Receptive MEDICINE LLC
Accurate • Effective • Compassionate

Dr. Rachel Meredith ND LAc
7 SE 30th Ave, Portland, OR 97214
PH: 971.501.5050 FAX: 503.236.0303

NEW PATIENT INTAKE FORMS

Name: ____ Today's Date: ___________

Address: ____ Apt __________________

City: ___________________________________ State:___________ Zip Code:___________

Phone (cell): _____________________ (home)________________ (work) _________________

E-mail address:____

Age: ________ Date of Birth: ______________

Gender (please circle): Female Male Trans Nonbinary Preferred Pronouns:______________

Education:____

Relationship Status:

Single____ Married_____ Separated _____ Divorced _____ Widowed_____ Partnership______

Live with: Spouse: ______Partner_____Parents____Children____Roommates____Alone_____

Occupation: ___________________________________Hours per week: _________ Retired_______

Employer:____

How did you hear about our clinic?____

Has any other family member already been a patient at the clinic? Y N

Name:____

Emergency Contact:

Name_______________________________________ Relationship:_____________________

Phone: _________________________ Email: ____

Address: ____

____

CONTEXT OF CARE

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

Why did you choose to come to this clinic? ______________________________

____

What do you know about our approach? ______________________________

____

What three expectations do you have for this visit to our clinic?

1)______________________________
2) ______________________________
3) ______________________________

What long term expectations do you have from working with our clinic? ______________________________

____

What expectations do you have of me personally as your physician? ______________________________

____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle and follow the treatment plan? (Rate from 0 to 10, with 10 being 100% committed)

(please circle) 0 1 2 3 4 5 6 7 8 9 10

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

____

____

What behaviors or habits do you currently engage in that you believe are self destructive habits?

____

____

What potential obstacles do you foresee in undermining your health and in your ability to follow the treatment plan we will share with you? ______________________________

____

Who do you know that will sincerely support you with the beneficial lifestyle changes you will be making?

____

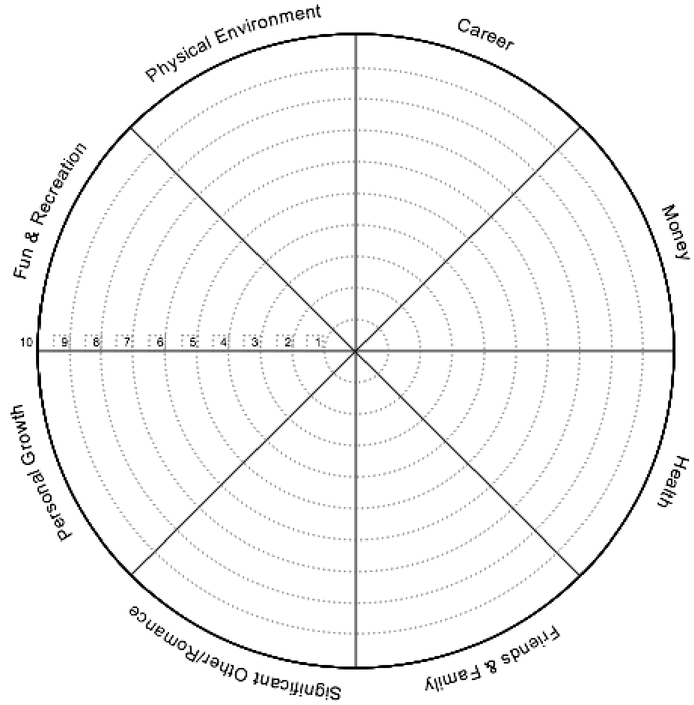
What do you love to do? What brings you joy?

____

CONTEXT OF CARE CONT'D

WHEEL OF BALANCE

Wellness is a balance of many factors. In the circle, shade your level of satisfaction in each area as it relates to you. I.E., if you are extremely happy in your career, shade the entire pie shape for "career."
Do the same for each area, starting from the center point, radiating outwards.



