Vital Source Natural Medicine

Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225

p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

Adult Intake Packet

Welcome to Vital Source Medicine, PLLC. In order to provide you with the best possible care, we ask you to complete this form in its entirety. It will be greatly appreciated if you can either mail (with sufficient time), fax, email, or drop this form off at the clinic prior to your appointment along with any pertinent lab/imaging records so that Dr. Van Dusen can review your health history ahead of time. Otherwise, just bring it completed with you to your appointment. Thank you!

Personal Information

Name: _____ Date: _____

Address: _____City, State, Zip: _____

Telephone: (home): _____ (work): _____(cell): _____

Preferred number for messages and appointment reminders?_____

Can Vital Source Natural Medicine identify themselves when leaving a message?_____

Is it okay to leave a message with detailed information?_____

E-mail: _____ Driver's license #, State: _____

Age: _____ Date of Birth: _____ Birth Gender: F M Identified Gender: F M GN

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____ Partnership: _____

Live with: Friends _____ Spouse _____ Partner _____ Parents _____ Children _____ Alone _____

Occupation: _____ # hrs/wk:_____ Retired:_____

Employer: _____

What is your ethnic heritage and/or cultural upbringing? _____

Have you ever seen a Naturopathic Physician before? yes___ no ___

Which one? _____

How did you hear about this clinic? _____

May we thank them for the referral? yes ___ no ___

Emergency Contact: _____

Relationship: _____Phone:_____

Current Health History

Do you have a primary care doctor? Y / N

Name:_____

Other healthcare providers you see on a regular basis: _____

_____

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What are your **most important health concerns**?

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Family History

Please fill in any health conditions for the following biological relatives. If they are deceased, please include age and cause of death.

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Maternal Aunts/Uncles: _____

Father: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Paternal Aunts/Uncles: _____

Sister/brother: _____

Childhood Illnesses

Please circle whether you had any of the following as a child:

Scarlet fever	Allergies	Rheumatic Fever
Mumps	Measles	Rubella
Chicken pox	Mononucleosis	Frequent infections
Eczema		

Immunizations

Polio	Y	N	Diphtheria	Y	N
Tetanus	Y	N	Pertussis	Y	N
Measles/Mumps/Rubella	Y	N	HPV	Y	N

Other: _____

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Past Medical History: Hospitalizations, Surgeries, Major Events

What hospitalizations, surgeries, and other major past medical history have you had?

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

Allergies

Are you hypersensitive or allergic to…(please explain the type of reaction)

Any drugs? _____

Any foods? _____

Environmental allergens/chemicals? _____

Exposures

Have you had daily or prolonged exposure to any toxic chemicals, paints, lead, mercury? Y N

If **yes**, what type and when?_____

Second hand smoke? Y N From age: _____ to age: _____

Current Medications and Supplements

Please list **any** prescription medications, over the counter medications, vitamins, herbs, or other supplements you are currently taking or use frequently. Include the dosage and potency.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Habits

Main interests and hobbies: _____

Do you exercise? Y N If yes, how often? _____

What type? _____

What behaviors or lifestyles habits do you engage in regularly that you believe support your health?

What behaviors or lifestyles habits do you engage in regularly that you believe are harmful to your health?

What is your present level of commitment toward addressing any underlying causes of your symptoms (0-100%)?

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Diet

Do you follow a specific diet? Please explain: _____

Typical Food Intake (on an average day):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water: _____ oz/day Coffee: _____ oz/day Other beverages: _____

Desserts/sweets: _____ How often? _____

General

Height: _____ Weight: _____lbs

Maximum weight: _____ When? _____

Rate your average energy (1-10): _____ Is this a change? Y N

At what time of the day is your energy at its best? _____ Worst? _____

Please rate your stress level on a scale of 1-10: _____

How is your mood? _____

For the following, please circle Yes, No, or Past

Average hours of sleep per night:				Enjoy your work?	Y	N	
Sleep well?	Y	N		Take vacations?	Y	N	
Awaken rested?	Y	N		Spend time outside daily?	Y	N	
In a supportive relationship?	Y	N	P	TV use (hours/day):			
Use recreational drugs?	Y	N	P	Computer use (hours/day):			
Please list type/frequency:				Reading (hours/day):			
Use alcoholic beverages?	Y	N	P	Eat 3 meals a day?	Y	N	
# of drinks/wk:				Do you eat out often?	Y	N	
Treated for alcoholism?	Y	N	P	Eat refined sugar?	Y	N	
Use tobacco?	Y	N	P	Do you add salt?	Y	N	
How many years?				Have a spiritual practice?	Y	N	
How many cigarettes per day?				If yes, what?			
Year quit (if applicable):							

