ITASCA NATUROPATHIC CLINIC
Integrating your healthcare holistically

Park Rapids Office
110 E. 1st Street
Park Rapids, MN 56470
218-237-2312

Bemidji Office
516 Beltrami Avenue North
Bemidji, MN 56601
218-444-5868

New Patient Checklist

Cancellation Policy:

-We request at least one week notice if you need to cancel or reschedule your appointment and *require* 24 hours. Failure to do so will lead to forfeiture of your $50.00 partial payment.

Before your first visit:

1. Fill out the enclosed new patient packet allowing 30-45 minutes to do so.
2. Have your partial payment of $50.00 in to our clinic at least one week before your first visit to hold your appointment. (If mailing, please send to the Park Rapids address). This amount will be applied to your first visit the total of which is typically $229.00 or $294.00, but can range from $122.00 to $411.00 depending on the length of your visit.

The day of your first visit:

1. Please plan to arrive ten to fifteen minutes early.
2. Have this completed new patient packet ready to hand to the receptionist upon arrival.
3. Bring any lab results & reports you have from any other practitioner done within the last five years. If Dr. Oppitz needs additional records our office will have you sign a release of information at your first appointment.
4. Bring all of your supplements with you and a list of all medications.
5. Have a photo ID and insurance card(s) with you. While we cannot bill insurance for your appointments or supplements, much of your labwork can and will be billed to insurance. We do not guarantee coverage, but Dr. Oppitz can give you an estimate of your obligation.
6. Anticipate 75-90 minutes total time in the office for your first visit. Patients with cancer or multiple health concerns may need up to two hours.

Itasca Naturopathic Clinic
Client's Bill of Rights

Welcome to Itasca Naturopathic Clinic. If this is your first time visiting a naturopath, you probably have a lot of questions. Your questions are important to us and we are happy to answer them. The philosophy of naturopathic medicine makes this field of health care unique. Naturopaths work with the healing power of nature to improve your quality of life. The goal is to build health and wellness. We do not treat disease and pathogens; we strengthen the body's vital force and stimulate healing of the body. Symptoms are an external expression that the body has some type of dysfunction occurring within, and instead of palliating these symptoms, we look for the cause of the problem.

Naturopaths are trained as primary care physicians and receive a doctorate degree at a four year accredited naturopathic medical school. Currently there are five institutions in the country; a four-year bachelor's degree is required to enter the program. Specific pre-medical courses in the basic sciences are required such as biology, chemistry, physics, etc. The basic courses taken in the first two years of naturopathic medical school are similar to those taken in conventional medical school including anatomy, physiology, biochemistry, histology, psychology, pathology, neuro-anatomy, microbiology, immunology, research and statistics, clinical and physical diagnosis, lab diagnosis, pharmacology, and public health. There are also courses in cardiology, gynecology, obstetrics, diagnostic imaging, minor surgery, pediatrics, geriatrics, environmental medicine, EENT, endocrinology, dermatology, neurology, proctology, oncology, urology, medical genetics, counseling, and stress management.

Naturopathic training is unique in that it teaches pharmacology and the role of conventional medicine, but the focus is on natural alternatives that can be used to improve health and wellness. There are a plethora of natural therapeutics taught at naturopathic medical schools including clinical nutrition, botanical (herbal) medicine, homeopathy, hydrotherapy, massage, naturopathic manipulative therapies, physiotherapy, and classical Chinese medicine. Clinical training occurs over the last three years of medical school under the supervision of licensed naturopathic doctors. During this three-year period, clinical rotations are performed in hydrotherapy and massage, naturopathic medicine, laboratory services, minor surgery, and women's health care. This curriculum provides the students with a vast exposure to a variety of conditions and treatment modalities in naturopathic patient care.

