

Dear Patient,

Thank you for your interest in naturopathic care at Partners in Healing of Minneapolis and the opportunity to be a partner with you in your health. Naturopathic medicine approaches health from a holistic perspective and provides safe, effective, natural medicine tailored specifically to you.

The following pages are the start of our comprehensive discussion to learn about you. This form is somewhat long, but I appreciate your time to thoughtfully answer these questions.

The first office visit is where we gather the largest amount of information. This visit will be a thorough assessment of your health and you will need to allow approximately 1 to 2 hrs (depending upon the complexity of your health concerns).

**In order for us to prepare for this visit, we kindly request that this form be mailed or faxed to Partners in Healing of Minneapolis at least 2 days prior to your first appointment.**

Additionally, if you are taking any supplements and/or medications, have recent laboratory work, or pertinent medical records, please bring these to the visit.

If you are unable to keep your scheduled appointment time, **please let us know at least 48 hours prior to the scheduled time** so that we may allow other patients to have your appointment.

Thank you again for your interest in working with me. I look forward to meeting you.

Sincerely,

Dr's Nate & Nita Champion  
*Naturopathic Doctors*

**Confidential Patient Information**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone or Alternate Phone: \_\_\_\_\_  
S.S. # \_\_\_\_\_ Sex: Female / Male

Who referred you or how did you hear about us?  
Other practitioner \_\_\_\_ who? \_\_\_\_\_ Friend \_\_\_\_ who? \_\_\_\_\_  
Internet search (specify website): \_\_\_\_\_ Other: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent or Guardian Information:  
Name: \_\_\_\_\_ Relationship to the Child: \_\_\_\_\_  
(  Check here if same as above)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Marital Status: Single / Married / Divorced  
Emergency Contact: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
Relationship to the Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

We are excited to keep in touch with you! Please provide us with an email address to receive our **E-Newsletter** for healthy living tips, clinic announcements, specials, discounts, etc.  
Email Address: \_\_\_\_\_  
(you may opt-out anytime you wish)

*Clinic Policy requires payment at time of services.*

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

**Consent to Treatment (Informed Consent)**

I, \_\_\_\_\_, hereby voluntarily consent to outpatient care at Champion Naturopathic Health/Partners in Healing of Minneapolis, encompassing, but not limited to the following:

- Interview (history taking)
- Physical Examination
- Routine Diagnostic procedures
- Routine Laboratory work (blood, stool, urine, saliva, etc.)
- Homeopathic medicines (highly dilutes substances)
- Botanical medicines/Nutraceuticals (supplements)
- Dietary Advice & Clinical Nutrition

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that the treatment suggestions provided are not all accepted by the United States FDA and therefore should not be taken as such.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Champion Naturopathic Health/Partners in Healing of Minneapolis.

Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

**Signature of Patient or Person Authorized to consent for patient:**

\_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

If the patient is a minor or is unable to consent, please complete the following:

Patient is a minor and is \_\_\_\_\_ years of age.

Name of Father: \_\_\_\_\_ Name of Mother: \_\_\_\_\_

**Please read the following regarding your financial obligations while under the care of Dr. Nate Champion and/or Dr. Nita Champion at Partners in Healing of Minneapolis.**

- Payment is due at the time of service.
- We accept cash, check, debit and credit cards including Visa, Master Card, and Discover.
- We do not accept insurance, however:
  - Out of courtesy to our patients we will prepare a health insurance claim form and submit it to your insurance company requesting reimbursement for your visit charges.
  - We will also bill your insurance company for labs, bloodwork, and/or imaging. Specialized labs will not be billed through insurance.
- All new patients are required to provide a valid credit card number, expiration date and billing zip code in order to schedule a new patient appointment.
- **New patient appointments:**
  - We require 48 hours notice for cancelations for new patient visits. If you fail to cancel or do not show for your appointment without notification, your credit card will be charged \$100.
  - If you cancel with less than 48 hours notice but choose to reschedule at that time your credit card will be charged \$50.
- **Follow up visits:**
  - We require 24 hours notice for cancelations for follow up visits. If you fail to cancel or reschedule within 24 hours of your visit or do not show for your visit, your credit card will be charged \$25.
- **Phone consultations:**
  - We bill for phone consultations with our doctors. They often require the same time and expertise as office visits.
  - Billing for phone consults will be at the doctor's discretion. Phone calls requiring uncomplicated questions regarding treatment are often not billed but phone calls requiring an extended discussion or a number of questions will likely be billed.
- There are no refunds for services or labs.
- We would like to share with you briefly why we have implemented this cancellation policy. We spend a great amount of time and energy with each and every one of our new patients because we are committed to providing the highest quality of care. In order for us to do so, our new patient visits require us to block off large time slots, which creates scheduling problems when canceling or rescheduling visits at the last minute. We have implemented this policy for us to be able to continue providing this level of individualized care, for each and every patient.