Are you currently receiving healthcare? Y N

Physician:

____

Clinic:____

Where did you last receive medical or health care and what labs were ordered?

____ Date: ______________________________

TEST HISTORY (Please list most recent)

TEST	DATE/YEAR	CLINIC NAME	FAX NUMBER
Blood Work			
DEXA Scan			
Stool Analysis			
Saliva Analysis			
PAP Smear			
Mammogram			
Other			

What are your most important health concerns? List them in order of importance:

1) ____
2) ____
3) ____
4) ____
5) ____

Do you have any known contagious diseases at this time? Y N

If yes, what? ____

____

HEALTH HISTORY

Do you have a family history of any of the following? (Please circle and write down family member who has/had it)

Cancer______________________ Diabetes_____________________ Heart Disease_______________________
Arthritis_____________________ Glaucoma____________________ Tuberculosis________________________
Stroke______________________ Anemia______________________ Mental Illness_______________________
Kidney Disease___________________________________ Asthma __________________________________
High Blood Pressure_______________________________ Epilepsy __________________________________
Any other relevant family history?

____

____

Childhood Illnesses: Please circle whether you had any of these as a child:

Scarlet fever   Diphtheria   Rheumatic fever   Mumps   Measles / German Measles

What hospitalizations, surgeries, X-rays, CAT Scans, EEG, EKGs have you had?

____ Year _______________
____ Year _______________
____ Year _______________

Allergies: Are you hypersensitive or allergic to:

Any drugs? ____

Any foods?____

Any environmentals or chemicals? ____

Current Medications

Do you take or use any of the following? (Please circle): Laxatives   Pain relievers   Antacids

Cortisone   Appetite suppressants   Antibiotics   Tranquilizers   Thyroid medication   Sleeping pills

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

Name:_______________________Dose:____________ Name:_______________________Dose:____________

Name:_______________________Dose:____________ Name:_______________________Dose:____________

Name:_______________________Dose:____________ Name:_______________________Dose:____________

General

Height: _____________ Weight:__________ lbs   Weight 1 year ago: ___________ lbs

Maximum weight: ____________________ when? _________________________________

When during the day is your energy the best?________________________ worst?________________________

What time do you: Go to bed: ______________ Fall asleep: _________________ Wake up: ________________

HABITS

WHERE APPLICABLE, PLEASE CIRCLE

Y = yes / a condition you have now	N = no / never had	P = I used to / experienced in the past

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

# of 8 oz cups of flat water/day? ___________ Prefer hot or cold? __________ Other drinks: _________________

Do you eat 3 meals a day?	Y	N	P	Do you drink sodas?	Y	N	P
Do you go on diets often?	Y	N	P	Do you eat refined sugar?	Y	N	P
Do you eat out often?	Y	N	P	Do you drink caffeine?	Y	N	P

How many cups/day of Coffee: _____________ Black tea: _____________ Green tea: ______________

Main interests and hobbies? ____

What kind of movement do you do? ____

How many days per week? ____

Sleep: Average over 7 hours?	Y	N		Do you enjoy your work?	Y	N	
Sleep well?	Y	N		Take vacations?	Y	N	
Awaken rested?	Y	N		Spend time in nature?	Y	N	
How many hours of TV/movies per day?_______				Read?	Y	N	
How many hours on your phone? ____________				How many hours do you read? _______________			
Have supportive relationships?	Y	N		Any car accidents?	Y	N	Age _______
Any major childhood traumas?	Y	N	P	Do you use tobacco/nicotine?	Y	N	P
Parents divorced?	Y	N		How many packs of nicotine? ______________________			
Your age when divorced: ________				How many years of nicotine use? ______________________			
Any deaths before age 18?	Y	N		How many alcoholic drinks per week? _________________			
If so, whom? _______________ Age _________				Do you use marijuana?	Y	N	P
Any physical abuse?	Y	N		What form of marijuana?____________________________			
Any emotional abuse?	Y	N		How many times per week (marijuana)? ________________			
Any sexual abuse?	Y	N		Treated for drug dependence?	Y	N	P
Any neglect?	Y	N		How many years in counseling? ______________________			
Other abuse: ____________________________							

