Sarah Silverman, ND
1221 SE Madison St.,
Portland, OR 97214

Silverman - Adult Intake

Please fill out this form in its entirety prior to your first appointment

Full Name * ______________________________

Do you have any former names? If yes, please specify. ______________________________

Date of Birth * ______________________________

What is your gender identity?
- [ ] Woman
- [ ] Man
- [ ] Transgender
- [ ] Transsexual
- [ ] FTM
- [ ] MTF
- [ ] Transqueer
- [ ] Intersex
- [ ] Others ______________________

What is your preferred pronoun?
- [ ] Them/They/Their
- [ ] She/Her
- [ ] He/Him
- [ ] Others ______________________

Primary Contact Details

Caregiver First Name ______________________________

Caregiver Last Name ______________________________

Email * ______________________________

Home Phone ______________________________

Mobile Phone ______________________________

Work Phone ______________________________

Extn ______________________________

Primary Phone
- [ ] Mobile Phone
- [ ] Home Phone
- [ ] Work Phone

Address Line1 * ______________________________

Address Line2 ______________________________

City * ______________________________

Country * ______________________________

State * ______________________________

Zip code * ______________________________

Postbox No ______________________________

Emergency Contact Name ______________________________

Emergency Contact Number ______________________

Extn ______________________

Context of Care Review

What three expectations do you have from this visit to our clinic? ______________________

What long term expectations do you have from working with our clinic? ______________________

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0%-100% committed. ______________________

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you? ______________________

Family History

Father

If living: age and health: ______________________

If deceased: age, year, and cause of death: ______________________

Mother

If living: age and health: ______________________

If deceased: age, year, and cause of death: ______________________

Is there any other significant family health history (i.e. grandparents, siblings with diabetes, heart disease, cancer, auto-immune disease)? ______________________

Personal Medical History

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom?

If no, when and where did you last receive healthcare?

What are your most important health problems? List in order of importance:

Have you ever been treated for this/these before? ☐ Yes ☐ No

List any major accidents, injuries, prolonged hospitalizations:

List any surgeries or diagnostic imaging you have had (X-ray, MRI, ultrasound, CT scan):

Where were you born (Home, hospital, birth center, out of the USA etc)?

How were you born?
☐ Vaginal birth ☐ C-section
☐ Premature ☐ Long Labor
☐ Complications

List any significant childhood health events:

Have you been vaccinated? ☐ Yes ☐ No

Current Medications and Supplements

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Allergies

____
____
____

List all medications (over the counter and prescription) you are taking with corresponding dosages: ______________________________

____
____
____

List all supplements you are taking with corresponding dosages: ______________________________

____
____
____

Social History

Relationship status:

- ☐ Married
- ☐ Divorced
- ☐ Partners
- ☐ Dating
- ☐ Others ___________________________
- ☐ Separated
- ☐ Partner
- ☐ Widowed

Occupational status: ______________________________

Do you enjoy your work? ______________________________

Main interests and hobbies: ______________________________

Do you exercise? If so, what and how often? ______________________________

How much screen time do you have/day?

- ☐ 1-2 hours
- ☐ 5-8 hours
- ☐ None
- ☐ 3-5 hours
- ☐ >8 hours/day

Do you like to read (select all that apply)?

- ☐ Books
- ☐ Newspapers
- ☐ On my computer
- ☐ Never
- ☐ Magazines
- ☐ Tablets
- ☐ Rarely

What recreational drugs do you use including marijuana? ______________________________

____
____
____

Have you ever been in treatment for alcohol or drug use? ☐ Yes ☐ No

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Do you use tobacco? ☐ Yes ☐ No

If yes, what do you use (chew, vaping, cigarettes etc.) and how much? ____________________

Do you drink alcohol?
☐ Rarely ☐ Occasionally
☐ Daily ☐ Never
☐ Past
☐ Others ____________________

How many drinks do you usually have at one time? ____________________

How many drinks do you have per week total? ____________________

How much caffeine do you drink each day? (coffee, tea, energy drinks, soda)?
☐ 0-1 drink (8 oz) ☐ 1-2 drinks
☐ 3+ drinks
☐ Others ____________________

Nutrition

Please list what you eat during a typical day and at what time:

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Drinks: ____________________

How many meals per day do you usually eat? ____________________

Describe your appetite?
☐ Always hungry ☐ Never hungry
☐ Recent change in hunger

Adult Mental Health

Rate your stress level on a scale of 1-10 during the average week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What do you do for stress-relief and self-care? ____________________

Have you received previous counseling? ☐ Yes ☐ No

Please specify:
☐ Psychiatrist ☐ Psychologist
☐ School Counselor ☐ Clergy

If yes, when? ____________________

Was it helpful? ____________________

Spiritual Orientation

Do you identify with having a religious or spiritual practice in your life?
- ☐ Yes ☐ No

