



## TAHOMA CLINIC

6839 Fort Dent Way, Suite 134  
Tukwila, Washington 98188  
Phone (206) 812-9988  
Fax (206) 812-9989  
Medical Director Jonathan V. Wright, MD

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

This is to confirm my appointment on: \_\_\_\_\_ at: \_\_\_\_\_

Physician: \_\_\_\_\_

Welcome to the Tahoma Clinic! We are honored that you have chosen us to help in your search for optimum health. This is your New Patient Information Packet. **Please read, fill out and sign the attached forms** and bring them with you to your appointment unless you have been instructed to send them in prior to your appointment.

If you wish to cancel or reschedule your appointment, please notify our office **48 hours** or more before your appointment. **If you choose to cancel your appointment entirely, we will collect a \$50.00 Charge.** It is our office policy to confirm appointments by phone **two days** before your appointment. If you have an answering machine or voice mail, a message will be left. In some cases, the doctor may request fasting lab tests, so we ask that you have no food **8 hours** prior to your appointment, if your appointment is before 1:00pm. If your appointment is scheduled after 1:00 and your doctor determines a fasting test is necessary for you, the test will need to be rescheduled at a later date. **Please do not fast, if you have diabetes, hypoglycemia or simply cannot do so.** If you have any questions please call our office at (206) 812-9988. We look forward to meeting you!

**Many of our patients are sensitive to environmental substances, therefore we ask all patients to refrain from wearing scented hairsprays, colognes, perfumes, aftershaves, etc. on the days you are here.**

---

6839 Fort Dent Way, Suite 134  
Tukwila, Washington 98188  
Phone (206) 812-9988  
Fax (206) 812-9989



TAHOMA CLINIC

Medical Director Jonathan V. Wright, MD

Case History

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Male  Female   
Last First MI

Address \_\_\_\_\_  
Street City State/Prov. Zip/Postal code

Telephone: Home/Cell ( ) \_\_\_\_\_

Is it okay to leave a **DETAILED** message at this number? Yes  No

Work ( ) \_\_\_\_\_ Email \_\_\_\_\_

Fax ( ) \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by (Please Circle):

- 1. Internet
- 2. Friends and Family Members
- 3. Yellow Pages
- 4. Drive by
- 5. Other \_\_\_\_\_

Emergency contact \_\_\_\_\_  
Name Telephone Address

Primary Care Physician \_\_\_\_\_  
Name Telephone Address

List the main problems that you are having, or reason for this appointment:

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

Please attach additional page if necessary

Are you of African or Ashkenazi Jewish ancestry? (This is an important factor in certain medical conditions and can also affect the choice of certain treatments.) No\_\_\_\_; Yes\_\_\_\_: African / Ashkenazi Jewish (please circle one)

***Past Medical History:***

**Major Illnesses:**

---

---

---

**Accidents or major trauma (Scars –Please give location)**

---

---

---

**Hospitalizations/Surgeries/Emergency visits – please give month/year if possible:**

---

---

---

**Dental Procedures (root canals, etc.)**

---

---

---

**Current Prescription Medications (names and doses)**

---

---

---

---

**Allergies and Sensitivities: Foods, environmental, etc.–Ever tested? Copies of reports?**

---

---

---

---

**Occupational Exposures:**

---

---

---

**Vaccinations:**

- ( ) DPT (Diphtheria, Pertussis, Tetanus) Year(s) \_\_\_\_\_
- ( ) Booster (Usually DT) Year(s) \_\_\_\_\_
- ( ) Polio injection ( ) Polio oral Year(s) \_\_\_\_\_
- ( ) MMR (Measles, Mumps, Rubella) Year(s) \_\_\_\_\_
- ( ) HBV (Hepatitis B Vaccine) Year(s) \_\_\_\_\_
- ( ) Other (Flu shots, etc.) Year(s) \_\_\_\_\_

**Women:**

Last Pap \_\_\_\_\_ First day of last menstrual period \_\_\_\_\_  
 Marital history: Years married \_\_\_\_\_ # of children \_\_\_\_\_ Ages \_\_\_\_\_  
 No. of Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_ complications \_\_\_\_\_  
 Last Mammogram \_\_\_\_\_ Last Thermogram \_\_\_\_\_

