Inside Passage Natural Medicine
Debbie Gillespie ND, CDM
Doctor of Naturopathic Medicine

853 Basin Road
Juneau, AK 99801
phone: (907) 463-2600
fax: (907) 463-2675

Client Registration

Date: _____ Social Security Number: _____
Name: First _____ Middle. _____ Last: _____
Address: _____ City: _____ Zip: _____
Mailing Address: _____
Home Phone: _____ Cell/other phone: _____
Birth date: _____ Marital Status: _____ email: _____
Employer: _____ Occupation _____
Work Status: Full ___ Part time___ Retired___ Student____
Spouse/Partner's Name: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Primary Insurance Holder. If same as above leave blank)
First Name: _____ M.I.___ Last Name: _____
Address: _____
Home Phone: _____ Birth date: _____ Marital Status: S M D W
Social Security Number: _____ Employer: _____
Occupation: _____
Work Status: Full___ Part time___ Retired____ Student___

Payment and Insurance Information

Primary Insurance: _____
Address: _____
Phone Number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Other Insurance: _____
Address: _____
Phone number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Assignment of Benefits, Release of Information & Payment Agreement

I understand that Inside Passage Midwifery and Natural Medicine will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Inside Passage.

I permit Inside Passage to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act)

I agree that I am responsible for full payment on this account. I agree if 60 days pass without payment or discussion of a payment plan, my account will be sent to collections and I will be responsible for the outstanding balance and any fees incurred in the collections process.

Client signature: _____ Date: _____

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INSURANCE AND FINANCIAL INFORMATION

I understand and agree that health and accident insurance are an arrangement between an insurance company and me. I hereby authorize Debbie Gillespie ND to furnish medical information to my insurance carriers concerning this condition. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

As a courtesy, we will bill your insurance company for you. Any amount not covered by your plan will be billed to you monthly. Vitamins and other supplements are not typically covered by insurance. If this naturopathic doctor recommends supplements as part of the treatment plan, you will be responsible for those costs should you choose to purchase them from Inside Passage or elsewhere.

In accordance with State of Alaska Naturopathic Regulations (12 AAC 42.900) please be advised that Deborah Gillespie is a Naturopath licensed by the state of Alaska. She earned her degree at Southwest College of Naturopathic Medicine and Health Sciences, which is accredited by the Council on Naturopathic Medical Education, the accrediting agency for naturopathic colleges and programs in the United States and Canada. She is not covered by malpractice insurance at this time.

Please also be advised that in addition to her Naturopathic practice, Dr. Gillespie is also a midwife. There is a possibility your appointments may need to be rescheduled in event of a labor/birth. Every effort will be made to reach you with as much notice as possible should the situation arise.

If you are unable to make your scheduled appointment, please call to cancel within 24 hours or as soon as possible.

By signing below, I have read and understand this policy.

Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian signature: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Context of Care Review

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

1. Why did you choose to see me?

2. What do you know about my approach?

3. What expectations do you have from **this** visit?

4. What **long term** expectations do you have from working with me?

5. What expectations do you have of me personally as your health care provider?

6. What is your present level of commitment to address any underlying causes of our signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed

   0% 0 1 2 3 4 5 6 7 8 9 10 100%

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

8. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols while I will be sharing with you?

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

10. What do you love to do?

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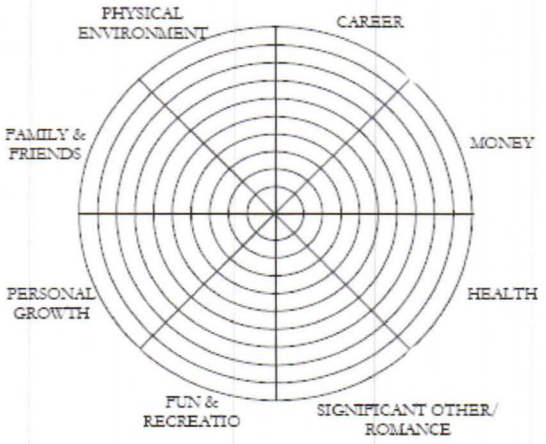
Name: _____

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

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Medical History:

Please mark if you have or have had any of the following conditions. In the space below record date, treatment and any follow-up care received. Also feel free to list any other conditions or concerns.