Review of Systems

Y = condition you have now N = never had P = significant problem in the past

Mental/ Emotional

Treated for emotional problems?	Y	N	P	Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P	Mood swings?	Y	N	P
Considered /Attempted Suicide?	Y	N	P	Tension/easily stressed?	Y	N	P
Poor Concentration?	Y	N	P	Eating disorder?	Y	N	P
Seasonal Affective Disorder?	Y	N	P				

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Head

Headaches?	Y	N	P	Head injury?	Y	N	P

Eyes

Dryness?	Y	N	P	Glaucoma?	Y	N	P
Impaired vision?	Y	N	P	Glasses or contacts?	Y	N	P
Cataracts?	Y	N	P	Eye pain/ strain?	Y	N	P
Tearing?	Y	N	P				

Ears

Impaired hearing?	Y	N	P	Ringing?	Y	N	P
Earaches?	Y	N	P	Frequent ear infections?	Y	N	P

Nose and Sinuses

Frequent colds?	Y	N	P	Nose bleeds?	Y	N	P
Sinus problems/stuffiness?	Y	N	P	Loss of smell?	Y	N	P

Mouth and Throat

Frequent sore throat?	Y	N	P	Mouth sores?	Y	N	P
Hoarseness?	Y	N	P	Jaw/TMJ problems?	Y	N	P
Teeth grinding?	Y	N	P	Gum problems?	Y	N	P
Frequent dental cavities?	Y	N	P				

Neck

Lumps in neck?	Y	N	P	Difficulty swallowing?	Y	N	P

Respiratory

Recurrent cough?	Y	N	P	Sputum?	Y	N	P
Asthma?	Y	N	P	Wheezing?	Y	N	P
Bronchitis?	Y	N	P	Coughing blood?	Y	N	P
Shortness of breath?	Y	N	P	Pain when breathing?	Y	N	P
Chronic lung disease?	Y	N	P	Pneumonia?	Y	N	P

Cardiovascular

Heart disease?	Y	N	P	High blood pressure?	Y	N	P
Blood clots?	Y	N	P	Low blood pressure?	Y	N	P
Murmurs?	Y	N	P	Fainting?	Y	N	P
Heart attack?	Y	N	P	Palpitations/fluttering?	Y	N	P
Rheumatic fever?	Y	N	P	Chest pain?	Y	N	P
Stroke?	Y	N	P				

Gastrointestinal

Change in appetite?	Y	N	P	Nausea?	Y	N	P
Vomiting?	Y	N	P	Ulcer?	Y	N	P
Liver disease?	Y	N	P	Gallbladder disease?	Y	N	P
Pancreatitis?	Y	N	P	Hemorrhoids?	Y	N	P
Abdominal pain/cramping?	Y	N	P	Heartburn?	Y	N	P
Constipation?	Y	N	P	Belching/passing gas?	Y	N	P
Blood in stool?	Y	N	P	Diarrhea/loose stools?	Y	N	P
Have you had a Colonoscopy?	Y	N		# of bowel movements/day:	_____		
Date: _____ Was it normal?	Y	N		Is this a change?	Y	N	

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Urinary

Increased urinary frequency?	Y	N	P	Inability to hold urine?	Y	N	P
Pain with urination?	Y	N	P	Kidney stones?	Y	N	P
Frequent urinary tract infection?	Y	N	P	Kidney disease?	Y	N	P
Abnormal color/odor of urine?	Y	N	P	Frequency at night (more than once)?	Y	N	P

Male Reproductive

Hernias?	Y	N	P	Testicular Masses?	Y	N	P
Testicular pain?	Y	N	P	Condyloma (warts)?	Y	N	P
Enlarged prostate (BPH)?	Y	N	P	Discharge or sores?	Y	N	P
Are you sexually active?	Y	N	P	Chlamydia?	Y	N	P
Sexual orientation?				Gonorrhea?	Y	N	P
Impotence?	Y	N	P	Syphilis?	Y	N	P
Premature ejaculation?	Y	N	P	Herpes?	Y	N	P
Low sex drive?	Y	N	P	Fertility issues?	Y	N	P
Prostate exam?	Y	N		PSA check?	Y	N	
Date: _____ Was it normal?	Y	N		Date: _____ Was it normal?	Y	N	

