Raina Lasse, ND
Listen. Understand. Heal.
@ PORTLAND HEALING SPACE

Patient Health History

*Please note that all health history is kept confidential

Name: ____ Date of Birth: ______________ Age _______

Gender M / F / Other/Preferred Pronoun __________ Email:____________________________________

Telephone: (M) ______________________ (W) ________________________

Address: ____ / _______________ / ______ / __________
Street #/PO Box City State Zip Code

Who may I contact in an emergency? Name: _________________________ Phone: ______________

How did you hear about Portland Healing Space?

Website _____ Google Search _____ Facebook _____ Twitter _____ Google Plus _____ Yelp ____

Friend (who should we thank?) ____________________________ Other ________________________

SOCIAL HISTORY

Occupation: ______________________ (circle) Full-Time / Part-time / Student / Retired / Disability

Employer / School: ____

Are you currently: (circle) Single / Married / long-term relationship / Widowed / Divorced / Other

Name of Partner: __________________________ Number of Children and ages? _______________

Have you traveled outside the US in the past 5 years? Y / N *If yes,*

Where? ___________________________________ When? ____________________________

HEALTH CONCERNS

(Please list, in order of importance, your health concerns followed by how long you have had each concern or condition)

For example: *High blood pressure* *5 years*

1. ________________________________
2. ________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________

What do you believe is the cause of condition #1?

____

____

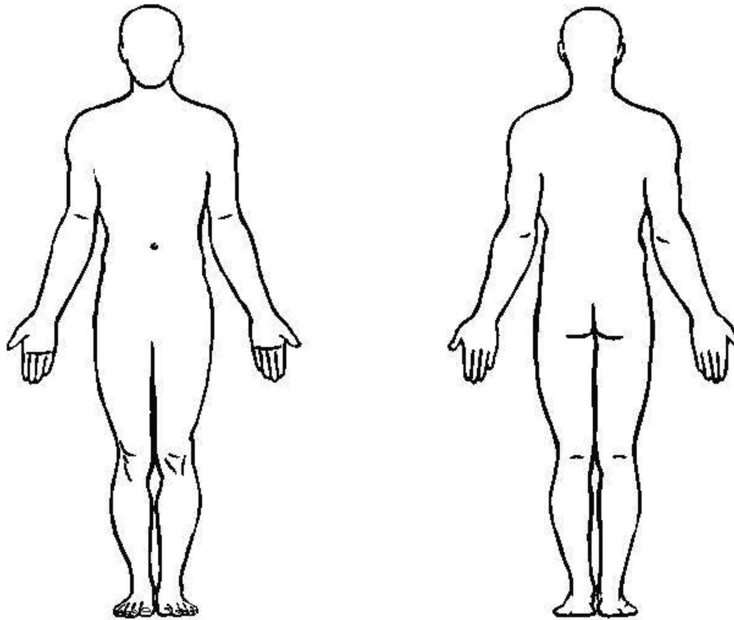
If you have been treated for this condition (by yourself or a doctor), what method or medicine was used? ____

____

Are you currently experiencing pain? Mark with an x on the figure where you are having pain.

Do you have numbness or tingling? Mark with "n" or "t" on the figure.

What kind of pain? Burning ____ Dull ____ Achy ____ Stabbing ____ Throbbing ____ Sharp ____



List and date any major surgeries / accidents / traumas:

1. ____ Onset? _____________ Severity? (1-10) ________
2. ____ Onset? _____________ Severity? (1-10) ________
3. ____ Onset? _____________ Severity? (1-10) ________

Do you have any allergies to foods, medications or allergens in your environment (cats, pollen, etc.)? Y / N If yes, please list: ____

____

____

Do you exercise, if so, what type and how often? ____

____

MEDICATIONS: (Please list all pharmaceutical medication(s) and dosage(s) that you are currently taking. You can use a separate sheet of paper if it's easier for you.)

For example: Lipitor 10 mg/day 5 years

1. _______________________________________
2. _______________________________________
3. _______________________________________
4. _______________________________________
5. _______________________________________

SUPPLEMENTS: (Please list all homeopathic remedies, herbs, vitamins and minerals, with dosage, that you are currently taking. You can use a separate sheet of paper if it's easier for you.)

