BLUE SPARK HEALTH
NATUROPATHIC MEDICINE

5224 Olympic Drive NW Suite 108
Gig Harbor, WA 98335
P: 253-525-108 F: 253-525-4130
info@bluesparkhealth.com
www.bluesparkhealth.com

PATIENT INFORMATION

Legal Name:_____ Preferred Name: _____

Date of Birth:_____Age:____ Gender or Orientation: _____

Address:_____City_____State:____Zip: _____

Occupation:_____Name of Employer: _____

Marital Status:_____If married, Name of Spouse: _____

I Authorize Blue Spark Health, PLLC to contact me at the following:

Home phone:_____Leave message at home: Yes:___No: _____

Mobile: _____ Leave message on mobile: Yes: _____ No: _____

Work Phone:_____Leave message at office: Yes:___No: _____

Email address: _____ Initials_____

EMERGENCY CONTACT

Emergency Contact Name:_____Relationship: _____

Emergency Contact Phone Number (s):_____ / _____

Name of Primary Care Doctor: _____

Names of Specialists: _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Name of Insured: _____ Date of Birth: _____

Whom may we thank for referring you to Blue Spark Health? _____

SYMPTOM SURVEY

Name: _____ Date: _____

What are your 3 primary health concerns/health goals in order of importance?

1. _____
2. _____
3. _____

Have you received other treatment for these conditions? If Yes, what, when, where?

_____

_____

_____

What are your hopes and expectations from treatment with Dr. Phillips?

_____

_____

_____

PLEASE CHECK AND/OR CIRCLE ANY SYMPTOMS THAT APPLY TO YOU ON THE FOLLOWING PAGES.

NOW	PAST	GENERAL SYMPTOMS
		Tired, weak, lack of energy
		Depression, melancholy, moodiness
		Worry, anxiety, nervousness, irritability
		Difficulty with sleep
		Frequent colds or other illness
		Headaches
		Don't sweat enough
		Sweat too much
		Night sweats
		Dizziness, fainting, convulsions
		Loss or gain of weight
Other:		

NOW	PAST	SKIN AND HAIR
		Acne or pimples
		Skin rashes
		Hives
		Stretch marks
		Skin ulcers or sores
		Dryness, roughness or scaling skin
		Hair loss or thinning
		Dry, coarse hair or split ends
		Bruise easily
		Nails weak, ridged or split easily
		Brown spots or bronzing skin
		Moles, warts, or skin tags
		Sunburn easily
		Cuts heal slowly or scar badly
		Flush easily
		Feet burn
		Athletes foot
Other:		

NOW	PAST	RESPIRATORY
		Spitting up mucus or blood
		Difficulty breathing
		Shortness of breath on exertion
		Shortness of breath lying flat
Other:		

NOW	PAST	EYES
		nearsightedness or farsightedness
		Blurred or failing vision
		Dry, burning or itching eyes
		Eyes water excessively
		Eyes sensitive to light
		Night blindness
		Bloodshot or puffy eyes
Other:		

NOW	PAST	EARS
		Earaches
		Noises or ringing in ears
		Ear discharges
		Loss of hearing
		Lots of wax
Other:		

NOW	PAST	MOUTH, NOSE AND THROAT
		Hay fever, sinusitis, runny nose
		Cracks in corners of mouth
		Dry mouth
		Stuffy nose
		Clear throat often
		Sore, red or cracked tongue
		Cold sores or herpes
		Inability to smell or taste
		Nose bleeds
		Bleeding gums
		Hoarseness
		Sore throats or tonsillitis
		Lot of cavities
		Amalgam fillings
		Root canals
Other:		

NOW	PAST	MUSCULO-SKELETAL
		Muscle pain or stiffness
		Where?
		Swollen, painful, or stiff joints
		Bone pains
		Painful feet, ankles or calves

NOW	PAST	GASTROINESTINAL	NOW	PAST	MUSCULO-SKELETAL
		Loss of appetite			Tremor or twitches
		Excessive appetite			Hernia
		Gagging, difficulty swallowing			Muscle wasting
		Nausea or vomiting			Hands or feet numb or tingling
		Bad breath	**Other:**		
		Metallic or bitter taste in mouth	**NOW**	**PAST**	**CARDIOVASCULAR**
		Food cravings or strong desires			Heart beats fast or irregularly
		Can't eat fats			Tightness in chest
		Heartburn			Dizzy or weak upon standing up
		Indigestion or distress			Swollen feet, ankles or legs
		Heaviness after eating			Discomfort at high altitude
		Belching or gas			Cold hands orfeet
		Bloating			Hands or feet turn blue
		Stomach or abdomen tender or painful			Blue fingernails
		Symptoms relieved after eating			Leg pains when walking
		Symptoms worse after eating			Varicose veins
		Avoid certain foods			Tendency to anemia
		If you skip a meal do you experience:			High blood pressure
		Headache			Low blood pressure
		Irritability or anxiety	**Other:**		
		Dizziness or fatigue			
		Diarrhea or loose stools	**NOW**	**PAST**	**URINARY**
		Constipation			Difficulty unration
		Change in bowel movements			Urinate frequently at night
		Light colored or greasy stools			Bed-wetting
		Dark stools or blood in stool			Incomplete urination or dribbling
		Feeling of incomplete evacuation			Pain when urinating
		Undigested food in stool			Bladder infections
		Foul odor of stool or gas			Kidney infections
		Hemorrhoids			Kidney stones
Other:					Lower back pain
			Other:		
NOW	**PAST**	**MALE**	**NOW**	**PAST**	**MALE**
		Prostate problems			Difficulty obtaining or maintaining an erection
		Difficult or unusual urination	**Other:**		
		Discomfort or pain in genital area			
		Diminished sexual desire			
		Excessive sexual desire			

