

DR. IRIS CRAWFORD
 4208 LEARY WAY
 SEATTLE, WA 98107
 206-508-2957
NEW PATIENT INTAKE FORM

PATIENT INFORMATION / PROFILE

Name:	Date of Birth:	Gender: M F Other
Address:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
(zip)	Number of people in household:	
Occupation:	Employer / School:	
Education completed: <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other		
Travel Outside US? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where / When?	

CONTACT INFORMATION

Phone Numbers:	<input type="checkbox"/> Phone (work):	<input type="checkbox"/> Phone (home):	<input type="checkbox"/> Phone (cell / pager):
Check the box next to the number where we can leave a private message that may contain confidential health information			
Name of Spouse or Partner:			
Name(s) of Children:			
Emergency Contact :	home phone:		
Relationship to patient:	work phone:		

REFERRALS AND ADJUNCTIVE CARE

Are you currently under medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes For:
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible):
How did you find Dr. Crawford? <input type="checkbox"/> Insurance Referral: <input type="checkbox"/> Physician Referral: <input type="checkbox"/> Patient Referral: <input type="checkbox"/> Other: <input type="checkbox"/> N/A
Referring Physician or Patient Name:
Who is your Primary Care Physician (PCP)?
Clinic Name, Address and phone:
Have you ever consulted with or been treated by a naturopathic physician, acupuncturist, chiropractor, nutritionist or massage therapist before? <input type="checkbox"/> No <input type="checkbox"/> Yes When? Who? (circle those that apply)

HEALTH CONCERNS (please list in order of importance to you)

1.	4.
2.	5.
3.	6.
Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Months?	
What goals do you have from your visit today and overall?	

What expectations do you have of your physician?

MEDICATIONS AND SUPPLEMENTS

Medications & dose:	
1.	4.
2.	5.
3.	6.
Supplements (vitamins, herbs, etc):	
1.	4.
2.	5.
3.	6.

HEALTH HISTORY / REVIEW OF SYSTEMS

Allergies or Reactions to:	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin / antibiotics	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local anesthetics
	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Nuts	<input type="checkbox"/> Scents	<input type="checkbox"/> Other:
Serious illnesses:				
Accidents:				
Hospitalizations / operations:				
Childhood Illnesses:	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella
	<input type="checkbox"/> German measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Other:
Have you ever been physically or emotionally abused?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have concerns with abuse / violence in your life now?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please check if you have or have ever had:

Condition	Never	Past	Current	Physician's Notes
1. General				
Weight loss / gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Max weight: Min. wt: Current Wt:
Fever / Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue / Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heat / Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cold Hands and Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sweats / Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Skin				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rashes / Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hair or nail dryness / changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yellow / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Head				
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Eyes				

Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Corrective Lenses / Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Floater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Ears	Never	Past	Current	Physician's Notes (Con't)
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing of Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Nose				
Sinus congestion or infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Mouth / Throat				
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cavities / Root canals / toothaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bitter or Metallic taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Lungs				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Breathing / Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain / Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough: Persistent or Bloody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Cardiovascular				
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots in Legs or Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling (Edema) of hands, feet, legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmurs / Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Circulatory Problems (raynauds, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Gastrointestinal				
Loss of / Excess Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty or pain with swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indigestion / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Gas / Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea (with or without blood?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colitis / Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anal Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood or Mucus in Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Black tarry or "coffee ground" stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol / Lipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

11. Genitourinary	Never	Past	Current	
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency to Urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wake to Urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty holding urine (sneeze / cough)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease / Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Musculoskeletal				
Muscle pain / spasm / strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint pain / sprain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Back Problems (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Endocrine				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hormone Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Blood / Lymphatic				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood / Lymph disease or cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Allergic / Immune				
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer / Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune (scleroderma, hashimotos, lupus, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever / Asthma / Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Environmental / Animal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Neurologic				
Epilepsy / Seizures / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with walking / coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paralysis / weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Psychologic				
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Sexual Health Information

Are you currently sexually active?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	With:	<input type="checkbox"/> Men	<input type="checkbox"/> Women	<input type="checkbox"/> Both	
Are you satisfied with your sex life?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Do you practice safer sex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
STDs:	<input type="checkbox"/> HIV	<input type="checkbox"/> Herpes	<input type="checkbox"/> HPV/ Warts	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Hepatitis

Male Health Information

Condition	Never	Past	Current	Physician's Notes
Difficult Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Testicular Pain / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impotence / Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Notes:				

