BRIDGER NATURAL MEDICINE CLINIC, LLC

DR. ROBERT LEMLEY, ND, NCMP
NATUROPATHIC DOCTOR / NAMS CERTIFIED MENOPAUSE PRACTITIONER
2419 W. MAIN, SUITE 1 • BOZEMAN, MONTANA • PH: 406-585-0205 • FAX: 406-585-0205

NEW PERSON INFORMATION

GENERAL INFORMATION (please print) Date: ____/____/____

Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Phone (please circle best contact number): Mobile: _____

Work: _____

Email: _____ Home: _____

SS: _____ Date of Birth: _____ AGE: _____

Employer: _____

Type of Work Performed: _____

Living Situation (circle): single married w/partner w/children
# of children: _____

NEAREST RELATIVE NOT LIVING WITH YOU OR EMERGENCY CONTACT PERSON

Name: _____ Relation: _____

Contact phone number: _____

IF PATIENT IS UNDER 18 YEARS OLD, THIS PORTION NEEDS TO BE FILLED OUT BY THE PARENT

Parent/Guardian: _____

Address (if different from above): _____

Phone contact (if different from above): _____

FINANCIAL POLICY

BRIDGER NATURAL MEDICINE CLINIC, LLC. IS COMMITTED TO PROVIDING EXCELLENT AND AFFORDABLE HEALTH CARE. The following policy is designed to help us continue doing so:

1) BILLING: Due to the increasing cost of the delivery of good health care, our patients are expected to make payments in the office at the time of service, unless payment arrangements have been approved in advance by the staff. Medicinary items such as botanicals, supplements, and homeopathic remedies must be paid for upon receipt.
2) INSURANCE: If you have health insurance that covers the type of care you will be receiving, be sure to supply us with the necessary information. The clinic does bill health insurance. Make sure the forms are completed on your part and are signed to authorize payments and release information. We may accept assignment in some instances. Please remember that it is a contract between you and your insurance company.
3) APPOINTMENTS: If unable to keep an appointment, please give us 24 hours notice. If you fail to keep your appointment or cancel without prior notice, a full office visit fee may be assessed.
4) COLLECTIONS: I understand and agree to pay any collection fees, interest, court fees and attorney fees if my account is placed in collections or court for non-payment.

I HAVE READ THE ABOVE AND AGREE TO THE CONDITIONS SET FORTH:

Signature: _____ Date: _____

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Welcome. As a new patient, please fill out the information found below to the best of your ability. All information given remains confidential.

Purpose of Appointment: _____

To what extent does this interfere with your daily activities? (e.g.- work, sleep, etc): _____

_____

What other care have you sought for relief? (circle)

naturopathy chiropractic acupuncture conventional other _____

Other health concerns: _____

HISTORY OF PRESENT ILLNESS

Location: _____ (Where is the pain/problem?) Quality: _____ (Ex: normal versus abnormal color, sensation: dull, throb, etc.)

Severity: _____ (How severe on a scale of 1-5, 5 being worst) Duration: _____ (How long have you had this pain/problem? When did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?) Context: _____ (Where were you at the onset of the pain/problem?)

Associated Signs/Symptoms: _____ (What other associated problems are being experienced?)

Modifying Factors: _____ (What makes the pain/problem better or worse? Or, Have you had previous episodes?)

PAST MEDICAL HISTORY

Have you ever experienced the following: (Circle "no or "yes", leave blank if uncertain)

Measles….. …….no yes	Anemia……...no yes	Back Trouble……...no yes	Hepatitis……no yes
Mumps……..no yes	Bladder Infxns…no yes	High Blood Pressure….no yes	Ulcer……...…no yes
Whooping Cough…no yes	Migraines…..…..no yes	Hemorrhoids……...no yes	Thyroid Dz…..…..no yes
Scarlet Fever……...no yes	Tuberculosis..…no yes	Date of last chest Xray_____	Bleeding Dz……..no yes
Diptheria……..no yes	Diabetes…..…no yes	Asthma……no yes	Any other Dz…....no yes
Smallpox……...no yes	Cancer……no yes	Hives or Eczema…….....no yes	(please list)
Pneumonia…….no yes	Polio……..no yes	AIDS, HIV, or HEP C….no yes	_____
Rheumatic Fever…no yes	Glaucoma... ……no yes	Infectious Mono…….no yes	
Heart Disease…….no yes	Hernia……..no yes	Bronchitis……..……no yes	_____
Arthritis……..no yes	Blood or Plasma	Mitral Valve Prolapse....no yes	
Venereal Dz……no yes	transfusion…...no yes	Stroke……..…no yes	_____

SOCIAL HISTORY (circle)

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously, but quit		Current packs/day_____	
Use of Drugs:	Never	Sometimes	Frequently	Type/Frequency	