By signing this agreement you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you give permission to us to charge your credit card for missed appointments, phone consultations, or any of the above stipulations that may apply to you. **We will automatically charge this card as described by the terms above.** If you request, phone consultations or other services may be paid with another card or account at the time of service. Your card on file can also serve as a convenient way to pay for supplements or services without having to wait in line at check out. As a courtesy, our front desk staff will call on the work day prior to your **new** patient appointment to remind you of your scheduled time. All other follow ups visits are your responsibility to remember.

Name of patient of legal guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Type of card:    Visa    MC    Discover    Card number: \_\_\_\_\_

Expiration date: \_\_\_\_\_ Security Code: \_\_\_\_\_ Billing zip code: \_\_\_\_\_

**Confidentiality Statement (HIPAA)**

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability & Accountability Act (HIPAA). You can learn more details regarding your rights by visiting the following website: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html> or by calling 1-866-627-7748.

**Your rights regarding your health information**

1. Ask to see and get a copy of your health records.
2. Have corrections added to your health information.
3. Receive a notice that tells you how your health information may be used or shared.
4. Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
5. Request where you would like to be contacted.
6. Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.
7. If you believe your rights are being denied or your health information isn't being protected, you can:
  - a. File a complaint with your doctor
  - b. File a complaint with the U.S. Government

**Shared information within Partners in Healing of Minneapolis**

In order to provide you with the best quality health care we do at times consult with our colleagues. Information regarding your medical history or current treatment plan may be shared with the other doctors/practitioners at Partners in Healing of Minneapolis.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at Partners in Healing of Minneapolis.

**Name of Patient or Legal Guardian:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Pediatric Intake Form

### Health Concerns

What are your child's most important health concerns? List in order of importance:

- |          |                       |
|----------|-----------------------|
| 1. _____ | Length of time: _____ |
| 2. _____ | Length of time: _____ |
| 3. _____ | Length of time: _____ |
| 4. _____ | Length of time: _____ |

### Hospitalizations or Surgeries

- |          |                           |
|----------|---------------------------|
| 1. _____ | When they occurred: _____ |
| 2. _____ | When they occurred: _____ |
| 3. _____ | When they occurred: _____ |

### Medications (drugstore or prescription)

- |          |                          |               |
|----------|--------------------------|---------------|
| 1. _____ | Condition Treated: _____ | Dosage: _____ |
| 2. _____ | Condition Treated: _____ | Dosage: _____ |
| 3. _____ | Condition Treated: _____ | Dosage: _____ |
| 4. _____ | Condition Treated: _____ | Dosage: _____ |

### Supplements

- |          |                          |               |
|----------|--------------------------|---------------|
| 1. _____ | Condition Treated: _____ | Dosage: _____ |
| 2. _____ | Condition Treated: _____ | Dosage: _____ |
| 3. _____ | Condition Treated: _____ | Dosage: _____ |
| 4. _____ | Condition Treated: _____ | Dosage: _____ |

Any known Allergies to food, drugs, environment, animals or other allergies (please describe):

