



bend naturopathic clinic



# New Patient Information Form

Dr. Azure Karli, N.D.  
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bend/oregon/97701  
541/389/9750  
541/389/2250 fx

Welcome to Bend Naturopathic Clinic for your health care needs. We appreciate your interest in Naturopathic Medicine and are here to help you obtain your greatest health potential by the safest medical methods possible.

**Payment Information:** We will apply a 10% discount to your service charges if payment is received in full by cash, check or credit card (Visa or MC) at the time of service. *We are happy to bill your insurance company for your visit if you have Naturopathic Care as a covered service. If your insurance company denies coverage for any reason you will be responsible for payment in full.* If you are unsure of coverage we suggest paying in full at time of service to receive the discount and submit the charges to your insurance company for reimbursement.

**Missed appointment:** A 24-hour cancellation policy is necessary, so that we may have the opportunity to accommodate other patients. Canceled office visits or phone consults without a 24 hour notice will result in a \$50.00 charge to you for the missed appointment.

**Late:** If you are more than 10 minutes late, your appointment may be rescheduled and a missed appointment fee may be charged.

**Phone calls:** As a courtesy, I am happy to answer questions by phone at any time I am available. However, telephone calls that extend more than five minutes will be billed at the usual rate. Most insurance companies will not cover phone consults.

**Medicinary and Labs:** All medicinary and lab fees are due at the time of service if provided by Bend Naturopathic Clinic.

**Returned Checks:** A fee of \$25.00 will be assessed for each returned check.

As a licensed Primary Care Health Practitioner, Dr. Karli can take care of your general health care needs including Physical Exams, Pap smears, and laboratory work. Bioidentical Hormone Therapy for both men and women is a special passion of Dr. Karli's. Other common conditions that are dealt with at BNC include anxiety, thyroid issues, adrenal issues, fatigue, digestive issues and allergies. This is a limited list. Please feel free to ask about any concerns that you may have.

**STATEMENT AND SIGNATURE:** I have read and fully understand the above information. I agree to the financial policy of Dr. Karli and understand that I am financially responsible for all services rendered. I will be liable for all financial and legal collection fees if applicable.

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Signature of Patient or Guardian Date

## New Patient Information

Please fill out the short form below:

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth (mo/day/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: F M

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_ ext. \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Education \_\_\_\_\_

How did you hear about us \_\_\_\_\_

Are you:

Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Significant Partner \_\_\_ Single \_\_\_

Live with:

Spouse \_\_\_ Partner \_\_\_ Relatives \_\_\_ Friends \_\_\_ Parents \_\_\_ Alone \_\_\_

Do you give Dr. Karli or her staff permission to leave messages stating Dr. Karli's or the clinic's name and reason for calling at the phone numbers listed above? *(Please circle your answer below to the corresponding phone numbers)*

Home: yes / no

Work: yes / no

Specific instructions for message leaving: \_\_\_\_\_

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

Next of kin or other to reach in an emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

## Health Care Questionnaire

**Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.**

When and where did you last receive medical or health care? \_\_\_\_\_  
 \_\_\_\_\_

What was the reason?  
 \_\_\_\_\_

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

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

### Family History

Check those applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good / P=poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hay fever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

**For the following sections, please circle Y=yes or N=no**

**Childhood Illnesses**

Scarlet Fever	Y / N	Diphtheria	Y / N	Rheumatic Fever	Y / N
Mumps	Y / N	Measles	Y / N	German measles	Y / N
Other	_____				

**Hospitalization and Surgery**

What Hospitalizations or surgeries have you had? \_\_\_\_\_

\_\_\_\_\_

**X-rays and Special Studies**

X-rays, CAT scans, or MRI's you have had: \_\_\_\_\_

Electrocardiogram: Y / N

Electroencephalogram: Y / N

**Immunizations**

Polio	Y / N	Pertussis	Y / N
Tetanus shot (not antitoxin)	Y / N	Diphtheria	Y / N
Measles/Mumps/Rubella	Y / N	Other	_____

**Allergies**

Please list any foods, drugs or other allergens: \_\_\_\_\_

\_\_\_\_\_

**Current Medications**

Do you take or use?

Laxatives	Y / N	Pain Relievers	Y / N	Antacids	Y / N
Cortisone	Y / N	Appetite Suppressants	Y / N	Sleeping Pills	Y / N
Tranquilizers	Y / N	Thyroid Medication	Y / N		

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

## Review of Symptoms

**For the following please circle the correct answer:**

Y= a condition you have now    N= never had    P= a condition you have had in the past

### General

Weight \_\_\_\_\_  
 Weight 1 yr. Ago \_\_\_\_\_  
 Maximum Weight \_\_\_\_\_  
 (when was this) \_\_\_\_\_

Height \_\_\_\_\_  
 Fatigue Y P N

### Skin

Rashes Y P N  
 Eczema, hives Y P N  
 Acne, boils Y P N  
 Itching Y P N  
 Color change Y P N  
 Lumps Y P N  
 Night Sweats Y P N

### Head

Headache Y P N  
 Head Injury Y P N

### Eyes

Impaired Vision Y P N  
 Glasses or contacts Y P N  
 Eye Pain Y P N  
 Tearing or dryness Y P N  
 Double vision Y P N  
 Glaucoma Y P N  
 Cataracts Y P N

