Wellspring Naturopathic Clinic
PATIENT PROFILE

Date_____

NOTE: Naturopathic care is only possible when the physician has a complete picture of the patient physically, mentally, and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. Please print and mark questions you don't understand with a question mark (?).

Patient Name_____ Age____ Date of Birth ___/___/_____ Sex: ____

If patient is not of legal age (18): Parent or guardian name _____

Address_____ _____City _____ State_____ Zip_____

Daytime Phone_____ Evening Phone _____Cell Phone_____

Education_____ Occupation_____

Employer_____ Full or Part Time _____Retired_____

SSN _____/_____/_____ Email Address :_____

Emergency Contact: _____Relationship_____ Phone:_____

How did you hear about us? _____

Reason for visit today? _____

Primary Health Concerns: (In order of importance)

1. _____

2. _____

3. _____

4. _____

Medical History

The general state of your health has been: Excellent ____Good ___Fair ___Poor____

What childhood illnesses have you had?

Rubella (3-day measles) ____Measles (2-week)____Whooping Cough ____Asthma____
Rheumatic Fever ____Mumps ____ Chickenpox ____ Scarlet Fever ____ Polio ____ Other_____

What immunizations have you had?
1. _____2._____
3. _____4._____

When and where did you last receive medical or health care?_____
Reason?_____

History of Illness

Now	Past	Never		Now	Past	Never	
___	___	___	Anemia	___	___	___	High blood pressure
___	___	___	Arthritis	___	___	___	Serious injury
___	___	___	Asthma	___	___	___	Pneumonia
___	___	___	Bleeding (uncontrolled)	___	___	___	Rheumatism
___	___	___	Cancer	___	___	___	Thyroid trouble
___	___	___	Diabetes	___	___	___	Venereal disease
___	___	___	Gout	___	___	___	Mental disease
___	___	___	Heart murmur	___	___	___	Migraine headaches
___	___	___	Emphysema	___	___	___	Ulcers
___	___	___	Liver disease; yellow jaundice, Hepatitis				

Please list Past Surgeries and/or Hospitalizations:

1) Date:

2) Date:

3) Date:

Have you had X-Rays taken?
1) Date:

2) Date:

3) Date:

Allergies: (Medications, Food, Environmental)

What happens when you have an "allergy attack"?

Please List the Medications you are currently taking: (with dosage)

1)

2)

3)

4)

5)

Please list the supplements you are taking: (with dosage)

1)

2)

3)

4)

5)

Family & Social History

Please list any significant health concerns for the following relatives.

	Age (if alive)	Age (at death)	Health Problems
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Maternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Paternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____

Has any **blood relative** had any of the following?

Now	Past	Unknown		Now	Past	Unknown	
___	___	___	Anemia	___	___	___	Hay fever
___	___	___	Arthritis	___	___	___	Heart attack
___	___	___	Asthma	___	___	___	High blood pressure
___	___	___	Bleeding (uncontrolled)	___	___	___	Seizure or Epilepsy
___	___	___	Cancer	___	___	___	Sickle Cell Anemia
___	___	___	Diabetes	___	___	___	Stroke
___	___	___	Eczema	___	___	___	Mental illness
___	___	___	Glaucoma	___	___	___	Thyroid trouble
___	___	___	Gout	___	___	___	Tuberculosis

Military Service:
When and where did you serve?

Type of discharge:

Have you traveled outside of the U.S.? When and Where?

