Blue Tree Healing Arts

Auky van Beek, PA-C, CST-C
Seattle WA
(206)-313-1656 PAauky@bluetreehealingarts.com

HEALTH HISTORY

Name: _____ Birthdate: _____ Date:_____/_____/_____

CHIEF COMPLAINTS: **Please list (in order of importance) the health concerns, symptoms, or problems you are experiencing:**

1. _____

2. _____

3. _____

Gender M / F Place of Birth: _____ Height _____ Weight _____

Relationship Status: _____ Children Y / N Ages _____

VITAMINS, MINERALS, HERBS (doses)

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (doses)

ALLERGIES (foods, drugs, environmental, other)

CIRCLE IF YOU:

Diet often	Are under excessive stress	Have chemicals at work	Do not sleep well
Alcohol (frequency)	Recreational Drugs	Spiritual Practice (specify →)	

WOMEN ONLY: Are you currently pregnant? Yes / No Age at onset of menses:_____

No of pregnancies: _____ No of miscarriages _____ No of abortions _____

Problems with period? _____ Age at menopause (if applicable):_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):

_____ ☐ None

_____

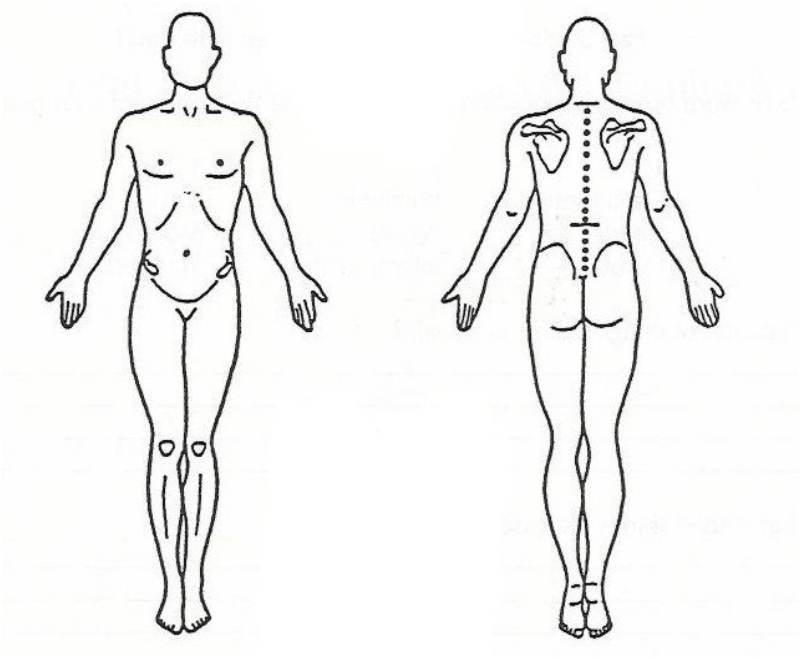
List all serious illnesses, operations, and other hospitalizations, please indicate year these occurred:

_____ ☐ None

_____

PLEASE INDICATE THE AREAS WHERE YOU ARE EXPERIENCING PAIN

assign an intensity between 0 and 10 (0 being no pain and 10 being the worst pain ever experienced).



When did your pain start?

_____

Was there a particular event that caused your pain?

_____

How often does it occur and for how long?

_____

Pain is (Please check all that apply)

❑Sharp ❑Dull ❑Aching ❑Numb
❑Tingling ❑Shooting ❑Numb ❑Burning
❑Superficial pain ❑Deep pain
❑Pain worse/better with cold
❑Pain worse am/pm
❑Pain worse/better pressure
❑Pain worse/better with heat ❑Other _____

I have (Please check all that apply)

❑Swollen joints ❑Arthritis/joint pain ❑Tendinitis ❑Bone pain ❑Muscle cramping ❑Muscle pain
❑Repetitive Strain Injury ❑Fractured Bone(s)