Female Health Information

Menstrual History			Obstetric History		
Age at first period			Have you ever been pregnant <input type="checkbox"/> No <input type="checkbox"/> Yes		
Date last menstrual period began			Age at first pregnancy		
Periods regular? <input type="checkbox"/> No <input type="checkbox"/> Yes			Number of pregnancies		
Days between periods			Number of living children		
Length of flow					
Heaviness of flow			Number of miscarriages <input type="checkbox"/> No <input type="checkbox"/> Yes		
Pain with Menses? <input type="checkbox"/> No <input type="checkbox"/> Yes			When in pregnancy?		
Menopause? <input type="checkbox"/> No <input type="checkbox"/> Yes			Date of last pregnancy		
			Difficulty conceiving <input type="checkbox"/> No <input type="checkbox"/> Yes		
			Difficulty with pregnancy <input type="checkbox"/> No <input type="checkbox"/> Yes		
PMS Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Bloating/swelling			Difficulty with labor or delivery <input type="checkbox"/> No <input type="checkbox"/> Yes		
<input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Acne <input type="checkbox"/> Mood Swings			Difficulty with breast feeding <input type="checkbox"/> No <input type="checkbox"/> Yes		
<input type="checkbox"/> Digestive changes <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache			Future OB plans <input type="checkbox"/> No <input type="checkbox"/> Yes		
<input type="checkbox"/> Other					
Vaginitis Symptoms:			Risk Factors		
Discharge <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current			History of Abnormal paps <input type="checkbox"/> No <input type="checkbox"/> Yes		
Irritation <input type="checkbox"/>			Did your mother take DES? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Itching <input type="checkbox"/>			Did your mother ever miscarry? <input type="checkbox"/> No <input type="checkbox"/> Yes		

Odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you do self breast exams?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Pain with sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long term Hormone Replacement?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bacteria (BV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Notes:						

Family History

Mother:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause	Age:
Father:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause	Age:
Siblings:	Number living:	Number deceased:	Causes / Ages:	
Children:	Number living:	Number deceased:	Causes / Ages:	
Has any family member had:	Yes	Which Relative(s) & Age of Onset	Physician's Notes	
Diabetes	<input type="checkbox"/>			
Severe allergies	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>			
Heart Attack	<input type="checkbox"/>			
Blood clots in lungs or legs	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>			
High Cholesterol	<input type="checkbox"/>			
Kidney Disease	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>			
Thyroid problems	<input type="checkbox"/>			
Colitis / Crohn's	<input type="checkbox"/>			
HIV / AIDS	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>			
Birth Defects	<input type="checkbox"/>			
Drinking or Drug problems	<input type="checkbox"/>			
Breast Cancer	<input type="checkbox"/>			
Colon Cancer	<input type="checkbox"/>			
Ovarian Cancer	<input type="checkbox"/>			
Uterine Cancer	<input type="checkbox"/>			
Other Cancer:	<input type="checkbox"/>			
Mental Illness/Depression	<input type="checkbox"/>			
Alzheimer's	<input type="checkbox"/>			
Other:	<input type="checkbox"/>			
	<input type="checkbox"/>			

Social & Lifestyle

Habits	Yes	No	Details	Notes
Current Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	
Past Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	
Quit?	<input type="checkbox"/>	<input type="checkbox"/>	When?	
Alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	Per day?	
Types:			Per week?	
Recreational Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	Type:	
Ever been treated for drug or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	When?	
Caffeine Use (coffee, tea, cola)	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day?	
			Type?	
Regular Exercise?	<input type="checkbox"/>	<input type="checkbox"/>	How much?	
Types:				

Health Hazards at home / work?	<input type="checkbox"/>	<input type="checkbox"/>		
Social				
Happy with relationship status?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have a good support network of family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	Who?	
What is your predominant emotion?				
Lifestyle				
Do you enjoy your work?	<input type="checkbox"/>	<input type="checkbox"/>	Hours per week:	
Stress Level	<input type="checkbox"/>	Low	<input type="checkbox"/>	Medium
			<input type="checkbox"/>	High
Stress source	<input type="checkbox"/>	Money	<input type="checkbox"/>	Job
			<input type="checkbox"/>	Family/ Relationship
What do you do to relieve stress?				

Sleep	Yes	No	Details
Problems falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Problems staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wake during the night?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wake rested in the am?	<input type="checkbox"/>	<input type="checkbox"/>	
Usual bed time / rising time:	Hours of sleep daily:		
Dreams?			
Diet			
Do you follow a particular Diet?			
Known food allergies / intolerances?			
What is a typical breakfast for you?			
Typical Lunch?			
Typical Dinner?			
Snacks?	Dessert / Treats?		
How much water do you drink per day?			

EXAM AND IMAGING HISTORY (Indicate date, doctor's name or place of most recent)

Physical Exam		HIV test	
Pap Smear		Chest X-ray	
Mammogram		EKG	
Colonoscopy		STD screen	
Prostate check		Cholesterol screen	
TB test		Bone density check	

Patient Signature

Date

*Signature of Physician
patient*

Date reviewed with

Dr. Iris Crawford
4208 Leary Way
Seattle, WA 98107
206-508-2957

Consent for treatment

I, _____, give consent to be treated by Dr. Crawford within the scope of Naturopathic medicine. I understand that I am free to withdraw consent and discontinue participation at any time. I realize that no guarantees have been made to me regarding cure or improvement of my condition. I understand that, as with all medicine, herbal or otherwise, risks are involved and may include allergic reactions or aggravation of symptoms.