Economic Status:
Income Sources_____ Does your income cover your expenses?_____

How often do you drink - wine? _____ beer _____other alcohol_____

Do you use tobacco _____ If yes, how much per day?_____ How many years have you smoked_____

Do you use marijuana or other drugs?_____ If yes, which and how often_____

How many meals do you generally eat per day_____, Irregular meals? _____ Number of snacks_____
Where do you usually buy your food? _____
Who cooks the food you eat? _____
List any foods you exclude from your diet_____
List the primary foods included in your diet_____
_____
_____
List any foods to which you have had a bad reaction_____
_____
List foods you crave_____
Are you satisfied with your diet as it is now? _____ If no, why not? _____
_____

What are your hobbies or primary interests?_____
_____
Do you exercise_____ What form(s)_____ How often_____

Symptoms

Please mark **1-** mild, **2-** moderate or **3-** severe, and if any of the following apply **N**ow or in the **P**ast
Example: 3N indicates symptom is severe-now

Head
____headaches
____dizziness
____blurry vision
____fainting/blackouts
____loss of balance
____eye pain/red eye
____near or far sighted
____ eyes are light sensitive
____cataracts/glaucoma
____earaches
____ringing in ears
____discharge from ears
____difficulty hearing
____nosebleeds
____sinus problems
____loss of smell
____persistent hoarseness
____grinding teeth
____neck lumps/swelling
____dental problems
____sore throat
____loss of voice
____sore/bleeding gums
____difficult swallowing
____cold or canker sore
____speech difficulties

Respiratory
____wheezing
____cough up blood
____cough up phlegm
____shortness of breath
____chest colds
____chronic cough
____nighttime breathing problems
How many pillows____

Cardiovascular
____palpitations
____chest pain
____night sweats
____unexplained fever
____rapid/skipped beats
____high blood pressure
____swollen feet/ankles
____leg pain when walking
____leg vein trouble
Have you ever had rheumatic fever or syphilis?
_____
When? _____
How far can you walk or how many stairs can you climb before having to stop?
_____
What makes you stop?
_____
_____

Gastrointestinal
____stomach pain
____indigestion
____trouble swallowing
____heartburn/acid reflux
____frequent or severe nausea
____blood in vomit
____jaundice
____constipation
____diarrhea
____vomiting
____hemorrhoids
____loss of appetite
____excessive appetite
____blood in stool
____light colored stool
____black stools
____rectal pain/itching
____change in bowel movements
____excessive gas / bloating
____excessive belching
____distress from fats or greasy food
____stools yellow or clay colored, foul-odor, shows undigested food
____ indigestion 2-3 hours after meals, fullness, bloating, sourness, etc.
____heavy full feeling after meals
____excessive lower bowel gas
____bad breath, bad taste in mouth, body or foot odor
____constipation alternating with diarrhea
____stomach pain 5-6 hrs after eating, usually at night, relieved by drinking milk
____above symptoms aggravated by stress
____indigestion immediately after eating
____difficulty belching, stomach cramps, colicky sensations in stomach
____nervousness, shakiness, headaches, relieved by eating sweets
____irritable if late for meals, miss meal, or before breakfast
____sudden cravings for sweets or alcohol
____wake up at night feeling hungry
____overweight
____gain weight or fail to lose on diets
____feel better mornings, worse afternoons
____loss of appetite
____good appetite, but fail to gain or lose weight
____sleepy during the day
____strain at stool

____change of appetite
Is it increased or decreased?
_____
How often do you have bowel movements?
_____

Genitourinary
____frequent urination
____night urination
____incontinence
____trouble starting urine
____blood in urine
____kidney stones
____trouble holding urine
____pain with urination
____bladder infections

Musculoskeletal
____aching muscles
____numbness/tingling
____restless legs
____broken bones
____weakness
____swollen joints
____sore joints
____leg cramps
____tender points
____backaches
____burning on soles of feet
____Unusual redness on palms of hands
____arthritis, if yes,
When?
_____
Where?
_____
What kind?
_____

SKIN
____acne
____itching
____rashes
____lesions
____easy bruising
____hives

Endocrine
____always cold
____always hot
____chronic fatigue
____weakness
____increased hunger
____increased thirst
____Unexplained weight loss/gain
____prefer hot weather
____prefer cold weather
____ can't stand cold
____ cold hands & feet
____ increased hunger

