Welcome to Gallatin Valley Natural Medicine, office of Dr. Breana McElgunn, N.D. We appreciate the opportunity to provide for your health needs, thoroughly and efficiently, so that you and your family can enjoy the benefits of healthy living. It is our belief that health care is at its best when there is friendly cooperation, mutual understanding, and open communication between a patient and their physician.

Your first visit will include a review of your medical history, a thorough examination if necessary, a consultation and a discussion of your personal health goals. In our practice, we prefer to utilize multiple treatment modalities to effectively and creatively address the causes of your particular health concerns. As part of your visit you will be provided an outline detailing your individual treatment plan.

Patients are seen by appointment only - this time is reserved exclusively for you. A limited number of acute visits are integrated into the weekly schedule to accommodate patients with urgent needs – call for availability. With increasing patient demand and a commitment to personalized attention, we have found it necessary to require a credit card number to guarantee your appointment time. If you should need to change your appointment time we will be happy to do so with 24 hours notice or you will be billed for your missed appointment. As a courtesy, our clinic will attempt to contact you prior to your appointment at the phone number you have provided to remind you of your scheduled visit.

Gallatin Valley Natural Medicine office hours are as follows:
Monday: 9:00 am to 5:00 pm
Tuesday: 9:00 am to 5:00 pm
Wednesday: 1:00 pm to 7:00 pm
Thursday: 9:00 am to 5:00 pm

Payment for services will be expected at the end of your visit; we accept cash, check, MasterCard, Visa, and American Express. Office visits are non-refundable. Unopened supplements will be accepted for refund only within 30 days of the date of purchase. Special order supplements are non-refundable.

If you would like to submit your bill to your insurance provider, we will gladly provide you with a form that will assist you with that process.

Thank you for your trust and confidence that you have placed in our clinic. We look forward to meeting you.

Your Appointment:

Sincerely,
Dr. Breana McElgunn, Naturopathic Physician
2002 North 22nd Ave. Suite 2 * Bozeman, MT 59718 * 406-587-0858 * www.gvnm.info

Please fill out the intake form from the website and bring it with you.

Patient Signature: ______________________________ Date: _____________

Gallatin Valley Natural Medicine

2002 North 22nd Ave. Suite 2 Bozeman, MT 59718
Phone: (406) 587-0858 Fax: (406) 586-0406

Patient Profile Intake Form

By completing this profile of your health history, I can offer you more complete naturopathic care. Please be assured that I keep this information confidential.

Name ______________________________ Age __________ Birth Date ____________________
Address ______________________________ City ____________________ State __________ Zip __________
Social Security # ____________________ Home Phone ____________________ Work Phone ____________________
Email address____
Emergency Contact & Phone ____

Married Partnered Separated Divorced Widowed Single Children? Yes / No
How did you hear about me?____

Where, when, from whom, and for what reason did you last receive any health care? ____________________
____
____

Please list, in order of importance, your health concerns and/or goals.
1.____
2.____
3.____

Family Health History: Y = Yes N = No D = Caused Death (age of death) P = In the past
Please indicate if a **family member** has had any of the following. If yes, specify who.

Anemia	Y	N	D	P________________
Arthritis	Y	N	D	P________________
Asthma / Hay fever	Y	N	D	P________________
Cancer (type?)	Y	N	D	P________________
Cystic Fibrosis	Y	N	D	P________________
Diabetes	Y	N	D	P________________
Epilepsy	Y	N	D	P________________
Glaucoma	Y	N	D	P________________
Heart Disease (heart attacks)	Y	N	D	P________________
High blood pressure	Y	N	D	P________________
Kidney Disease	Y	N	D	P________________
Mental Illness	Y	N	D	P________________
Lung Disease	Y	N	D	P________________
Stroke	Y	N	D	P________________
Substance Abuse (drugs, alcohol)	Y	N	D	P________________
Venereal Disease	Y	N	D	P________________

Childhood Illnesses Please circle if you have had any of the following.
Scarlet fever Measles Diphtheria German measles Chicken pox Rheumatic fever
Mumps Others ____________________ Last Tetanus shot ____________________ Blood type________________

Allergies:
Drugs? ____
Foods? ____
Environmental? ____

Have you ever been hospitalized? Please list when and why.
Illnesses: ____
Surgeries:____
Other: ____

Diagnosed illnesses for which you currently take medications: ______________________________

Medications: Please indicate if you have used any of the following. (P = in the past)

Sleeping pills	Y	N	P	Birth Control Pill or Implant	Y	N	P
Antacids	Y	N	P	Thyroid Medicine	Y	N	P
Laxatives	Y	N	P	Cortisone/steroids	Y	N	P