At Itasca Naturopathic Clinic, our naturopaths are graduates from the National College of Natural Medicine in Portland, Oregon. If you have more questions regarding the medical training of our naturopaths, we will provide you with direct contact information for the schools and the national organization. If you are looking for graduates in other locations, please visit the website of the American Association of Naturopathic Physicians which is the nationwide professional organization for the field of naturopathic medicine: www. naturopathic.org.

AS OF JULY 1, 2009, MINNESOTA STATUTE CHAPTER 147E RECOGNIZES NATUROPATHIC DOCTORS WHO MEET ALL QUALIFICATIONS AS OUTLINED BY THAT LAW.

All information provided during office visits, such as chart notes and lab reports are confidential. Information will not be released without the patient's written and signed request. All patients have the right to access this information. It is our policy to provide copies of laboratory reports to patients during follow-up appointments. All patients have the right to be seen by other practitioners; at the written request of the patient, we will transfer the information from our clinic to the new provider to ensure continuity of care. Patients have the right to refuse any recommended services or treatments, and Itasca Naturopathic Clinic has the right to refuse service to anyone. All facilities are guaranteed to be free of sexual abuse. Patients may assert their rights without retaliation.

Clinic Locations

If complaints arise for any reason for any of our employees, please contact Chris Oppitz at our Park Rapids location.

Itasca Naturopathic Clinic

110 E. First Street
Park Rapids, MN 56470
218-237-2312
218-237-2499 (fax)
oppitz@arvig.net

516 Beltrami Avenue N.
Bemidji, MN 56601
218-444-5868

If you are unable to resolve your complaints, please contact the Minnesota Department of Health at 651-215-5800.

Policy Statement

Appointments: Initial office visits will be scheduled for 60 to 90 minutes. Follow-up appointments will vary depending on patient needs, and are typically 20 to 45 minutes. All patients are seen on an appointment basis and appointments should be made as far in advance as possible.

Cancellation Policy: If you miss an appointment or fail to cancel the appointment at least 24 hours before your scheduled time, you will be charged at the ½ hour rate.

Telephone Consultations: If you have questions that require speaking directly to the doctor, you will be asked to set up a telephone consultation. Any call over 5 minutes will be billed at the same rate as an office visit.

Payments: *Payment is due in full at the time of service.* We accept cash, check and all major credit & debit cards as well as H.S.A. & flex plan cards.

Insurance: Naturopathic care is <u>not</u> covered by insurance in most states including Minnesota and the Dakotas, however, your insurance may cover some or all of any labwork Dr. Oppitz orders for you. Please provide the receptionist your card when you arrive for your first visit.

Past-Due Accounts: A monthly finance charge of 1.5% is added to all accounts not paid in full at the time of service. If past due accounts are shown to have no activity for more than 120 days, they will be turned over to a collection agency.

Change of Address and Telephone Number: We request that you keep your file current by informing us of any changes of address and/or telephone number.

Mail Order Service: Mail orders are available for patients who need refills and are unable to pick up medicinary items at one of our clinic locations.

Naturopathic Consultation Fee Schedule

Initial Appointment (45-120 minutes)	$177-411
Return Appointment (15-60 minutes)	$64-229
Missed Appointment	equal to ½ hour rate
Medicinary	By item
Laboratory Services	By item
Supplement Shipping	$4.95
Lab Kit Shipping	$7.50
NSF Check fee	$25.00
Collections Fee	$25.00
Records Retrieval	$16.24 + 1.23/page
Letter Writing/Research Fee (2-3 weeks)	$25.00 per instance
Express Letter Writing/Research Fee (<1 week)	$50.00 per instance
Supplement Substitution Research (2-3 weeks)	$10.00 per item
Express Supplement Substitution Research (<1 week)	$20.00 per item

Declaration and Consent to Treatment

Name _____ Date of Birth ____/____/____

Address_____ City_____ State_____ Zip_____

Phone (_____) _____ E-mail address_____

The undersigned understands that any treatment or advice provided by INC is not mutually exclusive from any treatment or advice that the undersigned may now be receiving or may receive in the future from another health care provider. The undersigned is at liberty to seek or continue medical care from a medical doctor, surgeon, or any other health care provider. No person has suggested or recommended that the undersigned refrain from seeking or following the advice from another health care provider.