Patient (print)

Patient signature

Date

Witness

Date

Dr. Iris Crawford
4208 LEARY WAY
SEATTLE, WA 98107
206-508-2957

Fees and Policies

Thank you for choosing Dr. Crawford to help you reach your health goals. The following is to alert you to the payment guidelines and appointment procedures of Dr. Crawford's private practice.

FEES. First office visit: \$220 (75 minutes)
Follow-up visit: \$110 (45 minutes)
Maintenance Visits: \$90 (30 minutes)
House calls: \$245 (90 minutes)
Telephone/Skype Consult: \$60 (15 minutes)
Telephone/Skype Consult: \$90 (30 minutes)

INSURANCE. Dr. Crawford does not currently accept insurance. You will be responsible for payment at the time of visit. You will be provided with a bill that you can submit to your insurance company for possible reimbursement. Check with your individual insurance policy for coverage.

PAYMENT. Payment is due at the time of service for office visits and any supplements purchased. You may pay by cash, check, or credit card.

RETURNED CHECK FEE. There is a \$25 fee for each returned check.

APPOINTMENT CANCELLATIONS. Dr. Crawford kindly requests that you provide 24- to 48- hour notice of cancellation. If you do not provide at least 24-hours notice of your intent to cancel an appointment, you will be charged 50% of your visit.

PHONE CONSULTS. There is no charge for brief questions that can be answered in a 5 or 10 minute phone call. If you are calling about a new or more involved health concern, you may be asked to schedule an appointment or we can arrange a phone consult.

LABORATORY. Dr. Crawford is affiliated with outside labs and you are responsible for scheduling and paying for lab services recommended by Dr. Crawford.

RETURNED MEDICINE. You may return unopened medicine within 14 days of purchase for a refund with the exception of perishable or refrigerated items.

Dr. Crawford reserves the right to make changes to all fees and policies at any time and will make every effort to notify patients of these changes as they occur.

If you have any questions regarding these guidelines please feel free to ask.

I agree to the above clinic policies.

Signature

Date

NOTICE OF PRIVACY PRACTICES

Dr. Iris Crawford 4208 Leary Way, Seattle, WA 98107 206-508-2957

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical/health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, a record of the care and services you receive is created in my office. I respect the privacy and confidentiality of medical/health information about you that which can be identified with you. This is your "protected health information".

Your protected health information is contained in a secure environment and locked cabinet as required by law. It includes demographic information and information that relates to your present, past or future physical or mental health and related health care services.

This Notice of Privacy Practices ("Notice") describes the ways in which we may use and disclose your protected health information. It also describes your rights and our legal obligations with respect to your protected health information.

This Notice applies to uses and disclosures we may make of all your protected health information, whether created by us in our practice or received by us from another health care provider.

MY LEGAL DUTY TO PROTECT YOUR HEALTH INFORMATION.

Federal and State Laws requires:

- Ensure the privacy of your protected health information, which I have either created in my practice or received from another health care provider, whether it is about your past, present, or future health care condition;
- Maintain the privacy of your protected health information regarding payment for your

health care;

- Explain the manner in which I may use and disclose your protected health information;
- Abide by the terms of this Notice, as currently in effect; and
- Obtain your written authorization to use or disclose your protected health information for reasons other than those listed below and permitted by law.

CHANGES TO THE NOTICE

I reserve the right to amend this Notice at any time in the future, and make the new provisions effective for all protected health information I maintain, regardless of when it was created or received.

If the Notice is amended, I will:

- Post the revised Notice, with the new effective date, in my office;
- Post the revised Notice on my website www.driscrawford.com; and
- Make copies of the revised Notice available to you upon request.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your protected health information that I maintain:

1. The Right to Access Your Protected Health Information:

Except under limited circumstances, and upon written request, you have the right to inspect and obtain a copy of your protected health information.

2. The Right to Request Restrictions:

You have the right to request a restriction on the way I use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on the protected health information that I disclose about you to a family member, friend or other person involved in your care or the payment of your care.

3. The Right to Request Confidential Communications:

You have the right to request that I communicate with you concerning your

health matters in a certain manner or at a certain location. For example, you can request that I contact you only at a certain phone number or a specific address.

You should submit your written request for confidential communications to me, telling me how and where you want to be contacted.

4. The Right to Request an Amendment:

You have the right to request that I amend medical or billing records, or other protected health information maintained by me, for as long as the information is kept by me.

5. The Right to An Accounting of Disclosures:

You have the right to request an accounting of certain disclosures of your protected health information made after April 14, 2003.

6. The Right to a Paper Copy of This Notice:

You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically.

Dr. Iris Crawford

4208 Leary Way, Seattle, WA 98107

206-508-2957

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Dr. Crawford has provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.

Patient Signature

Date