Where? _____

PAST MEDICAL HISTORY

Car Accidents	no	yes	Stroke	no	yes	Polio	no	yes
Sports Accidents	no	yes	Cancer	no	yes	Venereal Disease (STD's)	no	yes
Chiari malformation	no	yes	Heart disease	no	yes	AIDs or HIV+	no	yes
Concussions	no	yes	Measles	no	yes	Kidney Disease	no	yes
Head trauma	no	yes	Mumps	no	yes	Bleeding tendency	no	yes
Pelvic trauma	no	yes	Rubella	no	yes	anemia	no	yes
Acute infection	no	yes	Chickenpox	no	yes	Blood Transfusions	no	yes
Thyroid Disease	no	yes	Whooping cough	no	yes	chest x-ray	no	yes
Hepatitis	no	yes	Mono	no	yes	Lyme disease	no	yes

Any other disease (please list) _____

FAMILY HISTORY:	**who**		**who**
Alcohol or Drug Problem		High Cholesterol	
Allergies		HIV	
Anemia		Kidney Disease	
Asthma		Thyroid Sisease	
Autoimmune disorders		Migraine / Headaches	
Cancer / Tumor		Multiple Sclerosis	
Chronic Lung Disease		Muscular Dystrophy	
Depression		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Parkinson's disease	
Glaucoma		Rheumatoid Arthritis / Gout	
Genetic diseases		Stroke	
Heart Disease		Ulcers	
Hepatitis		Mental Illness	
Herpes		Other:	
High Blood Pressure		Other:	

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PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ Middle Name: _____

Address _____ City _____ State _____ Zip code_____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____ Email_____

May we leave confidential voice-mail messages for you at any of the above numbers? No Yes specify: **Home Work Cell**

Date of Birth (required) _____/_____/_____ Birth Gender _____Gender Identity _____ Preferred Pronouns _____

Employer/School _____

Minors Only: Mother's Name: _____ Father's Name: _____

Emergency Contact Name: _____ Contact's Phone: (_____) _____

Relationship to Emergency Contact _____

Do you have special needs? _____ Are you visually impaired? Yes **No** Hearing impaired? Yes No

In this section fill out Insurance / Card Holder's Information

Insured Last Name _____ Insured First Name _____ Insured Middle Initial _____

Insurance Company _____ ID# _____ Group # _____

Insurance PO Box _____ City _____ State _____ Zip _____

Insurance Phone (_____) _____ Insured Date of Birth (required) ____/_____/_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____
Guarantor's Signature **Date**

Terms of Admission

Financial Terms: I understand that I am responsible for all charges. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency, and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so.

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature Date

_____
Relationship to Patient/Representative Authority

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INFORMED CONSENT FOR TREATMENT

Name_____ **Date of Birth**_____

I hereby authorize Auky van Beek, PA-C to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **Common procedures**: e.g., venipuncture, injections.
- **Minor office procedures**: e.g., dressing a wound, ear cleansing.
- **Medicinal use of nutrition**: therapeutic nutrition, nutritional supplementation.
- **Botanical medicine**: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.
- **Homeopathic medicine**: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene**: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
- **Psychological Counseling**
- **Physical Medicine**: naturopathic osseous manipulation and soft tissue work, including Craniosacral Therapy.
- **Prescription medications:** may be prescribed as necessary.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: all interventions carry potential risks, including but not limited to: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures, possible interaction between natural supplements or products prescribed and prescription drugs.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the provider if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Auky van Beek, PA-C regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept securely for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Auky van Beek, PA-C

_____
Signature of Patient

_____
Signature of Patient Representative or Guardian

_____
Date

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NOTICE OF PRIVACY POLICES

ACKNOWLEDGEMENT

Auky van Beek PA-C, CST-C are required to provide you with a copy of their Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at this clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact Auky van Beek PA-C, CST-C at the address, email, or phone number above.

I hereby acknowledge that I have received a copy of Auky van Beek PA-C CST-C of Blue Tree Healing Arts Notice of Privacy Practices.

_____ _____

Patient's Name Date of Birth

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority