



Santiam Community Health

serving our community

CLASSES • WORKSHOPS • MEDICAL SERVICES

Health History

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 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**: _____

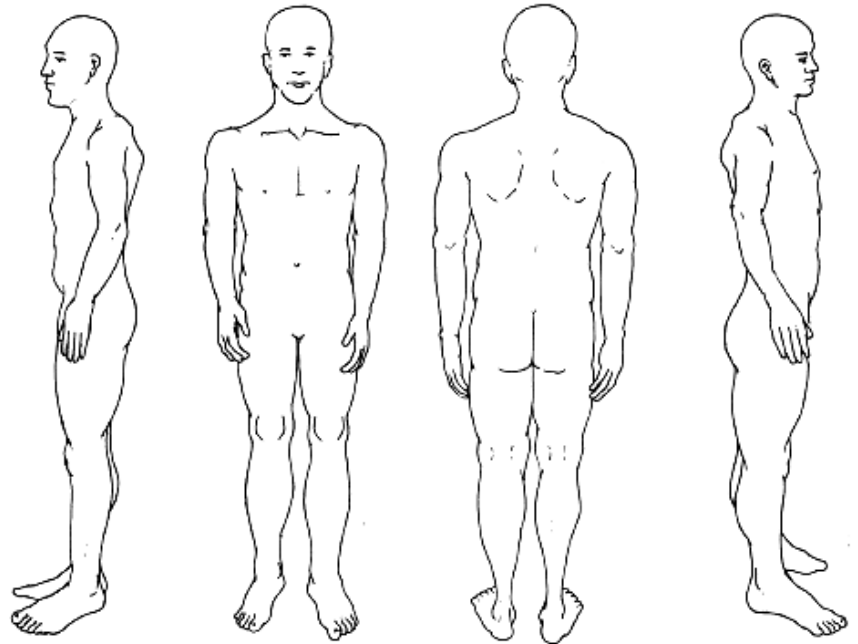
Are you allergic to lidocaine or other anesthetics? No Yes

Primary care 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

- | | | |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] Headaches | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Arm/hand numbness/tingling | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Chills/fever |
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] Visual <u>or</u> hearing pain <u>or</u> loss | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Arm/hand fatigue/weakness | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Dizziness <u>or</u> light-headedness |
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] Joint pain <u>or</u> swelling | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Memory loss or disturbances | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Weight gain/loss |
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] Leg/foot numbness/tingling | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Fatigue <u>or</u> loss of energy | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Fainting <u>or</u> convulsions |
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] Neck pain <u>or</u> stiffness | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Leg/foot fatigue/weakness | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Trouble with balance |
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] Pain <u>or</u> difficulty swallowing | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Nausea <u>or</u> vomiting | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Abdominal Pain |
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] Low back pain | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Pain with/trouble breathing | <input type="checkbox"/> <input type="checkbox"/> [N] [P] Diarrhea <u>or</u> constipation |
| <input type="checkbox"/> <input type="checkbox"/> [N] [P] 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. Eloise 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, 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 the Prolotherapy Pop-Up clinic operates by offering standard fees, or a reduced rate if I am a Non-profit qualifying patient, have submitted my application, and continue to meet the qualifications. Rate levels are influenced by non-profit donations and thus are subject to 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 acute or chronic infections.

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 at www.santiamhealth.org for you to review prior to your visit, where you may obtain a digital copy if desired.

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

Patient Name (printed): _____

Signature: _____ Date: _____

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

(one more page to go! ↓)

Non-profit Participation Application

(signing this page allows us to offer you discounted rates)

Initial one box and sign at the bottom:

I am electing to pay the standard/ non-discounted rates (new patient \$300, return patient \$250). Thank you! Your generosity allows us to help us more in the community.

OR

I am applying for non-profit participation/discounted rates (new patient \$200, return patient \$150). **I am selecting the following qualification... (check one below)**

Uninsured or underinsured

Low Income (as defined in Oregon by the Department of Housing and Urban Development, which is: 1 Person in household = \$41,840; 2 People = \$47,800; 3 People = \$53,800; 4 People = \$59,750; 5 People = \$64,550, 6 People = 69,350; 7 People = \$74,100; 8 People = \$78,900).

Unemployed / Disability / Fixed Income (such as Students, Seniors, those on SSI)

Significant chronic medical condition(s) creating financial hardship

Active Military or Veteran (thank you for your service!)

Name (printed): _____ Signature: _____ Date: _____

Santiam Community Health Mission Statement

Our mission is to educate, support and provide for those in our community who are under- or uninsured or otherwise experience barriers to receiving comprehensive healthcare.

Through community health education classes, workshops and medical services, we strive to improve the health of our community, one member at a time.

We seek to expand health education and services also to those traditionally under-served by the customary medical model, including: low-income, students, seniors, active military, veterans, those on SSI and/or experiencing significant chronic medical conditions.

We are here to serve you, the community!