How active are these beliefs in your life?
- ☐ Very active ☐ Somewhat active
- ☐ Not very active

How much do your beliefs help you when times are difficult?
____
____
____
____

Health History

General

Height: ____

Weight: ____

Maximum weight and when? ____

Endocrine

How is your sleep?
- ☐ Great ☐ Good
- ☐ Poor ☐ Less than 6-8 hours/night
- ☐ More than 6-8 hours/night ☐ I awaken feeling rested
- ☐ I awaken feeling unrefreshed
- ☐ Others ______________________

Cannot fall asleep?
- ☐ Yes ☐ No
- ☐ In Past

Cannot stay asleep?
- ☐ Yes ☐ No
- ☐ In Past

Tired or sluggish?
- ☐ Yes ☐ No
- ☐ In Past

Dizziness when standing up quickly?
- ☐ Yes ☐ No
- ☐ In Past

Hyperthyroid/Hypothyroid?
- ☐ Yes ☐ No
- ☐ In Past

Hypoglycemia?
- ☐ Yes ☐ No
- ☐ In Past

Difficulty losing weight?
- ☐ Yes ☐ No
- ☐ In Past

Run cold or hot?
- ☐ Always cold ☐ Always hot
- ☐ Cold hands and feet ☐ None

Thinning of hair on scalp, face, or genitals or excessive hair loss?
- ☐ Yes ☐ No
- ☐ In Past

Neurologic

Numbness or Tingling?
- ☐ Yes ☐ No
- ☐ In Past

Loss of memory
- ☐ Yes ☐ No
- ☐ In Past

Difficulty with cognition or mental sluggishness?	☐ Yes ☐ In Past	☐ No
Vertigo or dizziness?	☐ Yes ☐ In Past	☐ No
Paralysis?	☐ Yes ☐ In Past	☐ No
Seizures?	☐ Yes ☐ In Past	☐ No

Neck

Pain or stiffness in neck?	☐ Yes ☐ In Past	☐ No
Difficulty swallowing?	☐ Yes ☐ In Past	☐ No
Lumps in neck?	☐ Yes ☐ In Past	☐ No

Immune

Reactions to immunizations?	☐ Yes ☐ In Past	☐ No
Chronically swollen glands?	☐ Yes ☐ In Past	☐ No
Slow would healing?	☐ Yes ☐ In Past	☐ No
Chronic fatigue syndrome?	☐ Yes ☐ In Past	☐ No
Chronic infections?	☐ Yes ☐ In Past	☐ No
Night sweats?	☐ Yes ☐ In Past	☐ No

Ears

Ear aches?	☐ Yes ☐ In Past	☐ No
Impaired hearing?	☐ Yes ☐ In Past	☐ No
Ringing in ears?	☐ Yes ☐ In Past	☐ No

Eyes

Do you wear glasses or contacts for impaired vision?	☐ Yes ☐ In Past ☐ Contacts	☐ No ☐ Glasses ☐ I had Lasix
Eye pain or strain?	☐ Yes ☐ In Past	☐ No
Difficulty seeing at night (eg. while driving)?	☐ Yes ☐ No	
Do you have any of the following?	☐ Cataracts ☐ Spots/Floaters in Vision	☐ Glaucoma ☐ Excessive Tearing/Dryness

Head

Headaches?	☐ Yes ☐ In Past	☐ No
Migraines?	☐ Yes	☐ No

	☐ In Past	
Head injury?	☐ Yes ☐ In Past	☐ No

Nose and Sinus

Chronic congestion?	☐ Yes ☐ In Past	☐ No
Sinus problems?	☐ Yes ☐ In Past	☐ No
Nose bleeds?	☐ Yes ☐ In Past	☐ No
Nasal polyps?	☐ Yes ☐ In Past	☐ No
Hay fever or seasonal allergies?	☐ Yes ☐ In Past	☐ No
Loss of smell?	☐ Yes ☐ In Past	☐ No

Mouth and Throat

Teeth grinding?	☐ Yes ☐ In Past	☐ No
Gum problems?	☐ Yes ☐ In Past	☐ No
Jaw clicks/TMJ problems?	☐ Yes ☐ In Past	☐ No
Sore tongue or lips?	☐ Yes ☐ In Past	☐ No
Hoarseness?	☐ Yes ☐ In Past	☐ No
Frequent sore throat?	☐ Yes ☐ In Past	☐ No

