



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.



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CASE HISTORY

Today's 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 to medications

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	REASON FOR TAKING
EXAMPLE: VITAMIN C	BRONSON	TABLET	500 MG	2 PER DAY	IMMUNE SUPPORT

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 2nd, 3rd, and 4th 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, Cash, or Traveler's checks. Please contact bookkeeping for more details. 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



TAHOMA CLINIC

Release of Information FRIENDS AND FAMILY AUTHORIZATION

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that some information is considered "sensitive". I understand that I must check the specific boxes in order for my provider or his/her designee to release any "sensitive" information.

- Mental Health/Psychiatric Disorders (including depression)*
- Chemical Dependency (drug and/or alcohol abuse/treatment)*
- HIV/AIDS Virus*
- Sexually Transmitted Diseases*

* A minor patient's signature is required in order to release information concerning care for: 1) Conditions relating the minor's sexuality including, but not limited to: contraception, pregnancy and sexually transmitted diseases (age 14 and above); 2) Alcohol and/or drug abuse (age 13 and above); and 3) Mental health conditions (age 13 and above).

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date as I recognize that relationships and friendships may change over time.

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number(s): _____

- Home Work Mobile

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Signature of Minor Releasing Info: _____

Date: _____

Parent/Legal Guardian Signature: _____

Date: _____