**Men:**

Last prostate exam \_\_\_\_\_ Last PSA result \_\_\_\_\_ Date \_\_\_\_\_

**Lifestyle factors (Please fill in the approximate amounts):**

|         | Never                    | Occasionally             | Weekly                   | Daily                    |
|---------|--------------------------|--------------------------|--------------------------|--------------------------|
| Coffee  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Exercise Activities**

|         | Never                    | Minutes | Hours | Weekly                   | Daily                    |
|---------|--------------------------|---------|-------|--------------------------|--------------------------|
| Swim    | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Run     | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Walk    | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Dance   | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Bike    | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Garden  | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Golf    | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Tennis  | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Ski     | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Weights | <input type="checkbox"/> | _____   | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Other \_\_\_\_\_

IN ORDER TO HELP FACILITATE THE VISIT BETWEEN YOU AND YOUR PHYSICIAN, PLEASE  
 FILL IN THIS FORM WITH ANY VITAMIN, MINERAL, AMINO ACID, OTHER SUPPLEMENTS OR  
 MEDICATION THAT YOU MAY BE TAKING.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DOCTOR: \_\_\_\_\_

| SUPPLEMENTS           | MANUFACTURER | FORM   | DOSAGE | FREQUENCY |
|-----------------------|--------------|--------|--------|-----------|
| EXAMPLE:<br>VITAMIN C | BRONSON      | TABLET | 500 MG | 2 PER DAY |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |
|                       |              |        |        |           |

**COMMENTS:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Diet Log

Please write down what you eat and drink for a week! This includes juice, coffee, alcohol. If you're attempting to follow any particular diet, please indicate that in the space below the table, IE Swank diet, Atkins.

|           | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|-----------|--------|---------|-----------|----------|--------|----------|--------|
| Breakfast |        |         |           |          |        |          |        |
| Snack     |        |         |           |          |        |          |        |
| Lunch     |        |         |           |          |        |          |        |
| Snack     |        |         |           |          |        |          |        |
| Dinner    |        |         |           |          |        |          |        |
| Snack     |        |         |           |          |        |          |        |

## Family Medical History

Please give age, lists of any illness, or if deceased.  
If deceased, list cause of death and age of death.

### Mother:

---

---

---

---

### Father:

---

---

---

---

### Brothers and Sisters:

---

---

---

### Mother's Parents:

---

---

---

### Father's Parents:

---

---

---

### Children:

---

---

---

---

### Possible Illnesses In Alphabetical Order:

Allergies  
Asthma  
Bleeding Tendency  
Cancer, Type  
Crohn's Disease  
Diabetes-Age at Onset  
Drug Abuse  
Epilepsy  
Gall Bladder  
Glaucoma  
Heart Disease-Type  
Hearing Loss  
Hypoglycemia  
Kidney Disease  
Liver Disease-Type  
Lupus  
Mental Illness- Type  
Multiple Sclerosis  
Rheumatoid Arthritis  
Thyroid Disease  
Tuberculosis  
Skin Disease-Type  
Other Conditions

## Basal Body Temperature Chart

Your body temperature gives an indication of your body's metabolism (the rate in which each cell in the body converts food into energy). A low temperature indicates a sluggish metabolism or "hypo-metabolism".

Most of the time, low body temperature occurs because the body cannot maintain a normal temperature even though the body thermostat may call for more heat. A number of conditions can be responsible: Low thyroid function, a deficiency of vitamins, minerals and calories or chronic allergies may contribute to the cause.

Thyroid blood tests are helpful, but they do not always give the information needed for treatment. Most infections and even cancer can elevate basal body temperatures. A normal reading does not rule out a sluggish metabolism.

This is an easily performed procedure which you can do at home and which may help an overall management of health. It is up to you to do it right. Please do not use an electric blanket as the body temperature can be artificially elevated. A digital thermometer does not go low enough and turns off too soon for this test. You must use a "shake-down" type of thermometer. The basal body temperature can indicate improvement or lack of progression in a treatment. Follow your temperature as an index of how well you are doing.