Do you have a religious or spiritual practice? Y N P

If yes, please describe: ____

REVIEW OF SYSTEMS

WHERE APPLICABLE, PLEASE CIRCLE

Y = yes / a condition you have now	N = no / never had	P = I used to / experienced in the past

Mental / Emotional

Treated for emotional problems?	Y	N	P	Considered suicide?	Y	N	P
Poor concentration?	Y	N	P	Attempted suicide?	Y	N	P

Which emotions do you get stuck into or have a hard time expressing? (please circle):

worry/overthinking sadness/grief fear depression frustration nervous/anxiety

---

Immune

Reaction to immunizations/vaccines?	Y	N	P	Colds begin where? (please circle)	throat	sinus	chest
Chronic infections?	Y	N	P	Slow wound healing?	Y	N	P
Chronically swollen glands?	Y	N	P	Number of courses of antibiotics? ______________			

Energy on a scale of 1-10 (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

Endocrine

Hypothyroid?	Y	N	P	Heat or cold intolerance?	Y	N	P
Hypoglycemia?	Y	N	P	Do you overheat easily?	Y	N	P
High or Low thirst? (please circle)	High	Low		Are you cold?	Y	N	P
Fatigue?	Y	N	P	Excessive hunger?	Y	N	P
Night sweats?	Y	N	P	Seasonal depression?	Y	N	P

Neurologic

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

Skin (check all that apply)

- ☐ Rashes
- ☐ Itching
- ☐ Lumps
- ☐ Eczema, Hives
- ☐ Color change
- ☐ Suspicious moles
- ☐ Acne
- ☐ Perpetual hair loss
- ☐ Psoriasis

WHERE APPLICABLE, PLEASE CIRCLE

Y = yes / a condition you have now	N = no / never had	P = I used to / experienced in the past

Head

Headaches?	Y	N	P	Head injury? Concussions?	Y	N	P
(please circle) Sharp or Aching				Date/Year of Injury ______________			
Migraines?	Y	N	P	Jaw/ TMJ Problems?	Y	N	
Where on Head: top___ sides___ back___ front ___							

Eyes

Spots in eyes?	Y	N	P	Cataracts?	Y	N	P
Blurriness?	Y	N	P	Eye pain/ strain?	Y	N	P
Color deficiency?	Y	N	P	Tearing or dryness?	Y	N	P
Double vision?	Y	N	P	Glaucoma?	Y	N	P
Family history of Glaucoma?	Y	N	P				

Ears

Impaired hearing?	Y	N	P	Ringing?	Y	N	P
Earaches?	Y	N	P	(please circle) High pitch or Low pitch			
Dizziness?	Y	N	P				

Nose and Sinuses

Frequent colds?	Y	N	P	Nose bleeds?	Y	N	P
Stuffiness?	Y	N	P	Hayfever? / Allergies?	Y	N	P
Frequent Sinus infections?	Y	N	P	Loss of smell?	Y	N	P

Mouth and throat

Frequent sore throat?	Y	N	P	Jaw clicks?	Y	N	P
Teeth grinding?	Y	N	P	HSV I / cold sores?	Y	N	P
Gum problems?	Y	N	P	Dental cavities?	Y	N	P

Neck

Lumps?	Y	N	P	Swollen glands?	Y	N	P
Goiter?	Y	N	P	Pain or stiffness?	Y	N	P

Respiratory

Cough?	Y	N	P	Sputum / mucous?	Y	N	P
Spitting up blood?	Y	N	P	Wheezing?	Y	N	P
Asthma?	Y	N	P	Bronchitis?	Y	N	P
Pneumonia?	Y	N	P	Pain on breathing?	Y	N	P
Difficulty breathing?	Y	N	P	Shortness of breath?	Y	N	P