Female Reproductive

Age of first menses?				Nipple discharge?	Y	N	P
Age of last menses?(if menopausal)				Vaginal odor?	Y	N	P
# of days between cycles:			days	Vaginal pain?	Y	N	P
Duration of menstruation:			days	Vaginal itching?	Y	N	P
Are cycles regular?	Y	N	P	Vaginal discharge?	Y	N	P
Painful menses?	Y	N	P	Endometriosis?	Y	N	P
Heavy or excessive flow?	Y	N	P	Ovarian cysts?	Y	N	P
Bleeding between cycles?	Y	N	P	Fibroids?	Y	N	P
PMS?	Y	N	P	Number of pregnancies?			
If yes, what are your symptoms?				Number of live births?			
				Number of miscarriages?			
Clotting?	Y	N	P	Number of abortions?			
Are you sexually active?	Y	N	P	Ectopic pregnancies?			
Sexual orientation?				Menopausal symptoms?	Y	N	P
Pain during intercourse?	Y	N	P	Gonorrhea?	Y	N	P
Low sex drive?	Y	N	P	Chlamydia?	Y	N	P
Difficulty conceiving?	Y	N	P	Condyloma (warts)?	Y	N	P
Birth control?	Y	N	P	Herpes?	Y	N	P
What type?				Syphilis?	Y	N	P
Do you do self breast exams?	Y	N	P	Date of last PAP?			
Breast pain/ tenderness?	Y	N	P	Abnormal PAP?	Y	N	P
Breast lumps?	Y	N	P	Cervical dysplasia?	Y	N	P
Mammogram/Thermography?	Y	N		Dexa Scan (bone density)	Y	N	
Date: _____ Was it normal?	Y	N		Date: _____Was it normal?	Y	N	

Immune

Reactions to immunizations?	Y	N	P	Auto-immune disease?	Y	N	P
Night sweats?	Y	N	P	Chronic infections?	Y	N	P
Chronically swollen glands?	Y	N	P	Cancer?	Y	N	P

Endocrine

Heat intolerance?	Y	N	P	Hypothyroid?	Y	N	P

Cold intolerance?	Y	N	P	Hyperthyroid?	Y	N	P
Excessive Thirst?	Y	N	P	Excessive Hunger?	Y	N	P
Fatigue?	Y	N	P	Diabetes?	Y	N	P
Hair loss?	Y	N	P	Hypoglycemia?	Y	N	P

Musculoskeletal

Joint pain or stiffness?	Y	N	P	Sciatica?	Y	N	P
Broken bones?	Y	N	P	Weakness?	Y	N	P
Muscle spasms or cramps?	Y	N	P				

Neurological

Seizures?	Y	N	P	Numbness or tingling?	Y	N	P
Loss of balance?	Y	N	P	Vertigo or dizziness?	Y	N	P
Loss of memory?	Y	N	P				

Skin

Rashes?	Y	N	P	Eczema?	Y	N	P
Acne, Boils?	Y	N	P	Itching?	Y	N	P
Color changes?	Y	N	P	Hives?	Y	N	P
Lumps?	Y	N	P	Brittle nails?	Y	N	P
Dry skin?	Y	N	P				

Blood/ Peripheral Vascular

Easy bleeding?	Y	N	P	Anemia?	Y	N	P
Blood clots?	Y	N	P	Cold hands/ feet?	Y	N	P
Varicose veins?	Y	N	P	Slow wound healing?	Y	N	P
Easy bruising?	Y	N	P	Leg/ankle swelling/edema?	Y	N	P

Date of last routine bloodwork: _____

Any information about you and your health that you would like to add?_____

_____

_____

_____

_____

Thank you for taking time to help me better understand your whole health. I look forward to working with you. If you have any questions please ask! *~ Dr. Van Dusen*

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Consent to Treatment

At Vital Source Natural Medicine we believe in treating people, not disease. Therefore, each individual patient will receive a treatment plan that is specifically developed for them. Treatments at Vital Source Natural Medicine include such therapeutic procedures as manual soft tissue work, Craniosacral and Core Synchronism therapy, nutritional consultation and supplementation, herbal therapy, homeopathy, hydrotherapy, and lifestyle counseling. Other forms of treatment include intramuscular vitamin injections and certain pharmaceuticals. It is understood that while our practices and procedures are safe and effective, not everyone responds the same way to different treatments, and occasionally side effects or complications may arise.

While the risk of complications or side effects from any of the above treatments is very rare, it is our policy to inform our patients about them. These complications may include, but are not limited to: soreness, bruising, inflammation, burns, infection, allergic reactions, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications of specific treatments is available upon request.

The way in which we choose to treat people will often be different than the conventional care of an MD. It is our policy to always present you with information about your condition, the procedure being performed, any risks, and alternative options available to you. If our explanation is not to your satisfaction, please ask for more information.

Please recognize that the care you receive at Vital Source Natural Medicine is voluntary. By signing this form, you are voluntarily consenting and authorizing our treatments and procedures. Please understand that you may refuse treatment and/or procedures at any time during your course of therapy and such requests will be respected.