The undersigned understands that the treatment and therapies rendered or recommended by INC may differ from those usually offered by a conventional medical doctor or health care provider. The undersigned is aware that the practice of naturopathic medicine is not an exact science and acknowledges that no guarantees have been made pertaining to the result of treatment.

The undersigned also understands that the treatments and/or procedures used by INC are of a naturopathic (alternative) medical practice and can be used as integrative health care along with allopathic (conventional) medicine.

I have received a copy of the Client's Bill of Rights for INC; I have read and fully understand the contents of the document.

_____ _____

Patient Signature or Guardian's signature (if under 18) Date

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Fax: 218.237.2499
Email: oppitz@arvig.net
www.itascanaturopathicclinic.com

Name_____
Address_____
City_____State_____Zip_____
Phone (Home)_____
(Cell)_____
(Work)_____
Email_____

How do you prefer to be contacted? (Please circle)

Home Cell Work Email

Employer_____
Occupation_____

Full Time Part Time Seasonal

Education_____
Referred by_____
Who is your primary care physician?_____
_____

Today's Date_____
Age_____ Date of Birth_____

Are you (please circle):

Married Separated Divorced Single Cohabitating

Live with (please circle):

Spouse Partner Parents Relatives Friends Pets Alone

Whom to call in case of emergency:

Name_____
Relationship_____
Phone (Home)_____
(Cell)_____
(Work)_____

A NOTE TO OUR PATIENTS: Naturopathic and preventive health care require the physician to have a complete picture of the patient physically, mentally and emotionally. Please take your time as you complete this health

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When, where and from whom did you last receive medical or health care?_____
_____
Date of most recent labwork_____
What are your most important health concerns?
1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Which of the above problems is of the most immediate concern?
_____
_____
_____
_____
_____

Current Medications:
(Prescription and Over-the-Counter)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Supplements:

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children
Ages (if living)					
Age at death					
Cause of death					

Check those applicable:

Anemia					
Arthritis					
Asthma/Hayfever/Hives					
Cancer					
Diabetes					
Heart disease					
High blood pressure					
Kidney disease					
Mental illness					
Seizures/Epilepsy					
Stroke					
Thyroid problems					
Autoimmune disease					
Dementia					
Osteoporosis/osteopenia					

FOR THE FOLLOWING, PLEASE MARK:

YES—a condition you currently have PAST—a condition you've had before

HEAD	YES	PAST
Headaches		
Migraines		
Head Injury		
Jaw/TMJ problems		
Double Vision		
Fainting Spells		
Dizziness		

EYES		
Macular Degeneration		
Spots in eyes		
Cataracts		
Blurriness		
Eye pain/strain		
Tearing		
Dryness		
Sensitivity to light		
Glaucoma		

EARS		
Discharge from ears		
Pain in ears		

EARS, CONTINUED	YES	PAST
Hearing problems		
Ringing in ears		
Sensitivity to noise		
Many ear infections		

NOSE & SINUSES		
Frequent colds		
Nose bleeds		
Stuffiness		
Hayfever		
Sinus problems		
Loss of smell		

MOUTH & THROAT		
Frequent sore throat		
Copious saliva		
Teeth grinding		
Mouth ulcers		
Bleeding gums		
Hoarseness		
Speech difficulties		
Loss of voice		

NECK	YES	PAST
Goiter		
Pain/stiffness		

CARDIOVASCULAR		
Heart disease		
Angina		
High blood pressure		
Low blood pressure		
Blood clots		
Fainting		
Palpitations		
Rheumatic fever		
Chest pain		
Swelling in ankles		
Heart murmurs		

