Santiam Community Health

serving the Willamette Valley

CLASSES • WORKSHOPS • MEDICAL SERVICES

Patient Intake & Consent Date: _____

Legal Name: _____Preferred Name (if different):_____ Birth Date: _____ Current Condition/Complaints (Please fill in as completely as possible)

What is your **primary complaint/problem**? (please mark on image)

_____

Other related symptoms:

_____

_____

_____

How did your symptoms first begin?

_____

_____

When did your symptoms first start?

_____

Have you had **symptoms like this before**? □No □Yes (describe) _____

_____

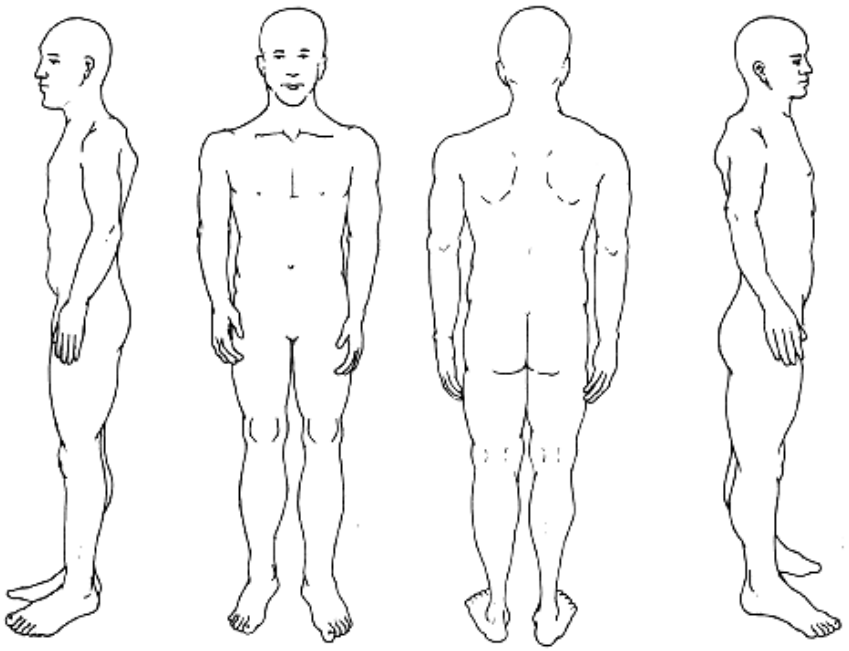
Are your symptoms **getting worse**? □No □Yes

Are they worse **at certain times** of the day or night? _____

What makes your symptoms **worse**? (list)

_____

_____



What makes your symptoms **better?** (list)

_____

List *all* doctors/therapists/specialists **seen for this problem** & treatment received:

_____

Have you had imaging relating to this concern: □ X-ray □ MRI / CT □ Other _____

How do your symptoms **interfere with your normal daily routine**? _____

_____

List all current over-the-counter and prescription **Medication/Vitamins/Supplements/Herbs/Birth Control** you take: _____

_____

List any **medication allergies and their reaction**: _____

Are you allergic to lidocaine or other anesthetics? □No □Yes

Are you currently under the care of a Primary care physician? □ NO* (you must find a PCP asap!)

□YES Clinic/Physician's Name: _____

Health concerns being treated: _____

If female, is there **a possibility that you are pregnant?** □ NO □ YES

Check the box for the following **symptoms you are experiencing NOW or have experienced in the PAST**:

[N] = NOW [P] = PAST

[N] [P]	[N] [P]	[N] [P]
□ □ Headaches	□ □ Arm/hand numbness/tingling	□ □ Chills/fever
□ □ Visual or hearing pain or loss	□ □ Arm/hand fatigue/weakness	□ □ Dizziness or light-headedness
□ □ Joint pain or swelling	□ □ Memory loss or disturbances	□ □ Weight gain/loss
□ □ Leg/foot numbness/tingling	□ □ Fatigue or loss of energy	□ □ Fainting or convulsions
□ □ Neck pain or stiffness	□ □ Leg/foot fatigue/weakness	□ □ Trouble with balance
□ □ Pain or difficulty swallowing	□ □ Nausea or vomiting	□ □ Abdominal Pain
□ □ Low back pain	□ □ Pain with/trouble breathing	□ □ Diarrhea or constipation
□ □ Chest pain		

Medical History (Please fill in as completely as possible)

List any ongoing/chronic health conditions/diagnoses: _____

List any **Surgeries or Hospitalizations** (include dates & reasons): _____

_____

List any **Significant Trauma** (Auto accidents, falls, etc. include dates): _____

_____

Any Family History related to your primary concern: _____

Any **Additional Information** about yourself: _____

_____

Prolotherapy Consent for Treatment and Acknowledgement of Billing Practices

I hereby consent to Naturopathic procedures to be performed on myself, (or on the patient named below, for whom I am legally responsible) by Dr. Angela Cortal ND. This consent includes any and all procedures consented to by named patient.

I understand and consent to the following procedures if deemed medically appropriate and indicated: physical examination, tests, dietary advice and therapeutic nutrition, prolotherapy and/or recommendation/referral for additional care or testing.

I understand, as with any health care procedures, that there are certain complications which may arise during in-office naturopathic treatments. Those complications include but are not limited to: pain, discomfort, bruising, infections (0.00033%), itching, loss of consciousness and deep tissue injury from needle insertions, CSF headache/leak, pneumothorax (0.00012% with thoracic sites), infiltration, fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations, and/or allergic reactions to injectate (0.0055%).

I understand that Dr. Cortal reserves the right to terminate the doctor/patient relationship if I am non-compliant with the treatment plan and/or if a conflict of interest arises.

Initial your consent and acknowledgement of the following:

____ *I understand that all visits and procedures performed by Dr. Cortal through Santiam Community Health are outside of insurance coverage and are not billed to insurance.*

____ *I agree that I am financially responsible for my treatment. I agree to pay for services performed at the time of service. I have been given this information prior to procedures being performed.*

_____ *I understand that Prolotherapy Pop-Up clinic rates are either standard fees, or a reduced rate if I am a Non-profit qualifying patient and have submitted my application. Rates are based on donations and can change. If I am unsure about current rates, I will ask prior to treatment.*

I understand that I have the right to refuse treatment at any time and/or have the choice to get treatment performed elsewhere.

Due to her concern of potentially incurring a needle stick, I understand I must disclose to Dr. Cortal all known and suspected active infections, whether acute or chronic, due to any infectious origin.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of standard of care, abstaining from care and other recommended procedures and options. I have had my questions answered to my satisfaction.

I also understand that standard expectations and effects of treatment have been described, but specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the treatments. I state that I have been informed and weighed the risks involved in prolotherapy treatment. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

The HIPAA Notice of Privacy Practices is available on our website www.santiamhealth.org for you to review prior to your visit and obtain a digital copy if desired.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO ALL OF THE ABOVE

Patient Name (printed): _____

Signature: _____ Date: _____

Signed by: Self □ Guardian/Responsible Party □ : _____

This consent and acknowledgement is hereby valid and active until such time that we receive written notification revoking consent.

Rev 9/25/18