

Scott L. Jamison, N.M.D., P.C.

6622 East Carondelet
Tucson, AZ 85710
Phone (520) 296.2800 Fax (520) 296.2802

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 _____

Health History
(Confidential)

Patient Name _____

Symptoms Check (v) 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 (v) 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

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

Hospitalizations

<i>Year</i>	<i>Reason for hospitalization and Outcome</i>	<i>Yr. of birth</i>	<i>Sex</i>	<i>Complications?</i>

Pregnancy History

<i>Year</i>	<i>Reason for hospitalization and Outcome</i>	<i>Yr. of birth</i>	<i>Sex</i>	<i>Complications?</i>

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

Caffeine _____
 Tobacco _____
 Drugs _____
 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 _____

Informed Patient Consent for Diagnosis and Treatment
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 notwithstanding, 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 _____