Nervous
____anxiety
____numbness
____tremor
____foggy thinking
____lack of strength
____convulsions
____loss of memory
____lack of concentration
____paralysis

Blood, Immune
____painful lymph nodes
____frequent bleeding
____anemia
____fluid retention
____swollen glands
____wounds heal slowly

Male Reproductive
____prostate problems
____painful erections
____infertility
____discharge from penis
____difficulty with or premature ejaculation
____lump or swelling in testicles
____painful testicles
____trouble maintaining or achieving erection
What contraception do you use?_____
_____

Female Reproductive
____lumps in breast(s)
____breast pain
____missed periods
____lack of sexual desire
____no lubrication when aroused
____sex is painful
____pelvic pain
____vaginal discharge
____heavy periods
____genital eruptions
____vaginal itching/burning
____bleeding or spotting between periods
____difficulty having orgasms
____premenstrual symptoms: cramps, water retention, breast tenderness, headaches, etc.
____infertility
____nipple discharge

Period every _____days,
Regular? Yes or No
Period usually lasts
_____days
Number of pads or tampons used per day
_____
Date of last period_____
What form of contraception do you use?
_____
Number of pregnancies_____
Number of births_____
Number of miscarriages_____
Number of abortions_____
Any complications of pregnancy? if yes please list_____
_____
_____
Age at first menstrual period_____

Did you have a “normal” puberty?_____
Have you ever had a venereal disease?
_____

Mental / Emotional
____depression
____suicidal thoughts
____angered easily
____afraid of being alone
____shy/timid
____restlessness
____excessive worry
____loneliness
____trouble getting along with people
____frequent nightmares
____mental confusion
____mood swings
____crying spells
____suspicious/jealous
____loss of a loved one
____feel pick-up from exercise
____feeling of worthlessness
____memory trouble
____hard to express anger
____place other’s interests before mine
____hear voices
____excess stress
____don’t remember dreams
____trouble sleeping
____don’t know how to relieve stress
____see things others don’t
____think others want to hurt me
____chronic lateness or procrastination

Thank You!

Please record your diet for three days prior to your appointment in the space provided. Use the back side if necessary.

Policy Statement

We welcome you as a patient and appreciate the opportunity to provide you with our professional services. The information that follows is designed to answer most of the questions that our patients ask, and to serve as a policy statement.

OFFICE HOURS: Tuesday through Friday, 8:30 AM – 5:00 PM

APPOINTMENTS: Dr. Healy sees patients on an appointment basis for both acute and chronic conditions, Tuesday through Friday. We can make other arrangements to accommodate patients whose schedules conflict with our usual hours. On occasion, bad weather or emergencies may prevent us from keeping an appointment; in this event you will be notified as soon as possible. If you miss an appointment or fail to cancel at least 24 hours before the scheduled time of the appointment, you may be charged at one half the hourly rate.

FOLLOW-UP VISITS , TELEPHONE CONSULTATIONS AND E-MAIL: Any call or correspondence that requires new instruction, case analysis, or prescription will be subject to a consultation charge. The fee is prorated according to the consultation time.

RESEARCH: Whenever possible the clinic manager will assist you on research requests. However, requests for more involved research by Helen Healy, N.D. may also be subject to consultation fees.

FEES	
Initial Visit – 90 minutes	$ 207.00
Hourly Rate	$ 138.00
Return Visits	Prorated depending on time of visit
Phone & Written Consultations	Prorated depending on time of Phone or Written Consultation
Dispensary	by item
Lab	by test
Shipping & handling	Priority postage + $2.50
NSF Checks	$ 29.00

PAYMENTS: Payment is due at the time of the visit. Acceptable forms of payment are cash, check, Visa, MasterCard, Discover, and American Express.

INSURANCE: If you have insurance that covers naturopathic out-patient services, we prefer that you make payment at the time of the visit and handle your own reimbursement with your insurance company. There is a $15.00 charge for time spent on insurance documentation.