WHERE APPLICABLE, PLEASE CIRCLE

Y = yes / a condition you have now	N = no / never had	P = I used to / experienced in the past

Cardiovascular

Heart disease?	Y	N	P	Chest pain?	Y	N	P
High/ Low blood pressure?	Y	N	P	Murmurs?	Y	N	P
Blood clots?	Y	N	P	Fainting?	Y	N	P
Phlebitis?	Y	N	P	Palpitations/ fluttering?	Y	N	P
History of Rheumatic Fever?	Y	N	P	Swelling in ankles?	Y	N	P

Gastrointestinal

Trouble swallowing?	Y	N	P	Heartburn?	Y	N	P
Change in thirst?	Y	N	P	Abdominal pain or cramps?	Y	N	P
Change in appetite?	Y	N	P	Belching or passing gas?	Y	N	P
Nausea/ vomiting?	Y	N	P	Constipation?	Y	N	P
Ulcer?	Y	N	P	Diarrhea?	Y	N	P
Jaundice (yellow skin)?	Y	N	P	Gall bladder disease?	Y	N	P
Liver disease?	Y	N	P	Hemorrhoids?	Y	N	P
Black stools?	Y	N	P	Blood in stool?	Y	N	P

Bowel Movements: How often? ____________________________ Is this a change? _______________________

Urinary

Pain on urination?	Y	N	P	Increased frequency?	Y	N	P
How many trips to urinate at night?	Y	N	P	Inability to hold urine?	Y	N	P
Frequent infections?	Y	N	P	Kidney stones?	Y	N	P

Musculoskeletal

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

Rate joint pain intensity for each location on a pain scale of 1-10 (1 = low pain; 10 = extreme pain; skip if no pain):

Neck _______	Upper back _______	Knee _______
Shoulders _______	Lower back _______	Ankle _______
Elbows _______	Hips _______	Feet/hands _______

Blood / Peripheral Vascular

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

Male Reproduction

Sexual Orientation: ________________________				Impotence?	Y	N	P
Hernias?	Y	N	P	Testicular masses?	Y	N	P
Testicular pain?	Y	N	P	Prostate disease?	Y	N	P
Sexually transmitted infections?	Y	N	P	Discharge or sores?	Y	N	P
Are you sexually active?	Y	N		Chlamydia?	Y	N	P
Birth control? Type: ______________________				Herpes?	Y	N	P
Premature ejaculation?	Y	N	P	Syphilis?	Y	N	P
Condyloma?	Y	N	P	Gonorrhea?	Y	N	
Other? ___________________________________							

Female Reproduction / Breasts

Sexual orientation: ________________________							
Age of first menses? ______________________				Date (or age(of last menses/period? __________________			
Date of last annual exam/ PAP? ____________				Abnormal PAP?	Y	N	P
Are cycles regular?	Y	N	P	Bleeding between cycles?	Y	N	P
Number of days of period? ________________				Discharge?	Y	N	P
Length of cycle? __________________________				Birth Control?	Y	N	P
Painful menses?	Y	N	P	What type(s)? ______________________________			
Heavy or excess flow?	Y	N	P	Number of pregnancies: _____________________			
Color of blood? (circle)	pale	red	dark	Number of live births: _______________________			
Clotting of blood? none	small	large		Number of miscarriages: _____________________			
Breast tenderness?	Y	N	P	Number of abortions: ________________________			
PMS: irritability?	Y	N	P	Difficulty conceiving?	Y	N	P
PMS: sadness?	Y	N	P	Are you sexually active?	Y	N	P
PMS: fatigue?	Y	N	P	Sexual difficulties?	Y	N	P
Endometriosis?	Y	N	P	Gonorrhea?	Y	N	P
Ovarian cysts?	Y	N	P	Herpes?	Y	N	P
Cervical Dysplasia?	Y	N	P	Chlamydia?	Y	N	P
Do you do breast self exams?	Y	N	P	Condyloma?	Y	N	P
Breast lumps?	Y	N	P	Syphilis?	Y	N	P
Nipple discharge?	Y	N	P	Other? ____________________________________			

Is there anything else you would like to comment on?

