Y= Yes N= No**

Constitutional

Fever	Y	N	Chills	Y	N	Weight Loss	Y	N
Malaise/Fatigue	Y	N	Sweating	Y	N	Weakness	Y	N

Skin

Rash	Y	N	Itching	Y	N	Color changes	Y	N

Head, Ears, Eyes, Nose, Throat

Headaches	Y	N	Hearing Loss	Y	N	Ringing in Ears	Y	N
Ear Pain	Y	N	Ear Discharge	Y	N	Nosebleeds	Y	N
Congestion	Y	N	Migraine headaches	Y	N	Sore Throat	Y	N

Eyes

Blurred Vision	Y	N	Double Vision	Y	N	Light Sensitivity	Y	N
Eye Pain	Y	N	Eye Discharge	Y	N	Eye Redness	Y	N

Cardiovascular

Chest Pain	Y	N	Palpitations	Y	N	Shortness of breath lying down	Y	N
Claudication	Y	N	Leg Swelling	Y	N	Heart Murmur	Y	N
High blood pressure	Y	N	Blood clots	Y	N	Heart disease	Y	N

Respiratory

Cough	Y	N	Coughing up Blood	Y	N	Sputum Production	Y	N
Shortness of breath	Y	N	Wheezing	Y	N	Asthma	Y	N

Gastrointestinal

Heartburn	Y	N	Nausea/Vomiting	Y	N	Abdominal Pain	Y	N
Diarrhea	Y	N	Constipation	Y	N	Blood in Stool/black stool	Y	N
How many Bowel Movements per day:			Bloating	Y	N			

Genitourinary

Painful Urination	Y	N	Urgency	Y	N	Frequency	Y	N
Blood in urine	Y	N	Flank Pain	Y	N	Incontinence	Y	N

Male Reproductive

Hernias	Y	N	Testicular masses	Y	N	Sexual difficulty	Y	N

Female Reproductive

Age of first menses:	Age of last menses:	Number of pregnancies:
Number of live births:	Number of miscarriages:	Number of abortions:

Musculoskeletal

Muscle Pain	Y	N	Neck Pain	Y	N	Back Pain	Y	N
Joint pain	Y	N	Falls	Y	N	Muscle spasms	Y	N

Endocrine/Heme/Allergies

Excessive thirst	Y	N	Env. Allergies	Y	N	Easy Bruising/Bleeding	Y	N
Cold intolerance	Y	N	Excessive hunger	Y	N	Heat intolerance	Y	N

Neurological

Dizziness/fainting	Y	N	Loss of memory	Y	N	Tremor/Seizures	Y	N
Sensory Change	Y	N	Speech Change	Y	N	Numbness/tingling	Y	N

Emotional (Psychiatric)

Depression	Y	N	Insomnia	Y	N	Substance Abuse	Y	N
Hallucinations	Y	N	Nervous/Anxious	Y	N			

Global Health

Please respond to each question or statement by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09r	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc).....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
Global10r	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		None	**Mild**	**Moderate**	**Severe**	**Very severe**
Global08r	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Global07r	How would you rate your pain on average?	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst pain imaginable**