### Five Simple Steps

1. Obtain a thermometer to record your body temperature. Thoroughly shake down the thermometer to 96 degrees and place it on your bedside table before retiring to bed. To remain in basal state, you should avoid any unnecessary movements when taking your temperature. It should be easily reached with minimum effort in the A.M.
2. Take your temperature first thing in the a.m. upon awakening. The temperature is taken by placing the thermometer snugly in the armpit. It must be kept there for at least 10 min. Please watch the clock to make sure it is a full 10 minutes.
3. Repeat this procedure daily for at least 15 days. As there may be some daily variation, it is best to get a series of readings for more accuracy.
4. Enter each day's temperature on the graph provided by placing a dot on the appropriate spot. Join the dots to make a curve. Make extra sheets to continue the graph if you wish.
5. Enter comments on the graph to indicate days of menstruation if applicable. An example might be M1 for the first day, M2 for the second etc. Other notable events may be listed.

In women, particularly, there may be a variation in temperature during different phases of the menstrual cycle. It is ordinarily slightly higher at mid-cycle during ovulation, (10-13 days prior to an expected period). Reading obtained 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> day of a menstrual period would most reveal a sub-normal basal body temperature.

If accurately measured, basal body temperatures, which consistently run below 97.8 degrees are highly suggestive of a hypo metabolic state. The normal range is 97.8 to 98.2. Temperatures that vary widely from day to day are indicative of need for thyroid as general rule. This is helpful once treatment is started since dosage is best titrated to the individual to keep it within that range. If it goes over that range and is not due to other causes, a reduction in dosage may be indicated.





**\*\*Very Important Information \*\***

**Please Read Carefully, Initial and Sign After Reading**

We at the Tahoma Clinic are here to help you take care of your health in the best way that we know how. We realize you came in about health and not finances. The following is to assist you in understanding the Tahoma Clinic financial policies.

**Payment Requirements:** Appointments must be paid for at time of service. We accept Visa, MasterCard, Discover, American Express, check, cash, or Traveler's checks. Please contact bookkeeping for more details. You will be charged a \$25 fee for returned checks. Any services rendered at the Tahoma Clinic Dispensary and Meridian Valley Lab must be paid directly to them.

\_\_\_\_\_  
INITIAL

**Fee Structure:** The Tahoma Clinic is not a membership organization. We do not charge a large up-front fee to cover membership and potential future expenses. Charges are based on actual time and services used. This means that each appointment and test, including check backs required to review lab work, is billed separately. This way you do not pay for services that you do not use.

\_\_\_\_\_  
INITIAL

**\*\*\*Phone appointments are charged the same as in-person appointments.**

**Appointments:** We require **48 hours notice** if you need to change or cancel your appointment. You will be charged a fee of \$50 of any missed appointment, or if the 48 hour advance cancellation policy was not met.

\_\_\_\_\_  
INITIAL

**Records:** We keep a record of your health care. Tahoma Clinic patients are given their patient records upon completion of their doctor visit. If for some reason your records become unavailable to you, we will furnish you with a copy of your medical records upon your signing an authorization form and returning it to our records department. Please allow up to 10 working days for us to process the request. A small fee will be charged for this service. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to.

\_\_\_\_\_  
INITIAL

**Insurance and Medicare:** Tahoma Clinic does not bill insurance companies. Our doctors are not preferred providers for any insurance company. You may submit your paid invoice to your insurance for reimbursement. **We are not a Medicare provider.** Medicare will not reimburse you for services rendered at the Tahoma Clinic and you should not seek reimbursement from Medicare. We do have staff available to answer any of your insurance questions.

\_\_\_\_\_  
INITIAL

I understand that I will have asked a practitioner of the Tahoma Clinic for help and that he/she will help to the best of his/her ability.

***I have read and understand the above statements.***

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

\_\_\_\_\_  
Signature (signed by guardian if under-age)

\_\_\_\_\_  
Date