Thank you for your time and effort. I look forward to providing you with the best possible care.
Dr. Rachel Meredith ND LAc
Receptive Medicine LLC

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7 SE 30th Ave, Portland, OR 97214
PH: 971.501.5050 FAX: 503.236.0303

MEDICAL RECORDS RELEASE FORM

Date: ________________

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or specific information listed below.

Patient Name: ______________________________________ Patient Date of Birth: _____________

Representative of Patient (parent/guardian/other): ____

The information you may release:
____ Lab records
____ Medical history
____ Other _______________________________

Release my information FROM:

____

____

____

____

____

Release my information TO:

Dr. Rachel Meredith ND L.A.c. for my medical care at
Receptive Medicine
7 SE 30th Ave, Portland, OR 97214
Office: 971-501-5050 | Fax: 503-236-0303

Patient Signature:____

Please send results ASAP and call the office with any questions. Thank you!

Receptive Medicine LLC
CONSENT AND TREATMENT FORM

Naturopathic examination and therapeutic procedures, such as acupuncture, are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are very small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, minor bleeding, inflammation, soft tissue injury, bruising, dizziness, burns, and temporary aggravation of symptoms. More serious complications, such as stroke following neck adjustments, or nerve damage and organ puncture are *extremely* rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure(s) being performed and the risks and alternative treatments available.

_________(initial) I understand that I can request further explanation regarding any and all possible risks attendant to my care.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee for specific cure or result. By signing below, I give my consent for Naturopath examination and acupuncture.

Signature: ____

Date: __________________

Patient is a minor (16 years of age or under):

I, ____________________________________ (parent or guardian), hereby authorize Dr. Rachel Meredith ND LAc to treat the minor listed below:

______________________________________ (patient minor) with or without my presence. By signing this consent, I acknowledge that I have legal right to grant this permission for said minor.

Parent or Guardian's signature: _________________________________

Date: __________________________

Receptive Medicine LLC
CANCELLATION POLICY AGREEMENT

Initial (New Patient) Visit Policy
Dr. Rachel Meredith and REceptive Medicine LLC have a strict **7 day cancellation policy** for initial visit appointments. This means that if you have to cancel with less than 7 days notice, you are responsible for a $250 late cancellation fee, which would be automatically charged to the card we have on file.

Late cancellations due to work emergencies are subject to the $250 late cancellation fee. The cancellation fee may be waived with the doctor's approval for true medical emergencies or if you are too unwell to drive.

I have read the above policy and agree to its terms:

Name: ____ Date: ________________

Signature: ____

Follow Up Visit Policy
Dr. Rachel Meredith and Receptive Medicine LLC have a strict **48 business hour cancellation policy** for follow up appointments. This means that if you have to cancel less than 48 business hours notice, you are responsible for the full cost of the visit at the standard non-insurance out of pocket rate. For most appointments, that is $333

For example, a 2:00 pm appointment on Tuesday must be canceled by 2:00 pm the previous Friday.

Late cancellations due to work emergencies are subject to the late cancellation fee. The cancellation fee may be waived with the doctor's approval for true medical emergencies or if you are too unwell to drive.

I have read the above policy and agree to its terms:

Name: ____ Date: ________________

Signature: ____

Receptive Medicine LLC
OFFICE POLICIES AGREEMENT

Please take time to read, initial, and sign:

_______ Your insurance policy is a contract between you and your insurance company. Billing of insurance is a courtesy performed by Receptive Medicine LLC. It is **your** responsibility to provide our office with your insurance details and present your insurance card to our staff. When possible, our staff will call to verify your insurance coverage prior to your appointment. Please be aware that an estimate of benefits is **not** a guarantee of payment. If an insurance company provides you or our staff with inaccurate information they may not honor the benefits that were quoted.