NOW	PAST	FEMALE	NOW	PAST	FEMALE
		Irregular menstruation			Hot flashes
		Pain prior to or on periods			Diminished sexual desire
		Depressed or irritable around periods			Excessive sexual desire
		Painful or swollen breasts			Difficulty having orgasm
		Lumps in breasts			Inability to conceive
		Discharge from breasts			Number of pregnancies
		Do symptoms occur monthly?			Miscarriages or abortions
		NO YES			
		Pain discomfort or itching in genital area	Other:		
		Vaginal discharge			

Date of last period_____ Number of days_____ Length of cycle_____
Date of last PAP smear_____ Have you ever had an abnormal PAP_____

Have you ever used birth control pills or an IUD? NO YES If Yes what type and for how long? _____
Current type of birth control? _____

GENERAL INFORMATION

Do you get regular exercise? Yes No If Yes, what type? _____ How often? _____
Do you watch television? Yes No If Yes, hours per day _____ Week_____
Habits:

Tobacco Coffee Tea Soda Alcohol Cannabis Drugs Sugar Salt Other_____How often_____
Average Daily Diet:
Morning:_____

Afternoon:_____

Evening : _____

Is your Diet?	Mediterranean	Kosher	Vegetarian	Low Fat or No Fat	Gluten Free	Fast Food	Vegan	Organic	Macrobiotic
Please check									

Other Food Sensitivities

_____

Do you have allergies? YES NO
Drugs:_____

_____

Foods:_____

_____

Environmental: _____

PRESCRIPTION MEDICINES AND OVER – THE-COUNTER MEDICATION Please list any medications you are currently taking (Use back of page if necessary)
VITAMINS, MINERALS, HERBS OR ANY NATURAL SUPPLEMENTS
Have you ever been hospitalized or had surgery, a serious illness or accident? **What? When?**

Have you or any of your family members had any of the problems in this chart?
Please indicate who has had which problems by checking the appropriate space.

	Self	Children	Mother	Father	Sister(s)	Brother(s)	Grandparents	Other
Thyroid Problems								
Diabetes								
Tuberculosis								
Hypoglycemia								
Stroke								
Heart Attack								
Epilepsy								
Cancer								
Asthma								
Allergies								
Anemia								
Migraines								
Hepatitis								
Heart Disease								
Birth Defects								
High blood pressure								
Gallbladder Disease								
Arthritis								
Alcoholism/Addiction								

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HIPAA Notice of Privacy Practices and Consent/Written Acknowledgment

I hereby consent to the use and disclosure of my protected health information by Blue Spark Health for the purposes of **treatment, payment and health care operations, or as otherwise required by law.**

* I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Blue Spark Health prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.

* I have the right to request restrictions to the usage and disclosure of my protected health information.

*I have the right to request an alternative to the standard method of communication of my protected health information.

* I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Blue Spark Health may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Blue Spark Health at the following address: **5224 Olympic Dr. NW Gig Harbor, WA 98335**

* I understand that if I have any questions or complaints, I may submit them in writing to the address above or contact Blue Spark Health by phone at: **(253) 525-1080**

* I am aware that Blue Spark Health reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Blue Spark Health will make available a revised Notice of Privacy Practice for my review.

PERSONAL IDENTIFICATION INFORMATION

Please be aware that you do NOT have to provide your social security number as a form of personal identification to receive health care. However, in compliance with state and federal guidelines, Blue Spark Health does require a front and back copy of your state drivers' license. Additionally, Blue Spark Health may require your social security number in order to extend certain financial options to you.
Your social security number or parent/guarantor's social security number may be required when:
* Payment for any balance due is being billed to/made by another third-party payer, including but not limited to the following:
A) Your health, motor vehicle accident, or workers' compensation insurance
B) Parent/guarantor, relative, attorney or any other payer agreeing to be financially responsible for charges you incur
*Payment arrangement is requested/made for any balance due not paid at the time of service
*Standard discounts are given for services, supplements, herbs, lab fees, and supplies.

I have fully read and understand the above terms for personal identification information.
NON-COVERED SERVICES WAIVER/ACKNOWLEDGEMENT
SERVICES/SUPPLEMENTS/SUPPLIES I understand and agree to the following:

* Any and all supplements, supplies, herbs, formulas, etc. prescribed by my provider and/or purchased by me at Blue Spark Health are my full financial responsibility with payment to be made at the time of service/purchase. No open products can be returned to the clinic for refund under any circumstances.

*Blue Spark Health does not bill insurance carriers, health saving plans or any other like entities for any supplements, herbs, formulas, or supplies. It is my full responsibility to submit the required information to these entities for reimbursement.

*Treatment/services such as acupuncture, hydrotherapy, cranial therapy, energy work, injections, IV therapy, etc. are generally not covered by insurance carriers and are my full financial responsibility.

* It is my full financial responsibility to pay for any charges to the provider and/or Blue Spark Health.

I have fully read and understand the above agreements and information.

STATEMENT OF FINANCIAL RESPONSIBILITY I understand and agree to the following general responsibilities:

* Financial options extended to me are based on the personal identification information and documentation I have provided.

* I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, supplies, lab work and tests, and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my health care, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.

*I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Blue Spark Health to release information necessary to secure payment.

* I understand that there will be a minimum $50 fee for any appointment not canceled within 24 hours of the scheduled appointment.

*Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

_____ _____

Client Signature Date