Skin

Skin rashes:	☐ Eczema ☐ Psoriasis	☐ Hives ☐ None
Dryness of skin or scalp?	☐ Yes ☐ In Past	☐ No
Itching?	☐ Yes ☐ In Past	☐ No
Acne/boils?	☐ Yes ☐ In Past	☐ No
Lumps or bumps on skin?	☐ Yes ☐ In Past	☐ No
Change in skin color?	☐ Yes ☐ In Past	☐ No
Weak nails?	☐ Yes ☐ In Past	☐ No

Respiratory/Cardiac

Shortness of breath?	☐ Yes ☐ In Past ☐ On lying down	☐ No ☐ With exercise
Pain with breathing?	☐ Yes ☐ In Past	☐ No

Cough?	☐ Yes ☐ In Past	☐ No
Asthma?	☐ Yes ☐ In Past	☐ No
Wheezing?	☐ Yes ☐ In Past	☐ No
Bronchitis?	☐ Yes ☐ In Past	☐ No
Emphysema?	☐ Yes ☐ In Past	☐ No
Heart murmur?	☐ Yes ☐ In Past	☐ No
Hearth palpitations?	☐ Yes ☐ In Past	☐ No
Chest pain?	☐ Yes ☐ In Past ☐ With stress	☐ No ☐ With exertion

Musculoskeletal

Muscle spasms or cramps?	☐ Yes ☐ In Past	☐ No
Joint pain or stiffness?	☐ Yes ☐ In Past	☐ No
Weakness?	☐ Yes ☐ In Past	☐ No
Arthritis?	☐ Yes ☐ In Past	☐ No
Sciatica?	☐ Yes ☐ In Past	☐ No
Broken bones?	☐ Yes ☐ In Past	☐ No
Scoliosis?	☐ Yes ☐ No	

Blood

Anemia (B12 or Iron deficiency)?	☐ Yes ☐ In Past	☐ No
Easy bleeding or bruising?	☐ Yes ☐ In Past	☐ No
Varicose veins?	☐ Yes ☐ In Past	☐ No
Cold hands/feet?	☐ Yes ☐ In Past	☐ No

Gastrointestinal

Abdominal pain or cramps?	☐ Yes ☐ In Past	☐ No
Nausea/vomiting?	☐ Yes ☐ In Past	☐ No
Heartburn?	☐ Yes ☐ In Past	☐ No
Use antacids?	☐ Yes ☐ In Past	☐ No

Excessive belching, burping, or bloating?	☐ Yes ☐ In Past	☐ No
Gas immediately following meals?	☐ Yes ☐ In Past	☐ No
Offensive breath?	☐ Yes ☐ In Past	☐ No
Ulcer?	☐ Yes ☐ In Past	☐ No
Gallbladder disease?	☐ Yes ☐ In Past	☐ No
Liver disease?	☐ Yes ☐ In Past	☐ No
Hemorrhoids?	☐ Yes ☐ In Past	☐ No
Bowel movements:	☐ Diarrhea ☐ Alternating diarrhea and constipation ☐ Undigested food in stool ☐ Foul smell ☐ Blood in stool	☐ Constipation ☐ Hard, dry or pellet stool ☐ Black stool ☐ Incomplete
Laxative use:	☐ Every day ☐ Rarely ☐ Magnesium or vitamin C as laxative ☐ Colace ☐ Others ____________________________	☐ Several times/week ☐ Never ☐ Senna laxative ☐ Miralax
Bowel movements: How often?	☐ Every day ☐ Every other day	☐ Multiple/day ☐ 2/week or less

Mental/Emotional

Easily stressed?	☐ Yes ☐ Childhood	☐ No
Anxiety or nervousness?	☐ Yes ☐ In Past	☐ No
Depression?	☐ Yes ☐ In Past	☐ No
Mood swings?	☐ Yes ☐ In Past	☐ No
Thoughts of or attempts at suicide?	☐ Yes ☐ In Past	☐ No

Urinary

Thirst level?	☐ Always thirsty ☐ Recent change in thirst	☐ Never thirsty
Increased frequency of urination?	☐ Yes ☐ In Past	☐ No
Pain with urination?	☐ Yes ☐ In Past	☐ No
Incontinence or involuntary urine loss?	☐ Yes ☐ In Past	☐ No
Nighttime urination?	☐ 0-1x/night ☐ Rarely	☐ 2-3x/night ☐ More than 3x/night
	☐ Yes	☐ No

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Frequent UTI's?	☐ In Past	
Kidney stones?	☐ Yes ☐ In Past	☐ No