PAST DUE ACCOUNTS: A monthly finance charge of 1.5% is assessed to all balances 30 days past the due date (60 days). Past due accounts with no payment activity for 90 days are subject to possible third party collection efforts.

CHANGE OF ADDRESS: We request that you keep your file current by informing us of any change of address, phone numbers, or email address.

I have read this policy statement and understand its contents.

Signature_____

Date_____

905 JEFFERSON AVE., SUITE 202 • ST. PAUL, MN •55102
PHONE: 651-222-4111• FAX: 651-222-8758
EMAIL: WELLSPRINGCLINIC@MSN.COM
WEBSITE: HELENHEALYND.COM
MEMBER A.A.N.P.

PATIENT INFORMED CONSENT

This Informed Consent is required by Minnesota Statute 147E in order that you, the patient, are aware of the nature of Helen C. Healy, ND's practice in naturopathic medicine. The Minnesota Board of Medical Practice has required that each individual seeing Helen C. Healy, ND read this form and sign it prior to initial consultation or treatment.

I, (print name) _____ , UNDERSTAND THAT:

1. Helen C. Healy, ND is fully credentialed and registered to practice naturopathic medicine in the State of Minnesota, pursuant to Minnesota Statute 147E. Her active registration number is 1007.
2. Dr. Healy received her four-year naturopathic medical training at the National College of Naturopathic Medicine in Portland, Oregon, and graduated in 1983.
3. Dr. Healy passed all the Oregon Board examinations and received her Oregon license in 1983 to practice as a naturopathic doctor. She maintains this license as well.
4. Dr. Healy, to the best of her ability, will present treatment facts and options accurately, and will make recommendations according to standards of good naturopathic medical practice.
5. The scope of practice of a registered naturopathic doctor in the State of Minnesota includes, but is not limited to, the following services: (a) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, glandular, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease; (b) performing or ordering physical examinations and physiological functions tests; (c) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);(d) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results; (e) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; (f) prescribing or performing naturopathic physical medicine; and, (g) admitting patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.
6. A registered naturopathic doctor is **not** allowed to: (a) administer therapeutic ionizing radiation or radioactive substances; (b) administer general or spinal anesthesia; (c) prescribe, dispense, or administer legend drugs or controlled substances including chemotherapeutic substances; (d) perform or induce abortions; or (e) perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue.
7. A registered naturopathic doctor is **not** allowed to practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietitian, nutritionist, or any other health care professional, unless the registered naturopathic doctor also holds the appropriate license or registration for the health care practice profession.
8. Potential risks include allergic reactions to prescribed herbs and supplements, side effects of natural medications, and/or the inconvenience of lifestyle changes.
9. All female patients must alert Dr. Healy if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.
10. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Helen C. Healy, ND or any of her personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understand the statements above. Dated: _____

Signature: _____

Driving Directions to
Wellspring Naturopathic Clinic
905 Jefferson Ave, Suite 202,
St Paul, MN 55102
651-222-4111

From the East, take 94 West:
Take 94 West to 35E South
Take the Victoria Exit, turn left. The next street is Jefferson Ave, turn right.
Office building is approximately ½ block on the right-905 Jefferson, Ste 202

From the West, take 94 East:
Take the Lexington exit; turn right (South);
Travel South crossing over Summit, Grand and St. Clair (theses are all stoplights);
The next stoplight is Jefferson, turn left.
Go down the hill under the 35E overpass;
Office building is on the left – 905 Jefferson, Suite 202

From the South, take 35E North:
Take the Randolph exit, turn right;
Go 2 blocks to Milton, turn left;
Go 4 blocks to Jefferson, turn right; office building is on the left, 905 Jefferson, Ste 202

From the North, take 35E South:
Take 35E into St Paul, take the Victoria exit, turn left;
At the first stop sign, turn right (Jefferson); office building is on the right;
905 Jefferson, Suite 202