\_\_\_\_\_

\_\_\_\_\_

Vaccination History: check if applies	Testing
<input type="checkbox"/> MMR <input type="checkbox"/> DPT <input type="checkbox"/> Hep B <input type="checkbox"/> Hib: <input type="checkbox"/> Polio: <input type="checkbox"/> Chickenpox: <input type="checkbox"/> Other: _____  Adverse reactions? (please explain) _____ _____	<b>Hearing test normal:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not tested  <b>Vision test:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not tested  <b>Speech impediments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past  <b>Learning impediments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Any particular household stressors child has witnessed or gone through:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Birth History																	
<p style="text-align: center;"><b>Prenatal</b></p> <p>Previous # pregnancy ____ Previous # births ____</p> <p>At time of conception:            Mother's age _____            Father's age _____</p> <p>Did you use prenatal vitamins: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mother's Pregnancy History:  <b>Please check all that apply</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Alcohol</td> <td><input type="checkbox"/> High blood pressure</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Nausea/vomiting</td> </tr> <tr> <td><input type="checkbox"/> Bleeding</td> <td><input type="checkbox"/> Physical trauma</td> </tr> <tr> <td><input type="checkbox"/> Caffeine intake</td> <td><input type="checkbox"/> Preeclampsia</td> </tr> <tr> <td><input type="checkbox"/> Emotional stress</td> <td><input type="checkbox"/> Smoking</td> </tr> <tr> <td><input type="checkbox"/> Gestational diabetes</td> <td><input type="checkbox"/> Recreational Drugs</td> </tr> <tr> <td><input type="checkbox"/> Infection</td> <td><input type="checkbox"/> Thyroid condition</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Prescription meds (please list) _____</td> </tr> </table>	<input type="checkbox"/> Alcohol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Physical trauma	<input type="checkbox"/> Caffeine intake	<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> Emotional stress	<input type="checkbox"/> Smoking	<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Recreational Drugs	<input type="checkbox"/> Infection	<input type="checkbox"/> Thyroid condition	<input type="checkbox"/> Prescription meds (please list) _____		<p style="text-align: center;"><b>Birth</b></p> <p>Please check all that apply:  <input type="checkbox"/> Vaginal birth <input type="checkbox"/> Cesarean  <input type="checkbox"/> Traumatic birth (please explain) _____</p> <p>Weight at birth: _____ Length at birth: _____</p> <p>Length of Labor: _____</p> <p>Health of baby at birth: _____</p> <p>Delivered on time? <input type="checkbox"/> Yes <input type="checkbox"/> No            If no, + weeks _____, or - weeks _____</p> <p>Any other complications: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<input type="checkbox"/> Alcohol	<input type="checkbox"/> High blood pressure																
<input type="checkbox"/> Anemia	<input type="checkbox"/> Nausea/vomiting																
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<input type="checkbox"/> Infection	<input type="checkbox"/> Thyroid condition																
<input type="checkbox"/> Prescription meds (please list) _____																	

Health History					
Now	Past		Now	Past	
		Anemia			Frequent colds: # of times _____
		Anxiety			Gastric reflux
		Asthma			Growing pains
		Bad foot odor			Headaches
		Bed-wetting			Hives
		Chicken pox			Hyperactivity
		Chronic sniffles/running nose			Jaundice
		Colic/gas			Mononucleosis
		Constipation			Mumps
		Cough/wheezing			Nightmares
		Cradle cap			Pneumonia
		Dental cavities			Rubella
		Diaper rash			Stomach aches
		Diarrhea			Strep throat/tonsillitis: # of times _____
		Disobedient			Sweats excessively
		Ear infections: # of times _____			Tantrums
		Early puberty			Teething difficulties
		Eczema or psoriasis			Thrush
		Epilepsy/seizures			Urinary tract infection
		Fears/phobias			Whooping cough
		Finicky eating			Other: _____

General	
<p>Was child breastfed: _____</p> <p>If yes, for how long: _____ If no, what formula: _____</p> <p>When was solid food introduced: _____</p> <p>When did the following milestones occur:</p> <p>Rolling over: _____ First tooth: _____ Sitting: _____</p> <p>Talking: _____ Walking: _____ Dressing self: _____</p>	

Family History				
	Mother	Father	Siblings	Grandparents
Allergies				
Asthma				
Eczema				
Diabetes				
Cancer				
Cardiovascular Disease				
Obesity				
Tuberculosis				
Mental illness				
Other: _____				

**Typical Day's Diet:**

Breakfast: \_\_\_\_\_  
 Snack: \_\_\_\_\_  
 Lunch: \_\_\_\_\_  
 Snack: \_\_\_\_\_  
 Supper: \_\_\_\_\_  
 Snack: \_\_\_\_\_

**Toxin Exposure:**

Has the child ever lived near a refinery or other highly polluted area? \_\_\_\_\_  
 Has the child ever lived in a house with lead paint? \_\_\_\_\_  
 Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all? \_\_\_\_\_  
 Do you spray pesticides or herbicides around the house or use other toxic chemicals? \_\_\_\_\_  
 Does the child seem particularly sensitive to perfumes or other vapors? \_\_\_\_\_

**Anything else you would like to add that we haven't asked you about?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_