RESPIRATORY		
Cough		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficulty breathing		
Pain upon breathing		
Shortness of breath (SOB)		
Tuberculosis		
Night sweats		

GASTROINTESTINAL		
Trouble swallowing		
Heartburn		
Bad breath		
Bad taste in mouth		
Change in thirst		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Constipation		
Blood in stool		
Mucus in stool		
Food in stool, except corn		
Diarrhea		
Pain or cramps		
Gall bladder disease		
Belching		
Ulcers		
Passing gas		

GASTROINTESTINAL, CONT.	YES	PAST
Hemorrhoids		
Eating disorder		
Distress from eating fats		
Black stools		
Jaundice		
Liver disease		
Bad body odor		
Bowel movements: how often?		
_____		
Is this a change?_____		

URINARY		
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Many urinary infections		
Problems starting urination		
Blood in urine		
Kidney stones		

MALE REPRODUCTION		
Hernias		
Testicular mass		
Testicular pain		
Prostate disease		
Discharge or sores		
Herpes		
Syphilis		
Chlamydia		
Gonorrhea		
Condyloma/Genital warts		
Impotence		
Vasectomy		
Painful erections		
Sexually active		
Sexual orientation:		
_____Heterosexual		
_____Bisexual		
_____Homosexual		

MUSCULOSKELETAL		
Joint pain/stiffness		
Arthritis		
Broken bones		
Weakness		
Muscle spasms/cramps		
Back pain		

BLOOD/PERIPHERAL VASCUALR		
Easy bleeding/bruising		
Anemia		
Deep leg pain		

BLOOD/PERIPHERAL VASCULAR, CONT.	YES	PAST
Cold hands/feet		
Varicose veins		
Thrombophlebitis		
Bleeding from unusual places		
Fluid retention		

EMOTIONAL		
Anxiety/nervousness		
Excessive worry		
Mood swings		
Depression		
Treated for emotional problems		
Panic attacks		
Considered/attempted suicide		
Tension		
Irritability		

NEUROLOGIC		
Seizures/epilepsy		
Muscle weakness		
Paralysis		
Numbness or tingling		
Loss of memory		
Easily stressed		
Vertigo or dizziness		
Loss of balance		

ENDOCRINE		
Hypothyroid		
Heat/cold intolerance		
Hypoglycemia		
Diabetes		
Excessive thirst		
Excessive hunger		
Change in sexual desire		
Seasonal depression		
Unexplained weight loss		
Unexplained weight gain		
Fatigue		

IMMUNE		
Reactions to vaccinations		
Chronic fatigue syndrome		
Chronic infections		
Chronically swollen glands		
Slow wound healing		
Cancer		

If yes, type & treatment:

_____

SKIN		
Rashes		
Eczema		

SKIN, CONTINUED	YES	PAST
Hives		
Acne/boils		
Itching		
Color changes		
Hair loss		
Lumps		
Warts		
Psoriasis		

HABITS		
Use alcoholic beverages		
If yes, types and amounts:		
_____		
Treated for alcoholism		
If yes, when? _____		
Use recreational drugs:		
If yes, types and amounts:		
_____		
Treated for drug dependency		
If yes, when?_____		
Smoke tobacco products		
If yes, types and amounts:		
_____		
Chew tobacco products		
If yes, types and amounts:		
_____		
Drink coffee		
If yes, amount:		
_____		
Drink black tea		
If yes, amount:		
_____		
Drink cola		
Diet often		
Eat excessive salt		
Eat out often		
Eat excessive sugar		

DENTAL HEALTH	YES	NO
Amalgam fillings		
How many?_____		
Composite fillings		
How many?_____		
Root canals		
How many?_____		
Dentures		
Do they fit properly?		
Dental pain		
Gum disease		

ALLERGIES

Are you hypersensitive or allergic to any:

Drugs_____

_____

_____

Foods_____

_____

_____

Chemicals or environmental toxins_____

_____

_____

_____

What happens when you have an "allergy attack"?