Female Reproductive

Age of first menses?	______________________________	
Age of last menses? (if menopausal)	______________________________	
Are your cycles regular?	☐ Yes ☐ In Past	☐ No
Length of cycle (in days)	______________________________	
Duration of menses (in days)	______________________________	
Bleeding between cycles?	☐ Yes ☐ In Past	☐ No
Quality of menses:	☐ Scanty ☐ Heavy	☐ Medium ☐ Clots
Pain and cramping during periods?	☐ Yes ☐ In Past	☐ No
PMS?	☐ Yes ☐ In Past	☐ No
Vaginal complaints?	☐ Odor ☐ Pain	☐ Change in discharge ☐ None
Menopausal symptoms?	☐ Hot flashes ☐ Irritability ☐ No	☐ Night sweats ☐ Vaginal dryness ☐ In Past
Male pattern hair growth?	☐ Facial hair ☐ Hair loss/thinning	☐ Chest hair ☐ None
Endometriosis?	☐ Yes ☐ In Past	☐ No
Ovarian cysts?	☐ Yes ☐ In Past	☐ No
Date of last PAP?	______________________________	
Abnormal PAP?	☐ Yes ☐ In Past	☐ No
Are you sexually active?	☐ Yes ☐ In Past	☐ No ☐ Never
Libido	☐ Increased ☐ Absent	☐ Decreased
Contraception:	☐ Hormonal birth control (IUD, pill, nuva ring, Implanon) ☐ Condoms ☐ Cervical Cap ☐ None	☐ Withdrawal method ☐ Fertility Awareness Method ☐ Diaphragm
History of STI's:	☐ Gonorrhea ☐ Herpes ☐ None ☐ Others ________________	☐ Chlamydia ☐ Genital Warts
Number of pregnancies?	______________________________	
Difficulty conceiving?	☐ Yes ☐ In Past	☐ No

Number of live births/children? ______________________________

Number of miscarriages or therapeutic abortions: ______________________________

Do you do self breast exams?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ____________________

Breast complaints:
- [ ] Pain
- [ ] Lumps
- [ ] Nipple discharge
- [ ] Rashes

Other symptoms?
____
____
____
____

Male Reproductive

Are you sexually active?
- [ ] Yes
- [ ] No
- [ ] In Past

Libido:
- [ ] Increased
- [ ] Normal
- [ ] Decreased
- [ ] Absent

Erectile dysfunction
- [ ] Yes
- [ ] No
- [ ] Past
- [ ] Decrease in spontaneous morning erection
- [ ] Decrease in fullness of erection
- [ ] Impotence

Premature ejaculation?
- [ ] Yes
- [ ] No
- [ ] In Past

History of STI's:
- [ ] Genital Warts
- [ ] Gonorrhea
- [ ] Chlamydia
- [ ] Genital herpes
- [ ] None
- [ ] Others ____________________

Testicular complaints?
- [ ] Yes--pain
- [ ] Yes--mass
- [ ] No
- [ ] In Past

Prostate disease?
- [ ] Yes
- [ ] No
- [ ] In Past

Hernias?
- [ ] Yes
- [ ] No
- [ ] In Past

Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice

- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one

accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways.
- Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

- Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
- Help with public health and safety issues
- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

We can use or share your information for health research.

- Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective

services
- Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

PATIENT SIGNATURE : ______________________________

Date: ______________________________

Consent to Treatment

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to inform the doctor's office of any changes in my medical status. I consent to services rendered and treatment provided by Dr. Sarah Silverman at Portland Natural Health. I recognize that Dr. Silverman is a licensed Naturopathic Physician. I have the right to refuse any treatment suggested that I am uncomfortable with. I have the right to ask questions to my satisfaction. Dr. Silverman has the right to treat me within the scope of her practice. Dr. Silverman has the right to refuse rendering of treatment or to make referrals to outside physicians if she feels that she can not be of service to my case.

PATIENT SIGNATURE : ______________________________

Date: ______________________________

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Financial Policy

• Missed Appointments/Cancellations

If for any reason you are unable to make your appointment, please give us 48 hours notice. For any missed appointments or less than 48 hour notice for cancellation your account will be charged $100.

If you are late for your appointment, your visit may be shortened and you will also be charged for the reserved time on the schedule.

Please see Cancellation Policy for further information on the following page.

• Insurance

You are required to confirm naturopathic coverage prior to your initial appointment.

Once you have verified your insurance, you will be responsible for any co-pays, deductibles, and amounts not covered by the insurance at the time of service.

• Payments

For cash paying patients, a Time of Service discount will be given to you. We accept cash, checks, and credit cards.

A sliding scale fee schedule based upon the US poverty guidelines is available for those who do not have naturopathic insurance coverage. Household proof of income is required to qualify for discounted rates.

Dishonored checks will be charged a $25 fee.

Any balances due on your account will be billed to you every 30 days. Balances that are 90 days past due may be submitted to collections if there is no communication.

PATIENT SIGNATURE : ______________________

Date: ______________________