### Ears

Impaired hearing Y P N  
 Ringing Y P N  
 Earache Y P N  
 Dizziness Y P N

### Nose and Sinuses

Frequent colds Y P N  
 Nose bleeds Y P N  
 Stuffiness Y P N  
 Hay fever Y P N  
 Sinus Problems Y P N

### Mouth and Throat

Frequent sore throat Y P N  
 Sore Tongue Y P N  
 Gum Problems Y P N  
 Hoarseness Y P N  
 Dental cavities Y P N

### Neck

Lumps Y P N  
 Swollen glands Y P N  
 Goiter Y P N  
 Pain or stiffness Y P N

### Respiratory

Cough Y P N  
 Sputum Y P N  
 Spitting up blood Y P N  
 Bronchitis Y P N  
 Wheezing Y P N  
 Asthma Y P N  
 Pleurisy Y P N  
 Emphysema Y P N  
 Difficulty breathing Y P N  
 Pain on breathing Y P N  
 Shortness of breath Y P N  
   - at night Y P N  
   - lying down Y P N  
 Tuberculosis Y P N

### Cardiovascular

Heart Disease Y P N  
 Angina Y P N  
 High Blood Pressure Y P N  
 Murmurs Y P N  
 Rheumatic fever Y P N  
 Chest Pain Y P N  
 Swelling in ankles Y P N  
 Palpitations, fluttering Y P N

### Gastrointestinal

Trouble swallowing Y P N  
 Heartburn Y P N  
 Change in thirst Y P N  
 Change in appetite Y P N  
 Nausea Y P N  
 Vomiting Y P N  
 Vomiting blood Y P N

### Bowel movements

How often? \_\_\_\_\_  
 Is this a change? \_\_\_\_\_

Blood in stool Y P N  
 Belching or passing gas Y P N  
 Jaundice (yellow skin) Y P N  
 Liver Disease Y P N  
 Gall Bladder disease Y P N  
 Ulcer Y P N  
 Hemorrhoids Y P N

### Urinary

Pain on urination Y P N  
 Increase frequency Y P N  
 Frequency at night Y P N  
 Inability to hold urine Y P N  
 Frequent infections Y P N  
 Kidney stones Y P N

*Continued on next page...*

**Review of Symptoms (Continued...)**

Y= a condition you have now    N= never had    P= a condition you have had in the past

**Female Reproductive**

Age menses began \_\_\_\_\_  
 Average number of days \_\_\_\_\_  
 Length of cycle \_\_\_\_\_  
 Bleeding between periods    Y P N  
 Are cycles regular    Y P  
 Pain during intercourse    Y P N  
 Painful menses    Y P N  
 Excessive flow    Y P N  
 Birth Control    Y N  
     What type? \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Number of abortions \_\_\_\_\_  
 Difficulty conceiving    Y P N  
 Menopausal symptoms    Y P N  
 Are you sexually active    Y N  
 Sexual difficulties    Y P N  
 Venereal disease    Y P N  
 Sexual preference:  
     Heterosexual \_\_\_\_\_  
     Bisexual \_\_\_\_\_  
     Homosexual \_\_\_\_\_

**Breasts**

Do you do self exams    Y P N  
 Lumps    Y P N  
 Pain (or tenderness)    Y P N  
 Nipple Discharge    Y P N

**Male Reproductive**

Hernias    Y P N  
 Testicular masses    Y P N  
 Testicular pain    Y P N  
 Are you sexually active?    Y N  
 Sexual difficulties    Y P N  
 Prostate disease    Y P N  
 Venereal disease    Y P N  
 Discharge or sores    Y P N  
 Sexual Preference:  
     Heterosexual \_\_\_\_\_  
     Bisexual \_\_\_\_\_  
     Homosexual \_\_\_\_\_

**Musculoskeletal**

Joint pain or stiffness    Y P N  
 Arthritis    Y P N  
 Broken bones    Y P N  
 Muscle spasm/cramps    Y P N  
 Weakness    Y P N

**Peripheral Vascular**

Deep leg pain    Y P N  
 Cold hands/feet    Y P N  
 Varicose veins    Y P N  
 Thrombophlebitis    Y P N

**Neurologic**

Fainting    Y P N  
 Seizures    Y P N  
 Paralysis    Y P N  
 Muscle weakness    Y P N  
 Numbness or tingling    Y P N  
 Loss of memory    Y P N

**Emotional**

Depression    Y P N  
 Mood Swings    Y P N  
 Anxiety or nervousness    Y P N  
 Tension    Y P N

**Endocrine**

Hypothyroid    Y P N  
 Heat or cold intolerance    Y P N  
 Excessive thirst    Y P N  
 Excessive hunger    Y P N

**Blood**

Anemia    Y P N  
 Easy bleeding or bruising    Y P N

**Habits**

What are your main interests and hobbies?

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

Do you exercise?    Y N

What forms? \_\_\_\_\_

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

How often? \_\_\_\_\_

\_\_\_\_\_

Do you eat three meals daily?    Y N

Awaken rested    Y N

Sleep well    Y N

Average 6-8 hours sleep    Y N

Enjoy work    Y N

Spend time outside    Y N

Watch television    Y N

    How many hours a day \_\_\_\_\_

Read    Y N

    How many hours a day \_\_\_\_\_

Take Vacations    Y N

Been treated for drug dependence    Y N

Use recreational drugs    Y N

Use alcoholic beverages    Y N

Been treated for alcoholism    Y N

Use tobacco    Y N