For example: Vitamin D_3 2,000 IU/day

1. ____
2. ____
3. ____
4. ____
5. ____

HEALTH GOALS

Please tell us a bit about your short and long-term health goals________________________________

____

____

____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Do you feel like you have a good support network? Yes / No

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list) ____

____

____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list) ____

____

____

Please tell us a little about what you expect from us as your wellness specialists so we can try our best to meet your needs: ____

____

____

Please circle any conditions you are currently experiencing or have experienced in the past.

Gastrointestinal

Nausea
Excess
Belching

SensitiveAbdo
men
Diarrhea
Pain/Cramps

Constipation
Hemorrhoids
Black Stools
Excess Gas

Bad Breath
Blood stools
Peptic Ulcers
Vomiting

Rectal
Bleeding
Gastritis
Heartburn

Cardiovascular

High Blood
Pressure
Low Blood
Pressure
Blood Clots

Dizziness
Fainting
Phlebitis
Chest Pain

Cold Hands/
Feet
Difficulty
Breathing

Irregular
Heartbeat
Swelling in
Hands/Feet

Other:________
____

Respiratory

Cough
Coughing Blood
Pneumonia

Asthma
Bronchitis
Tight Chest

Production of
Phlegm

Difficulty Breathing
When Lying Down

Pregnancy and Gynecology

Are you pregnant? _____ Y _____ N   If Yes, how many months? ________________________
# of Children _____ Ages ____

# of Pregnancies ____
# of Births ____
Premature Births _____
Miscarriages ____

Last PAP ________
Age at First Period_____
Period Duration (days) ______
Last Period ________
Flow: Heavy / Light / Regular

Menopause ____Y ____ N
Premenopausal ____Y____
Vaginal Sores ____ Y____N
Breast Lumps____Y____N

Do you experience clotting and/or vaginal discharge? If yes, please detail how much and how often?
____

Genito-Urinary

Pain on Urination
Incontinence
Urgency to Urinate

Frequent Urination
Kidney Stones
Impotency

Blood in Urine
STD

Wake up to Urinate
____/night

Neuropsychological

Seizures
Depression

Areas of Numbness
Anxiety

Poor memory
Mood swings

Concussion
Easily Stressed

Have you been treated for emotional difficulties? if so, when? _______________________________

Head, Eyes, Ears, Nose, Throat

Grinding Teeth
Teeth problems
Jaw Clicks
Dry Mouth
Dry Throat
Excess Saliva
Gum Problems

Recurrent Sore Throats
Sores on Lips & Tongue
Sinus problems
Nose Bleeds
Excess Mucus
Dizziness
Migraines

Facial Pain
Poor hearing
Ringing in Ears
Earaches
Blurry Vision
Cataracts
Spots in Eyes

Eye Strain
Night Blindness
Glasses/Contacts
Eye Pain
Poor vision
Glaucoma
Macular Degeneration

Skin & Hair

Rashes
Acne
Itching
Eczema
Hives
Loss of Hair
Ulcerations
Dandruff
Change in hair/skin texture? ______ Yes ______ No
Other hair/skin problems? ____

Sleep

Cannot Fall Asleep
Excessive Sleep
Tired Upon Waking
Wake up too Early
Snoring
Cannot Fall Asleep After Waking
Tossing & Turning During Sleep
Lots of Dreams
Wake up Easily ____/night

Appetite

Large
None
Average
Snacks Between Meals

Sweat

Easily Perspires
Night Sweats
Rarely Perspires

Temperature

Feeling of heat? Where? ______________
Alternating Chills or Feverishness?
Feeling of coldness? Where? _____________

Please Fill this out according to your current lifestyle:

	None	A Little	Some	A Lot
Fruits & Veggies				
Meat				
Dairy				
Fast Food				
Soda/Caffeine				
Sugar				
Gluten				
Cigarettes				
Canabis Marijuana				
Exercise				
Alcohol				

Please list any other recreational drugs : ____

MEDICAL HISTORY

Please mark P (past) or C (current) for any of the following conditions that you or your family members have had:

Condition	Self	Father	Mother	Sibling(s)	Aunt/ Uncle	Grand Parent(s)	Child
ADD/ADHD							
Alcoholism							
Allergies							
Anemia/Blood Disorder							
Anxiety/Depression							
Arthritis							
Asthma							
Autoimmune Disease							
Blood Vessel Disorder							
Cancer							
Chemical Sensitivities							
Diabetes							
Drug/Other Addiction							
Eating Disorder							
Epilepsy/Seizures							
Gall Bladder Disease							
Gastrointestinal Disorder							
Glaucoma/Cataracts							
Gum Disease							
Headaches/Migraines							
Heart Disease							
Heart Murmur							
High Blood Pressure							
Hypoglycemia							
Infertility							

Condition	Self	Father	Mother	Sibling(s)	Aunt/ Uncle	Grand Parent(s)	Child
Liver Disease							
Lung Disease							
Menstrual Disorder							
Mental Illness							
Muscular Disorder							
Neurological Disorder							
Pain, Chronic							
Skeletal Disorder							
Skin Disorder							
Stroke							
Thyroid Disorder							
Tuberculosis							
Ulcer (Gastrointestinal)							
Urinary Disorder							
Vision Problems							
Yeast Infections							

Financial Policy

The purpose of this policy is to assist you in maintaining a balance between the clinic (for services rendered) and your best interest. Portland Healing Space feels that by maintaining an equitable balance, both communication and healing are furthered.

Please read the following carefully and **INITIAL** on the line next to the agreement that applies to you:

____ **PRIVATE PAY** I will pay for all services as they are rendered. Portland Healing Space prefers cash or check but also accept credit cards for your convenience.

____ **PPO/INSURANCE COMPANY/GROUP HEALTH** I acknowledge that I am responsible for reviewing and understanding my insurance benefits before the time of service.

____ **MVA (Motor Vehicle Accident)**

____ **Workman's Comp**

- As a courtesy to you, we will gladly submit your medical bills to your insurance company; however, ultimately, you will be responsible directly to Portland Healing Space for full payment of your account if your insurance company fails to make payments to us.
- I understand that I am responsible for whatever copayment, deductible, and non-covered services that my plan has set forth at the time the services are rendered. We have a "time of service" discount for the patients that pay the day services are rendered. If you are unable to pay in full, you may choose to arrange a payment plan. Payment plans may not be extended to patients who have failed to make timely payments in the past.
- I understand it is my responsibility to keep my medical record up to date with current address and insurance information so that billing can be done in a timely manner. Some insurance companies require claims be submitted within 7 days and if new insurance coverage is not provided prior to services, it will not be possible for us to bill or collect from your insurance carrier.
- Checks returned by your bank will be subject to a $35 service fee.
- Payments received from your insurance after you have paid will be promptly returned to you.
- There will be a $60.00 charge for all missed scheduled appointments that have not been cancelled with a 24 hour notice.

By signing below, I certify that I understand and agree to the financial policy presented to me by Portland Healing Space.

Signature: ____ Date: ________________
Print Name: ____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS NOT A RELEASE OF YOUR MEDICAL INFORMATION

This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. “PHI” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Y our PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose 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 PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Y our PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. Healthcare

Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations w without your authorizations.

These situations include: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers’ Compensation, Inmates.

Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other Permitted and Required Uses and Disclosures will be made only with your consent. Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights: You have the right to inspect and copy your PHI, under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. T his means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request; even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your PHI, if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such
rebuttal. You have the right to receive an accounting of certain disclosures we've made, if any of your PHI 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.

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. W e will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI.
If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (503) 894-9437.

Signature below is acknowledgement that I have received this notice of privacy practices.

Signature: ____ Date: ____________________
Print Name: ____

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PAYMENT INFORMATION

We encourage your questions and participation in all aspects of your care. Please read and initial the following statements and provide the following information.

_________ Payment for all services and medicinary items is due at the time of visit. We accept cash, visa and checks. Returned checks will be subject to at $35.00 NSF fee.