_______ It is your responsibility to be aware of your coverage, co-pay, or coinsurance, as well as any deductible and maximums, per your insurance contract.

_______ In the event of financial discrepancies between your insurance company and Receptive Medicine LLC and providers, the balance of services rendered is your responsibility up to the fullest extent. This may include paying out of pocket for services performed that are not covered under your policy.

_______ In the event that you need to cancel or reschedule an appointment, we require 48 business hours notice. If there is less than 48 hours notice, you are responsible to pay the cash rate for your visit unless it is a medical emergency. This fee cannot be billed to insurance companies and is fully the patient's responsibility.

_______ Patients are financially responsible for the cost of supplements, herbal products, and supplies.

_______ As a courtesy to our patients, we ask that you silence your cell phone and other personal devices when entering our building. We also ask that you use a soft voice while in the building, so as not to disturb other patients receiving treatment.

By signing below, I acknowledge that I have read, understand, and accept the terms of this document.

Printed Name: ____

Signature: ____

Date: ______________________

Receptive Medicine LLC
PRIVACY POLICY AGREEMENT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that information.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. We may also share medical information about you to your other healthcare providers to assist them in treating you, with your permission.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use and disclose your information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials needed to serve you. We may use or disclose your protected health information in the following situations without your authorization, as required by law: public health issues, communicable disease, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, and workers compensation. You may revoke this authorization at any time, inwriting, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in, a civil, criminal, or administrative action or proceeding. A copy of your records must be requested in writing. You have the right to request a restriction of your protected health information. The physician is not required to agree to a restriction that you request. You have the right to request that we communicate with you about your medical information by different means or to a different location. This request must be made in writing. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may request a copy of this notice.

Questions or complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

By signing below, I acknowledge that I have read, understand, and accept the terms of this document.

Printed Name: ____ Date: ________________________

Signature: ____ Date of Birth: _________________

Receptive Medicine LLC
INSURANCE ELIGIBILITY & BENEFITS

Please fill out this form as completely as possible. It is your responsibility to know what your benefits are at least a week before your appointment, and recheck your benefits at the beginning of each insurance or calendar year. Call the customer service number on the back of your card. This is not a guarantee of payment: Insurance companies may give out inaccurate information or not honor the benefits that were quoted.
We wish you the best of luck, and thank you for providing as much information as possible!

Your name: ____ Date: ______________________________

Name of Insurance Company: ____

ID # ____ Group # _________________________________

What is the insurance renewal date? ____

Name of representative? ____ Date/Time: ___________________

Does your insurance plan cover **Naturopathic Medicine**? YES or NO

Does your insurance plan have out-of-network benefits for Naturopathic? YES or NO

Is Rachel Meredith ND IN NETWORK with your plan? YES or NO

Is a pre-authorization required for code 99215? YES or NO

Do you need to meet a deductible before benefits start? YES or NO

How much is the deductible? (If you have a high deductible, let us know) $___________
How much of my deductible do I still need to meet this year? $__________

Copy amount: $_________ OR Coinsurance (percent you pay): __________ %
Annual Visit Limit: ________ OR Annual dollar limit: $_______________

Does your insurance cover **acupuncture**? YES or NO

Does your insurance plan have out-of-network benefits for acupuncture? YES or NO

Is Rachel Meredith IN NETWORK with your plan? YES or NO

Is pre-authorization required for codes 97810 and 97811? YES or NO

Do you need to meet a deductible before benefits start? YES or NO

How much is the deductible? (If you have a high deductible, let us know) $___________
How much of my deductible do I still need to meet this year? $__________

Copy amount: $_________ OR Coinsurance (percent you pay): __________ %
Annual Visit Limit: ________ OR Annual dollar limit: $_______________

Dr. Meredith does not do pre-authorizations. If a benefit requires one, the service will need to be paid out of pocket at a discounted rate instead of through insurance.