SWIFTWATER NATUROPATHIC
Olivia Franks, ND
116 N Oakes Ave, Ste A
Cle Elum, WA 98922

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
2. Advertisement
4. Drive by
5. Other_________________

Emergency contact____
Name Telephone Address

Primary Care Physician____
Name Telephone Address

Insurance Carrier______________________ ID Number ________________________

Subscriber Name _______________________ Subscriber Birthday _________________

Relation to you _________________________

I certify that the above information is true and accurate and accept responsibility for all information provided. I agree that I choose to be seen by Olivia Franks ND and have complied with the terms of my health coverage program. In the event that my insurance will not cover my services, I acknowledge I must pay for all charges incurred. I authorize Olivia Franks ND to release any information required to process my claim.
I also acknowledge that I have received a copy of Notice of Privacy Practices.

________________ ______________________________ ____________
Patient Name Signature of Legally Responsible Party Date

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

1____

2____

3____

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 Year(s)_______________________________
( ) 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 menstrualperiod______________________
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	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐

Exercise Activities

	Never	Minutes	Hours	Weekly	Daily
Swim	☐	_____	_______	☐	☐
Run	☐	_____	_______	☐	☐
Walk	☐	_____	_______	☐	☐
Dance	☐	_____	_______	☐	☐
Bike	☐	_____	_______	☐	☐
Garden	☐	_____	_______	☐	☐
Golf	☐	_____	_______	☐	☐
Tennis	☐	_____	_______	☐	☐
Ski	☐	_____	_______	☐	☐
Weights	☐	_____	_______	☐	☐

Other____

Supplement List

Name	Brand	Dosage	Frequency
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________
____________	___________	_____________	__________

Symptoms – circle if yes

Fatigue
Chills
Fever
Blurry vision
Eye pain
Chronic sinus issues
Runny nose
Ear infections
Allergies –seasonal, dogs/cats
Bruise easily
Frequent infections

Heartburn
Constipation
Diarhhea
Abdominal pain
Bloating
Headache
Tremor
Numbness
Joint pain
Muscle pain
Muscle cramps

Cough
Wheezing
Asthma
Racing heartbeat
Palpitations
Hemorrhoids
Irritability
Anxiety
Depression
Stress

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.

	Breakfast	Snack	Lunch	Snack	Dinner
Monday	________	________	________	________	_______
Tuesday	________	________	________	________	_______
Wednesday	________	________	________	________	_______
Thursday	________	________	________	________	_______
Friday	________	________	________	________	_______
Saturday	________	________	________	________	_______
Sunday	________	________	________	________	_______

____
____

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:
____
____
____
____