_____

_____

_____

What prior types of allergy testing have you had?

None ___
Scratch ___
Blood IgG food ___
Blood IgE inhalant/food ___
Intradermal ___
Kinesiology ___
Electroacupuncture (EAv) ___
Other ___

GENERAL INFORMATION

Weight _____
Weight one year ago_____
Maximum weight_____ When_____
Height_____ft _____inches
When is your energy best during the day?

_____

When is your energy worst during the day?

_____

CHILDHOOD ILLNESSES

Rubella (German 3-day measles) ___
Measles (2 weeks) ___
Mumps ___
Chickenpox ___
Whooping cough ___
Rheumatic fever ___
Polio ___
Scarlet fever ___
Roseola ___
Asthma ___
Others

_____

_____

_____

LIFESTYLE

The information you provide below will be helpful in allowing the doctor to make the right choices specific to you and your case. All information is confidential and if you don't feel comfortable putting it all down on paper, we can discuss these issues in person within your boundaries.

Main interests and hobbies:_____

_____

_____

Do you exercise? _____
If yes, explain:_____

_____

Do you have a religious or spiritual practice?_____

_____

Do you eat three meals a day? _____
If no, how many? _____

_____

How many hours of sleep do you get on average? _____

_____

Do you have difficulty falling asleep?_____

_____

Do you have difficulty staying asleep?_____

_____

Do you awaken rested?_____

_____

Do you enjoy your work?_____

_____

Do you spend time outside?_____
If yes, how much time on average?_____

_____

Do you watch television? _____
If yes, how much?_____
Do you read?_____
If yes, how much?_____
Do you take vacations?_____
How many days off per year?_____
Do you have a supportive relationship?_____

_____

Do you have a history of abuse or trauma?_____

_____

How would you rate your average energy level on a scale of 0-10, where 0 = none and 10 = best ever?_____

_____

How would you rate your average level of stress on a scale of 0-10, where 0 = none and 10 = catastrophic?___

_____

HOSPITALIZATION & SURGERY

What hospitalizations or surgeries have you had?_____

_____

_____

_____

VACCINATIONS

Pertussis_____
Tetanus_____
Polio_____
Diptheria_____
Measles/Mumps/Rubella (MMR)_____
Hepatitus_____
Influenza_____
Pneumonia_____
Shingles_____
Other_____

X-RAYS & SPECIAL STUDIES

What x-rays, CAT scans, EKGs, MRIs, or other studies have you had?_____
_____
_____
_____
_____

WOMEN'S HEALTH SCREEN

Date of last gynecological exam_____
Date of most recent PAP_____
Date of most recent mammogram_____
Any abnormal results?_____
Date of last menstrual cycle_____
Length of cycle_____
Interval of time between cycles_____
Do you have spotting between cycles?_____
Irregular cycles?_____
Any recent changes in normal menstrual flow?_____
_____
_____
Age at first period_____
Have you ever taken oral contraceptives?_____
If so, for how long?_____
Current form of birth control_____
_____
Number of children_____
Number of pregnancies_____
C-Sections?_____
Surgical menopause date_____
Total or partial hysterectomy?_____
Endometriosis_____
Infertility_____
Fibrocystic Breasts_____
Fibroids_____
Ovarian cysts_____
Breast Cancer_____
Ovarian Cancer_____
Uterine Cancer_____
Bacterial Vaginitis_____
Yeast Infections_____
STDs_____
Painful intercourse_____
Vaginal Discharge_____
Do you have PMS?_____
If so, how many days does it last?_____
What are your PMS symptoms?_____
_____
_____
_____
Do you have cramps with your menstrual cycle?_____
_____
If yes, how many days do they last?_____
If yes, how severe?_____
Do you have heavy bleeding?_____
If yes, how many days?_____
Do you have perimenopausal/menopausal symptoms?
_____
If yes, what are they?_____
_____
_____