Excessive exposure at home or work to:

Fumes Dust Solvents Air-Borne Particles Noise

CONSTITUTIONAL SYMPTOMS

Good general health lately no yes
Recent weight change no yes
Fever no yes
Fatigue no yes
Headaches no yes

EYES

Eye disease or injury no yes
Wear glasses/contact lenses no yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing no yes
Earaches or drainage no yes
Chronic sinus/rhinitis problem no yes
Nose bleeds no yes
Mouth sores no yes
Bleeding gums no yes
Bad breath or bad taste no yes
Sore throat or voice change no yes
Swollen glands in neck no yes

CARDIOVASCULAR

Heart trouble no yes
Chest pain/angina pectoris no yes
Palpations no yes
Shortness of breath w/walking no yes
or lying flat no yes
Swelling of fee/ankles no yes

RESPIRATORY

Chronic or frequent coughs no yes
Spitting up blood no yes
Shortness of breath no yes
Wheezing no yes

GASTROINTESTINAL

Loss of appetite no yes
Change in bowel movement no yes
Nausea or vomiting no yes
Painful bowel movement no yes
Constipation no yes
Rectal bleeding/blood in stool no yes
Abdominal pain no yes
Indigestion no yes

GENITOURINARY

frequent urination no yes
Burning or painful urination no yes
Blood in urine no yes
Change in force of strain
when urinating no yes
Incontinence or dribbling no yes
Kidney stones no yes
Sexual difficulty no yes
Female- pain with cycle no yes
Female- irregular cycle no yes
Female- vaginal discharge no yes
Female- # of pregnancies _____
Female- # of miscarriages _____
Female- date of last PAP _____

MUSCULOSKELETAL

Joint Pain no yes
Joint stiffness or swelling no yes
Weakness in muscles/joints no yes
Muscle pain or cramps no yes
Back pain no yes
Cold extremities no yes
Difficulty in walking no yes

INTEGUMENTARY (skin/breast)

Rash or itching no yes
Change in skin color no yes
Change in hair or nails no yes
Varicose veins no yes
Breast pain no yes
Breast lump no yes
Breast discharge no yes

NEUROLOGICAL

Frequent/recurring H/A's no yes
Light headed or dizzy no yes
Convulsions or seizures no yes
Tremors no yes
Paralysis no yes
Head injury no yes

PSYCHIATRIC

Memory loss or confusion no yes
Nervousness no yes
Depression/Anxiety no yes
Insomnia no yes

ENDOCRINE

glandular/hormonal problem no yes
Excessive thirst or urination no yes
Skin becoming dryer no yes
Change in hat or glove size no yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts no yes
Bleeding/bruising tendency no yes
Anemia no yes
Phlebitis no yes
Past transfusion no yes
Enlarged glands no yes

ALLERGIC/IMMUNOLOGICAL

History of skin reaction or other
adverse reaction to:
Penicillin or other antibiotic no yes
Morphine, Demerol, or other
narcotics no yes
Novocaine/other anesthetic no yes
Aspirin/pain remedies no yes
Tetanus antitoxin or other
serums/immunizations no yes
Iodine, Merthiolate or other
antiseptic no yes
Drugs/medications: _____
_____
_____
Known food allergies: _____
_____
_____
Known environmental allergies: ____
_____
_____

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES? **WHEN?** **HOSPITAL/CITY/STATE?**

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST (IN CHRONOLOGICAL ORDER):

Where you have lived: _____

_____

Your work history (type of job): _____

_____

The progression of your illness (symptom history): _____

_____

_____

FINAL QUESTIONS:

When did you last feel well? _____

Are you sensitive to taking medications?	yes	no
Are you senstitive to perfumes, gasoline odors, detergents, soaps, etc…?	yes	no
Any exposure to environmental or second hand tobacco smoke (even as a child)?	yes	no
Do you live in a new house or a house under 10 years old?	yes	no
Do you have any body parts that are not your own (ex: rods, Teflon, titanium, or breast implants)?	yes	no

If yes, please list: _____

Number of mercury amalgram fillings? _____

Any occupational exposure to chemicals, solvents, pesticides, heavy metals prior to illness?	yes	no
Any residential exposures to chemicals, solvents, pesticides, heavy metals prior to illness?	yes	no
Any hobby related exposures to chemicals, solvents, pesticides, heavy metals prior to illness?	yes	no

If answer "yes" to the above 3 questions, please list: _____

_____

MEDICATIONS (include ALL prescription/non-prescription/supplements/vitamins and dosage) _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be detrimental to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. Ialso authorize the healthcare staff to perform the necessary services I may need. I further understand that all information provided will be kept confidential.

_____ _____

Signature of Person Responsible Date