

*Inside Passage
Midwifery and Natural Medicine, LLC*

Client Information/Registration

Date: _____ Social Security Number: _____
Name: First _____ Middle. _____ Last: _____
Address: _____ City: _____ Zip: _____
Mailing Address: _____
Home Phone: _____ Cell/other phone: _____
Birth date: _____ Marital Status: _____ Race: _____
Employer: _____ Occupation _____
Work Status: Full ___ Part time ___ Retired ___ Student ___
Spouse/Partner's Name: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Primary Insurance Holder. If same as above leave blank)

First Name: _____ M.I. _____ Last Name: _____
Address: _____
Home Phone: _____ Birth date: _____ Marital Status: S M D W
Social Security Number: _____ Employer: _____
Occupation: _____
Work Status: Full ___ Part time ___ Retired ___ Student ___

Payment and Insurance Information

Primary Insurance: _____
Address: _____
Phone Number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Other Insurance: _____
Address: _____
Phone number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Assignment of Benefits, Release of Information & Payment Agreement

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Inside Passage Midwifery and Natural Medicine will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Inside Passage.

I permit Inside Passage to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act)

I agree that I am responsible for full payment on this account.

Client signature: _____ Date: _____
Responsible Party (if different): _____ Date: _____

Inside Passage Natural Medicine

800 Glacier Avenue

Juneau, AK 99801

(907) 463-2600

INSURANCE AND FINANCIAL INFORMATION

I understand and agree that health and accident insurance are an arrangement between an insurance company and me. I hereby authorize Debbie Gillespie ND to furnish medical information to my insurance carriers concerning this condition. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

As a courtesy, we will bill your insurance company for you. Any amount not covered by your plan will be billed to you monthly. Vitamins and other supplements are not typically covered by insurance. If this naturopathic doctor recommends supplements as part of the treatment plan, you will be responsible for those costs should you choose to purchase them from Inside Passage or elsewhere.

In accordance with State of Alaska Naturopathic Regulations (12 AAC 42.900) please be advised that Deborah Gillespie is a Naturopath licensed by the state of Alaska. She earned her degree at Southwest College of Naturopathic Medicine and Health Sciences, which is accredited by the Council on Naturopathic Medical Education, the accrediting agency for naturopathic colleges and programs in the United States and Canada. She is not covered by malpractice insurance at this time.

Please also be advised that in addition to her Naturopathic practice, Dr. Gillespie is also a midwife. There is a possibility your appointments may need to be rescheduled in event of a labor/birth. Every effort will be made to reach you with as much notice as possible should the situation arise.

If you are unable to make your scheduled appointment, please call to cancel within 24 hours or as soon as possible.

By signing below, I have read and understand this policy.

Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian signature: _____

Context of Care Review

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the person physically, mentally and emotionally. The nature of your responses to the following questions will go a long way in assisting my understanding of your needs. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

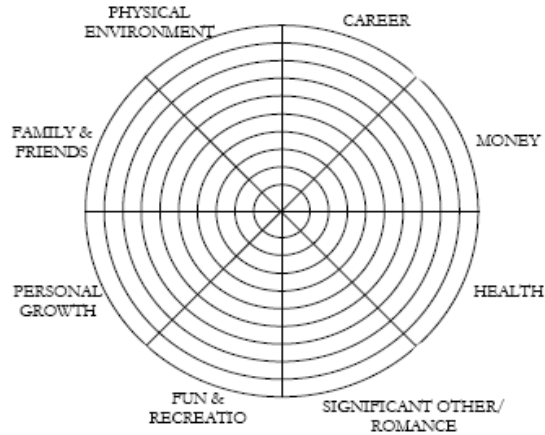
1. Why did you choose to see me?
2. What do you know about my approach?
3. What **three** expectations do you have from **this** visit?
4. What **long term** expectations do you have from working with me?
5. What expectations do you have of me personally as your health care provider?
6. What is your present level of commitment to address any underlying causes of the symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed
0% 0 1 2 3 4 5 6 7 8 9 10 100%
7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?
8. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols while I will be sharing with you?
9. Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?
10. What do you love to do?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

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

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay Fever	Hives	

Any other relevant family history? _____

CHILDHOOD ILLNESSES

Please circle whether you have had any of the following:

Rheumatic fever	Diphtheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATIONS / SURGERY / IMAGING

What hospitalizations, surgeries x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____	_____ year _____
_____ year _____	_____ year _____
_____ year _____	_____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any medications? _____

Any foods? _____

Any environmental or chemical allergies? _____

CURRENT MEDICATIONS

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

- | | |
|-----------|-----------|
| 1.) _____ | 5.) _____ |
| 2.) _____ | 6.) _____ |
| 3.) _____ | 7.) _____ |
| 4.) _____ | 8.) _____ |

NEUROLOGIC

Seizures	Y	N	P
Muscle weakness	Y	N	P
Loss of memory	Y	N	P
Vertigo or dizziness	Y	N	P
Paralysis	Y	N	P
Numbness or tingling	Y	N	P
Easily stressed	Y	N	P
Loss of balance	Y	N	P

