

Alpine Physicians Health Center
613 W. Lamme Street
Bozeman, MT 59715
406-586-2392

Appointment Date: _____

Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone Number: Home _____ Work _____

Email: _____

Occupation: _____

Name and Address of Person Responsible for the bill if other than the above:

Who referred you to our clinic: _____

CANCELLATION POLICY

24 hours notice is necessary for cancelled appointments. This allows the clinic to schedule acute and walk in appointments. We reserve the right to bill for missed appointments.

DISPENSARY

Our supplement center is open to serve you during normal open office hours. We carry only items selected for their purity, effectiveness and from reputable companies.

RETURN POLICY: NO opened dispensary items can be returned for credit. Un-opened items can be returned in special circumstances within two weeks of purchase for credit only.

SCENT POLICY

Many individuals visiting our office are extremely sensitive to odors, chemicals, and other products. Because of this, we ask that you please refrain from wearing any cologne, perfume, aftershave, or any other scented products (i.e.: fabric softener/bounce) when you come to our clinic.

DIRECTIONS TO THE CLINIC

We are located at 613 West Lamme Street, 2 blocks north of Main Street off North 7th Avenue. From I-90 take the North 7th Avenue, Exit 306, and travel 1 mile south, turn left at Lamme, the clinic is the second building on the left.

WHAT TO EXPECT ON YOUR FIRST VISIT

Naturopathic medicine takes time to search for the underlying cause of your illness or symptoms and to not just provide you with symptomatic relief. Because of this, please be prepared to take the time necessary to give us a detailed history, to review body systems, and to come up with an individualized treatment plan for you. If you do not understand your treatment or are having problems with following your treatment plan, then we encourage you to call us, so that we can help you appropriately. Thank-you and we look forward to serving you.

I have read the above information and fully understand my obligations and relationship with the APHC
Signature _____ Date _____

Eyes: _____
__cataracts __floaters __light sensitive __blurred vision __discharge
__burning __dyslexia __glaucoma __infections __other

Ears: _____
__excessive wax __infection __sound sensitive __vertigo __earaches
__hearing loss __itching __ringing __hearing voices __other

Nose & Sinuses: _____
__frequent colds __itching __nose bleeds __sinus trouble __stiffness
__hayfever __polyps __asthma __other

Mouth & Throat: _____
__amalgams(silver fillings) __canker sores __grind teeth __bad breath __dentures
__gingivitis __hoarseness __bleeding gums __implants __bridges __crowns
__freq sore throats __gold fillings __infections __metal braces __mouth ulcers
__root canals __sore tongue __trouble swallowing __other

Respiratory: _____
__apnea __bronchitis __cough __pleurisy __emphysema __TB
__shortness of breath __at night __lying __with exercise __asthma __congestion
__difficulty breathing __pain with breathing __sputum __pneumonia __wheezing
__coughing up blood __other

__History of smoking
Smoke more than a pack per day Y____ N____

Cardiac: _____
__cold extremities __dyspnea __flushing of skin __palpitations __edema
__chest pain __heart murmurs __high B/P __low B/P __tight chest
__History of heart surgery __atherosclerosis __other

Gastrointestinal: _____
__abdominal pain __bloating __diarrhea __gall bladder problems __indigestion
__nausea __anal itching __colitis __difficulty swallowing __heartburn __irritable bowel
__regurgitation __belching __constipation __flatulence __blood __hemorrhoids __mucus
__ulcers __vomiting __fat intolerance __change in appetite __other

Bowel Movements/how often _____ is this a change __Y __N
Consistency: _____ Color: _____

Urinary: _____
__burning __frequency __incontinence __kidney disease __urgency __cystitis
__hesitancy __infections __stones __at night (how often)____ __other

Genital (male) _____
__discharge __impotence __itching __prostatic hypertrophy __sores
__testicular mass or pain __genital herpes __infertility __painful urination __infection
__hernias __other
__heterosexual __bisexual __homosexual

Genital (female) _____

- birth control pills endometriosis genital herpes infertility spotting
- menopausal symptom discharge excess hair growth hot flashes irregular cycle
- PMS tender breasts dysmenorrhea vaginal dryness hysterectomy itching
- yeast infections decreased libido other
- Age menses began average # of days irregular cycles painful menses
- excess flow
- pain during intercourse PMS number of pregnancies Age menopause began
- heterosexual bisexual homosexual

Musculoskeletal _____

- arthritis fractures joint swelling muscle weakness spasticity atrophy
- fibromyalgia limited range/motion rigidity stiffness backache muscle pain
- spasms uneven muscular development other

Neurologic _____

- Abnormal gait confusion headaches learning problems tremors
- delusional hyperactivity mood swings poor memory weakness depression
- nervousness restlessness seizures tension
- anxiety insomnia excessive sleepiness nightmares tics
- autistic apathy tingling irritable fainting numbness sciatica
- loss of memory poor coordination unprovoked anger other

Endocrine _____

- edema excessive thirst HRT (hormone replacement therapy) thyroid disease
- underweight cold intolerance excessive hunger fatigue diabetes
- excessive sweating heat intolerance hypoglycemia overweight other

Immune _____

- autoimmune cancer history hepatitis lupus recurrent illness
- breast implants chronic fatigue infections Lyme disease swollen glands
- allergic to everything chemical intolerance dental implants other

ENVIRONMENTAL AND TOXIC EXPOSURES _____

Check any that apply to you:

- Live in an agricultural area now or in the past _____
- Live near industrial areas _____
- Live in an area that is sprayed with herbicides or pesticides _____
- Use of pesticides on your personal grounds _____
- List any known chemical exposure: _____

Are you currently being exposed to any of the following?

- tobacco smoke paints solvents fabric softener chemical pet collars dry cleaning
- nail polish hair dyes/permanents new carpet electric blankets mothballs
- candles metal tooth fillings other

What type of heat do you have for your home:

- gas oil electric wood wood pellets coal other

Do you have symptoms of fatigue if you are exposed to any of the above Y N

MEDICATIONS/SUPPLEMENTS

Please list any and all prescription medications, over the counter medications, vitamins, herbs and stimulants. On your first visit bring in all supplement containers.

Name of Product	Brand	Dose/Frequency	How Long
Example: Vitamin C	Thorne Research	1,000 mg per day	2 years
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Add additional pages if necessary)

Do you have any adverse reactions to medications: Y N If yes, explain:

Do you have any food allergies or sensitivities that you are aware of: Y N If yes, explain:

I agree to pay for treatment at time services are rendered.

Signature _____ Date: _____