Bridger Natural Medicine Clinic LLC
Dr. Robert Lemley, ND, NCMP
Naturopathic Doctor / NAMS Certified Menopause Practitioner

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 not 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