_________ You will be charged a Cancellation Fee of $60.00 for any appointments cancelled with less than 24 hours notice. If you completely miss your appointment and do not contact us, you will be charged for the full visit.

Card # _________________________________Exp. Date__________ CVC________ Zip_________

I have read and understand the above-stated policies of Portland Healing Space and will comply with them in all respects. If my insurance required release of my medical records, I hereby give my permission by singing this form.

____
Patient Name(Please Print. Include patent/guardian name if patient is a minor)

____ ____/____/___
Patient Signature (parent/guardian signature is minor) Date

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INFORMED CONSENT FORM

I hereby consent to the performance of acupuncture, naturopathic, massage therapy, pilates, physical therapy, nutrition services, and chiropractic adjustments, on me by the licensed doctors and practitioners who now or in the future work at Portland Healing Space.

Acupuncture I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

Naturopathic I understand that Naturopathic evaluation and treatment may include but is not limited to physical exam (including general exam, musculoskeletal, EENT, heart and lung, orthopedic,and neurological assessments), massage, dietary advice and therapeutic nutrition (the use of foods, diet plan, nutritional supplements), botanical and heal medicines, homeopathic remedies (highly dilute quantities of naturally occurring substances) , hydrotherapy (the use of hot and cold water), over-the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians). I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Lasse, including but not limited to questions regarding my suspected diagnosis(es) or condition. The nature , purpose, goals and potential benefits of the proposed care. The inherent risks, complications, potential hazards or side effects of a treatment or procedure, the probability or likelihood of success, reasonable available alternatives to the proposed treatment or procedure, potential consequences if treatment or advice is not followed.

Shiatsu bodywork and massage I understand the benefits that I may receive from the massage given here include but are not limited to stress reduction, relief from muscular tension and spasm, reduction of pain, promotion of circulation and lymph activity, improved sports performance, enhanced endurance, increased flexibility, injury prevention, and enhanced mental function. Although many people experience these benefits, there are no guarantees. Risks can include muscular soreness, bruising with certain deep tissue work. When the body is healing naturally, you may feel worse before feeling better. Contraindications for massage can include but are not limited to acute infection, injury, or disease, skin conditions, DVT, recent surgery.

Chiropractic I have had an opportunity to discuss with the clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

It is your responsibility to notify your practitioner of changes in your experience throughout your course of treatment, whether they are due to the treatment or incidental. Should you become pregnant, or develop any illness or injury, you must notify your practitioner at your next appointment, so that their care for you is comprehensive and safe.

I have read, or have had read to me, the above consent. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient signature: ____ Date: _______________

Printed name: ____

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Determining Health Insurance Eligibility

Portland Healing Space gladly provides billing services for their patients. Before billing can take place patient eligibility must clarified. It is **your responsibility** to be informed of your coverage, co-pay, and deductible. Please call your insurance company prior to your visit and answer the following questions:

Health Insurance Company: ____

Phone Number: _________________Member ID #:_________________ Group ID #:________________

Insurance Benefits

Date Verified: ______________ Rep I spoke with: ________________________________

Coverage Start Date: _______________________ through ________________________

Referral needed from Primary Care Physician for alternative services? Yes____ No____

Deductible: _____________ Remaining: _____________ as of: _____________________

- Is the practitioner In-Network or a preferred provider with my insurance? Yes____ No ____
- Are labs covered? Yes____ No____
- Is there a preferred lab? ____
- Is there a co-pay per visit or per specialty? Please circle which one.

Naturopathic Benefits:

% Covered_________ Co-pay/Co-Insurance _________ Year Max: _________

Visits Authorized per year: ___________Visits used: ______________

Acupuncture Benefits:

% Covered_________ Co-pay/Co-Insurance _________ Year Max: _________

Visits Authorized per year: ___________Visits used: ______________

Chiropractic Benefits:

% Covered_________ Co-pay/Co-Insurance _________ Year Max: _________

Visits Authorized per year: ___________Visits used: ______________

I have reviewed the above information and understand that services rendered are my responsibility. If there are services not covered by my insurance company I am responsible for payment of those charges.

Signature: ____ Date: _____________________