HEAD

Headaches	Y	N	P
Migraines	Y	N	P
Head injury	Y	N	P
Jaw or TMJ problems	Y	N	P

NOSE AND SINUS

Frequent colds	Y	N	P
Stuffiness	Y	N	P
Sinus problems	Y	N	P
Nose bleeds	Y	N	P
Hayfever	Y	N	P
Loss of smell	Y	N	P

RESPIRATORY

Cough	Y	N	P
Sputum	Y	N	P
Asthma	Y	N	P
Wheezing	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Difficulty breathing	Y	N	P
Shortness of breath	Y	N	P
Pain with breathing	Y	N	P
Emphysema	Y	N	P
Tuberculosis	Y	N	P

GASTROINTESTINAL

Trouble swallowing	Y	N	P
Change in thirst	Y	N	P
Change in appetite	Y	N	P
Nausea/vomiting	Y	N	P
Ulcer	Y	N	P
Jaundice	Y	N	P
Gall bladder disease	Y	N	P
Liver disease	Y	N	P
Hemorrhoids	Y	N	P
Pancreatitis	Y	N	P
Heartburn	Y	N	P

EYES

Impaired Vision	Y	N	P
Cataracts	Y	N	P
Glaucoma	Y	N	P
Spots in vision	Y	N	P
Color blindness	Y	N	P
Tearing or dryness	Y	N	P
Eye pain or strain	Y	N	P
Double vision	Y	N	P

NECK

Lumps in neck	Y	N	P
Goiter	Y	N	P
Difficulty swallowing	Y	N	P
Pain or stiffness	Y	N	P

MOUTH AND THROAT

Frequent sore throat	Y	N	P
Dental cavities	Y	N	P
Hoarseness	Y	N	P
Jaw clicks	Y	N	P
Teeth grinding	Y	N	P
Gum problems	Y	N	P

CARDIOVASCULAR

Heart disease	Y	N	P
Angina	Y	N	P
High/Low blood pressure	Y	N	P
Heart murmurs	Y	N	P
Blood clots	Y	N	P
Fainting	Y	N	P
Phlebitis	Y	N	P
Palpitations	Y	N	P
Chest pains	Y	N	P
Rheumatic fever	Y	N	P
Swelling in ankles	Y	N	P

SKIN

Rashes	Y	N	P
Acne/boils	Y	N	P
Change in skin color	Y	N	P
Eczema or hives	Y	N	P
Itching	Y	N	P
Perpetual hair loss	Y	N	P

MENTAL / EMOTIONAL

Treated for emotional problems	Y	N	P
Depression	Y	N	P
Anxiety or nervousness	Y	N	P

GASTROINTESTINAL CONT.

Abdominal pain or cramps Y N P
 Belching or passing gas Y N P
 Constipation Y N P
 Bowel movements how often? _____
 Is this a change? _____
 Black stools Y N P
 Blood in stools Y N P

FEMALE REPRODUCTIVE

Age of first menses _____
 Age of last menses (if menopausal) _____
 Length of cycle _____ days between
 Duration of menses _____ day of bleeding
 Are your cycles regular Y N P
 Painful menses Y N P
 Heavy or excessive flow Y N P
 PMS Y N P
 Symptoms: _____

Bleeding between cycles Y N P
 Clotting Y N P
 Endometriosis Y N P
 Ovarian cysts Y N P
 Vaginal odor Y N P
 Vaginal discharge Y N P

Date of last Pap smear _____
 Abnormal Pap Y N P
 Cervical dysplasia Y N P
 Are you sexually active Y N P
 Sexual orientation: _____

Birth control? Type: _____

Pain during intercourse Y N P
 Gonorrhea Y N P
 Chlamydia Y N P
 Genital warts Y N P
 Syphilis Y N P
 Difficulty conceiving Y N P
 Number of pregnancies: _____
 Number of live births: _____
 Number of miscarriages: _____
 Number of abortions: _____

Do you do self breast exams Y N P
 Breast pain/tenderness Y N P
 Breast lumps Y N P
 Nipple discharge Y N P
 Menopausal symptoms Y N P

MENTAL / EMOTIONAL CONT.

Poor Concentration Y N P
 Do you have mood swings Y N P
 Considered suicide Y N P
 Attempted suicide Y N P
 Tension Y N P
 Memory problems Y N P

URINARY

Increased frequency Y N P
 Inability to hold urine Y N P
 Pain on urination Y N P
 Frequency at night Y N P
 Frequent UTIs Y N P
 Kidney stones Y N P

MUSCULOSKELETAL

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

BLOOD

Anemia Y N P
 Easy bleeding or bruising Y N P
 Cold hands and/or feet Y N P
 Deep leg pain Y N P
 Thrombophlebitis Y N P
 Varicose veins Y N P

MALE REPRODUCTIVE

Are you sexually active Y N P
 Sexual orientation: _____
 Birth control? Type: _____
 Discharge or sore Y N P
 Chlamydia Y N P
 Gonorrhea Y N P
 Herpes Y N P
 Syphilis Y N P
 Hernias Y N P
 Testicular masses Y N P
 Testicular pain Y N P
 Prostate disease Y N P
 Premature ejaculation Y N P

Thank you for your time and effort. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page.