___ Endocrine: diabetes, disorders involving thyroid, adrenal, pituitary or parathyroid glands
___ Cardiovascular: high blood pressure, heart or valve problems, chest pain, irregular heart beat
___ Gastrointestinal: constipation, diarrhea, IBS, GERD/reflux, ulcers, nausea, vomiting
___ Hematological: anemia, bleeding disorders, blood transfusions, thrombophlebitis
___ Musculoskeletal: fractures, neck problems, back problems, injuries, trauma, arthritis, fibromyalgia
___ Pulmonary: asthma, cough, pneumonia, pulmonary embolism, tuberculosis
___ Neurological: epilepsy, seizure, strokes, neuropathy, headaches, head injury
___ Autoimmune: lupus, multiple sclerosis, rheumatoid arthritis, celiac disease
___ Dermatological: eczema, allergy, psoriasis, warts, acne
___ Mental/Emotional: depression, anxiety, eating disorders, addictions,
___ Other: accidents, surgery, significant illness, domestic violence

_____
_____
_____
_____
_____
_____

Women Only:

How old were you when you had your first menstrual period? _____
When was your last Pap? _____
Have you ever had an abnormal Pap? _____
Please mark if you have ever had any of the following conditions or procedures:

	Yeast infection		Pelvic Inflammatory disease		Uterine fibroids
	Bacterial vaginosis		Cervicitis		Uterine surgery
	Chlamydia		Cervical polyps		Breast lumps
	Gonorrhea		Ovarian cysts		Breast surgery
	Syphilis		Polycystic ovarian syndrome, PCOS		Repeated miscarriage
	Trichomonas		Endometriosis		Infertility
	Genital herpes		Abnormal bleeding		Other
	Genital warts		Cervical surgery/LEEP		
	Group B strep		HPV: human papilloma virus		

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Name: _____

Childhood Medical History:

Prenatal History: Any complications during your mother's pregnancy with you? __ yes __ no
If yes, describe:_____
_____

Birth History: __ vaginal __ cesarean section __ forceps __ vacuum __ trauma?
Any problems as a newborn? _____

Nourishment: As a baby, were you fed __ Breast milk __ Formula __ Mixed

Childhood Illness: How often did you get sick as a child? _____
What kind of illnesses did you usually experience? Ear infections, sore throat, cough, Allergies, asthma… _____
_____
How often did you take antibiotics? _____
Other medications taken regularly as a child? _____
_____

Did you ever have:
__ Measles __ Mumps __ Rubella __Chicken Pox __Rheumatic Fever
__ Polio __ Pertussis __ Other infectious diseases

List Any Other Medical Problems You Had As A Child:
_____
_____
_____
_____

Home Environment: How many children in your family? _____ Your birth order (i.e. 2nd of 3) _____
What adults lived with you? _____
Was your home safe? _____
Did you have any traumas or losses as a child? _____
_____
Any difficulties in school? _____
Did anyone in your home smoke or use drugs regularly? _____

Family History

Do you or anyone in your family have a history of any of the following? Circle and indicate relation

Cancer	Diabetes	Heart Disease	High Blood Pressure	Kidney Disease
Arthritis	Stroke	Autoimmune Disease	Chemical Dependency	Mental Illness

Any other relevant family history? _____
_____
_____

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Hospitalizations/Surgery/Imaging:

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ Year:_____ _____ Year: _____
_____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____

Allergies:

Are you allergic or hypersensitive to
:
Medications: _____

Foods: _____

Environmental or Chemical: _____

Current Medications:

Please list any of the following you currently take.

Prescription Medications:

_____
_____
_____
_____

Over the Counter Drugs:

_____
_____
_____

Vitamins and Other Supplements:

_____
_____
_____
_____
_____

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Name: _____

Lifestyle:

Sleep: How many hours of sleep do you normally get? _____ Wake rested? _____.
Describe any sleep issues you have: _____

Activity: How would you describe your activity level?
__ Sedentary ___ Mild exercise __ Occasional vigorous exercise __ Regular vigorous exercise
_____

Diet: How would you describe your diet? _____
_____
_____

Water: How much water do you normally drink per day? _____

Caffeine: Do you consume caffeine? Coffee, tea, soda? If yes how much per day? _____
_____

Alcohol: Do you drink alcohol? ___ Yes ___ No
If yes, describe your daily/weekly intake: _____
_____

Tobacco: Do you use tobacco? ___ Yes ___ No
If yes describe type, how often, how many years. If yes in the past, when did you quit?
_____
_____

Drug: Do you currently use recreational or street drugs? ___ Yes ___ N0
If yes, please describe: _____

Home: Is your home a sanctuary for you? ___ Yes ___ No _____
_____
Who lives with you? _____
_____
_____
Do you have: ___ telephone ___ electricity/heat ___ enough food
Is your home safe? ___ Yes ___ No _____
_____
Is there a gun in your home? ___ Yes ___ No

Work: Do you work outside the home? ___ Yes ___ No.
Please describe your work: hours/week, days/week, sitting at a desk all day?
_____
_____

Thank you for your time and effort. I look forward to providing you with the best possible care. If there is anything else you think I should know, or your thoughts on why you are experiencing health issues, please use the back of this page to describe.

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Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score