Scott L. Jamison, N.M.D., P.C.
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Please: Wear no perfumes or scented lotions to the office.

Patient Information

Please complete all forms

Name _____Nickname_____
Birth Date _____Age _____ Sex: Female/Male Occupation _____
Address _____City/State _____Zip_____
Mailing address _____City/State _____Zip_____
Phone: Home _____Cell/Pager _____Work_____
Spouse/Significant Other _____ Occupation_____
Phone: Home _____Cell/Pager _____Work_____
Other contact not living with patient _____Relationship_____
Phone: Home _____Cell/Pager _____Work _____

Insurance Information

Most insurance policies do not cover Naturopathic services. Therefore, fees for services, supplements and treatments must be paid for at the time of the visit. We are glad to furnish you with insurance-ready billing receipts, which you may submit to your insurance company for reimbursement.

Why Are You Here?

A Note to Our Patients: Naturopathic, holistic, and preventive health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Please complete all pages of this questionnaire as thoroughly as possible. Thank you.

In your opinion, what are you most important health concerns?

1 _____ 4 _____
2 _____ 5 _____
3 _____ 6 _____

What health concerns do you want to talk about today?

1 _____ 4 _____
2 _____ 5 _____
3 _____ 6 _____

Other _____
_____

Date _____ **Patient Signature** _____

Patient Name _____ **Date**_____

Medications **Dosage Frequency** **Why you use it**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies

_____
_____
_____
_____

Pharmacy Name_____ **Phone**_____

Supplements **Dosage Frequency** **Why you use it**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Supplement / Drug Allergies

_____
_____
_____
_____

Food Allergies

_____
_____

Health History
(Confidential)

Patient Name _____

Symptoms Check (√) symptoms you currently have or have had in the past year

General
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Muscle / Joint / Bone
pain, weakness, numbness in
- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

Genito-Urinary
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Gastrointestinal
- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Cardiovascular
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Eye, Ear, Nose, Throat
- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear Discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - flashes
- Vision - halos

Skin
- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

Men only
- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

Women only
- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

Conditions Check (√) conditions you have or have had in the past

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney disease
- Liver disease
- Measles
- Migraine headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate problem
- Psychiatric care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal infections
- Venereal Disease

Family History Fill in health information about your family

Relation	Age	State of health	Age at death	Cause of death	Check (√) if your blood relatives had any of the following: **Disease** √ **Relation to you**
Father					**Arthritis, Gout**
Mother					**Asthma, Hay Fever**
Brothers					**Cancer**
					Chemical Dependence
					Diabetes
					Heart Disease, Strokes
Sisters					**High Blood Pressure**
					Kidney Disease
					Tuberculosis
					Other

Hospitalizations

Year Reason for hospitalization and Outcome Yr. of birth Sex____

_____

_____

_____

_____

_____

Pregnancy History

Complications?_____

Health Habits **Check (√) which substances you use and describe how much you use**

Caffeine _____ **Drugs** _____

Tobacco _____ **Other** _____

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates _____

_____

Serious injuries/illnesses Date Outcome

_____

_____

Occupational Concerns **Check (√) if your work exposes you to:**

Stress _____ **Hazardous substances** _____

Heavy lifting _____ **Other**_____

Scott L. Jamison, N.M.D., P.C. - Naturopathic Physician

I understand that Dr. Scott L. Jamison, N.M.D. is a Naturopathic Physician licensed through the Arizona Naturopathic Physicians Board of Medical Examiners. I am relying on Dr. Jamison's skill and treatment as a Naturopathic Physician and homeopath and understand that he will treat me according to his best judgment and the generally accepted standard of care for Naturopathic Physicians.

I understand that Dr. Jamison may elect to do diagnostic tests or physical examinations in order to develop an appropriate course of treatment to meet my health care needs and goals.

I understand that Dr. Jamison may elect to use acupuncture, neural therapy, chelation therapies, vitamin and mineral therapies, peroxide therapies, herbal therapies, dietary and natural therapies, biological therapies, light therapies, magnetic and electromagnetic therapies, manipulative therapies, behavior modification, or other therapies and treatments. I have been told that homeopathic remedies are natural substances that do not contain drugs of any kind.

I understand that, as a Naturopathic Physician, Dr. Jamison may elect to use treatments that may or may not be recognized by the allopathic medical system.

I understand that services by Naturopathic Physicians are NOT covered by Medicare and that most medical insurance companies and HMO's do NOT recognize the services of Naturopathic Physicians.
Because Medicare and most insurance companies do not pay for the services provided by Dr. Jamison, I agree to pay him for services directly.

I understand that I may be asked to sign specific consents for an individual therapy (such as chelation or peroxide therapy). Such additional consents will describe in detail the nature, risks, alternatives, possible benefits, and possible complications of the treatment being offered. Such additional consents not withstanding, I also give my general consent for Dr. Jamison and his staff to work with me and to administer to my needs according to the best standards of Naturopathic Practice.

I understand that I have the right to consent, or not to consent, to any proposed procedure, treatment, or therapeutic course.

Date_____ Patient Name_____

Patient Signature _____

Legal Representative _____Relationship_____

Witness_____ Title_____