By signing below, I acknowledge that I have read and understand the above statements regarding treatments and side effects. I understand that during my course of treatment at Vital Source Natural Medicine, I will be given an opportunity to ask questions about my condition. I will also be given the opportunity to ask questions regarding the benefits, risks, and alternatives to treatments offered. I understand that no guarantee has been made as to the result of my care at Vital Source Natural Medicine.

I hereby consent to examination and treatment with naturopathic medicine and/or Craniosacral and Core Synchronism therapy by Dr. Jessica Van Dusen at Vital Source Natural Medicine, PLLC.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature or Guardian if patient is a minor Date

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Payment Agreement

Please read and **initial** the following statements. Feel free to ask if you have any questions about our policies.

_____ Payment for all services and medicinary items is due at the time of the visit. Payment may be made by cash, check, Visa, or MasterCard. Returned checks will be subject to a $35.00 non-sufficient funds fee.

_____ You will be charged a missed appointment fee of $35.00 for any missed appointments or late cancellations (less than 24 hours notice), emergencies excluded. If more than 1 appointment is missed or cancelled late, you will either be responsible for the full cost of the scheduled visit or will forfeit your right to re-schedule.

_____ You will be responsible for any additional expenses beyond office visits incurred in connection to your health care provided at Vital Source Natural Medicine. Such expenses may include postage, phone calls to our office wherein medical advice is provided to you (other than brief clarifying questions regarding your current treatment plan), or laboratory fees. If we make a payment for you, or on your behalf, you will need to reimburse the clinic promptly. You will always be informed of these charges in advance if/when this comes up.

I have read and understand the above-stated policies of Vital Source Natural Medicine, PLLC and will comply with them in all respects. If my insurance company requires release of my medical records for payment purposes, I hereby give my permission by signing this form.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature (Parent/guardian signature if minor) Date

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Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care.

It is important that you understand that your information can be used and shared in the following ways:

- For your treatment (i.e. to contact you or to manage your care) and care coordination (multiple health care providers may be involved in your treatment directly and indirectly).
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease).
- In response to a court or administrative order.
- For research.
- To bill you or to obtain payment from third party payers.
- We may share your health information with a person(s) that *you have named* to be involved with your healthcare.

You have the following rights relating to your protected health information:

- To inspect your health record and receive a copy of your health record upon request.
- To request limits on the use or disclosure of your protected health information.
- To ask us not to share information with your health insurer regarding a service or health care item for which you have paid out-of-pocket in full.
- To choose someone to exercise your rights and make choices about your health information if you have named that person your medical power of attorney or if that person is your legal guardian.
- To request that your physician amend information in your health record you believe is inaccurate or incomplete.
- To receive an accounting of certain disclosures we have made, if any, of your protected health information.
- To receive a copy of this notice upon request.

You have the right to receive confidential communications from us by alternative means or at an alternative location if you choose. Please tell us how to best contact you when needed:

___Please do not phone me at home. Use this alternate phone number:_____

___Please do not phone me at work. Use this alternate phone number: _____

___Please do not leave messages on my voicemail.

___Please do not contact me by email.

___Please send mail, including my bills, to this alternate address:_____

___Other request (please describe): _____

You can complain if you feel we have violated your rights by contacting us or you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

I give permission for Vital Source Natural Medicine to share my personal health information with the following person upon their request: Name: _____ DOB: _____ Relationship: _____

By signing below, I acknowledge that I have received and read this notice of privacy practices:

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ ___/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

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E-Mail Agreement

Vital Source Natural Medicine may use e-mail to correspond with patients as a convenience. This includes appointment reminders and occasional clinic e-newsletters. Dr. Van Dusen and/or clinic staff will never initiate communication regarding personal health information over e-mail. Communication regarding lab results, changes to your treatment plan, or other matters pertaining to your healthcare will always take place over the phone unless you request otherwise. If you choose to ask questions regarding your treatment plan or health information via e-mail to Dr. Van Dusen, understand that this is not a secure way to do so.

I have been advised that:

E-mail is never, ever appropriate for urgent or emergency problems.

E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.

E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.

There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.

All e-mail correspondence will become a part of my medical record at Vital Source Natural Medicine. It is extremely important to include my name on each and every e-mail sent to the clinic.

Since e-mail may not be monitored while Dr. Van Dusen is out of the office, I will follow-up by telephone or in person if I do not receive a response within a reasonable time frame for the nature of my question.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between myself and Vital Source Natural Medicine, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting Vital Source Natural Medicine.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print e-mail address clearly:_____

Printed Name: _____

Signature:_____ Date:_____