Please list current prescription drugs and milligram dosages ______________________________

____

____

Please list current herbal or nutritional supplements ______________________________

____

____

Health Conditions Y = Yes N = No P = A condition you've had in the past

Skin

Acne	Y	N	P	Skin Cancer	Y	N	P
Eczema	Y	N	P	Psoriasis	Y	N	P
Hives or Boils	Y	N	P	Itching	Y	N	P
Lumps	Y	N	P	Suspicious Moles	Y	N	P

Mouth and Throat

Bleeding gums	Y	N	P	Difficulty swallowing	Y	N	P
Dental cavities	Y	N	P	Sore throat or tongue	Y	N	P
Hoarseness	Y	N	P	Dentures	Y	N	
Chewing tobacco	Y	N	P				

Eyes

Eye pain or injuries	Y	N	P	Cataracts	Y	N	P
Double vision	Y	N	P	Dryness	Y	N	P
Tearing	Y	N	P	Glaucoma	Y	N	P
Glasses/Contacts	Y	N	P	Last eye exam ______________			

Ears

Discharge	Y	N	P	Earaches	Y	N	P
Dizziness	Y	N	P	Impaired hearing	Y	N	P
Ringing	Y	N	P	Injuries	Y	N	P

Head

Hair loss	Y	N	P	Headaches	Y	N	P
Head injury	Y	N	P	Skull fracture	Y	N	P

Nose and Sinuses

Frequent colds	Y	N	P	Hay fever	Y	N	P
Nose bleeds	Y	N	P	Sinus pain	Y	N	P
Stuffiness	Y	N	P	Persistent runny nose	Y	N	P

Neck

Goiter	Y	N	P	Pain/Stiffness/Injuries	Y	N	P
Swollen glands	Y	N	P				

Respiratory

Short of breath	Y	N	P	Asthma/Wheezing	Y	N	P
with exertion	Y	N	P	Emphysema	Y	N	P
while lying down	Y	N	P	Pneumonia	Y	N	P
Tuberculosis	Y	N	P	Bronchitis	Y	N	P
Spitting up blood	Y	N	P	Difficult/Painful breathing	Y	N	P

Cardiovascular

Angina	Y	N	P	Dizziness after standing	Y	N	P
Chest pain	Y	N	P	High blood pressure	Y	N	P

Heart disease	Y	N	P	Swollen ankles	Y	N	P
Murmurs	Y	N	P	Rheumatic fever	Y	N	P
Palpitations	Y	N	P	Fluttering	Y	N	P

Gastrointestinal

Blood in stool	Y	N	P	Bowel movements:__________________ x/day			
Change in thirst/appetite	Y	N	P	Consistency & Color ______________________			
Nausea/vomiting	Y	N	P	Foul odor?	Y	N	
Heartburn	Y	N	P	Belching/Passing gas	Y	N	P
Hemorrhoids	Y	N	P	Jaundice/Yellow skin	Y	N	P
Ulcers	Y	N	P	Liver disease	Y	N	P
Hernia	Y	N	P	Abdominal pain	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P

Urinary

Kidney stones	Y	N	P	Frequent infections	Y	N	P
Kidney pain	Y	N	P	Increased frequency	Y	N	P
Nighttime frequency	Y	N	P	Incontinence	Y	N	P
Pain with urination	Y	N	P	Urethral discharge	Y	N	P
Hesitancy	Y	N	P	Dribbling	Y	N	P

Female Reproductive

Date and results of last pap smear______________________________________ By Whom? _______________________

History of abnormal pap smears: Y N When? ____

Age menses began __________________________				Birth Control	Y	N	P
Age menopause began _______________________				Type ________________________________			
Average # of days of flow _____________________				Days between periods___________________			
Number of pregnancies _______________________				Number of live births ___________________			
Number of miscarriages _______________________				Number of abortions ___________________			
Hysterectomy Y	N	Month/Year _______________________		Ovaries removed	Y	N	
Difficulty conceiving	Y	N	P	PMS	Y	N	P
Pain during intercourse	Y	N	P	Excess flow	Y	N	P
Irregular cycles	Y	N	P	Painful menses	Y	N	P
Menopausal symptoms	Y	N	P	Sexual difficulties	Y	N	P
Are you sexually active	Y	N		Sexually Transmitted Infection	Y	N	P

Sexual orientation: Heterosexual Homosexual Bisexual

Breasts

Do you do self exams	Y	N		Lumps	Y	N	P
Pain	Y	N	P	Nipple discharge	Y	N	P

Last mammogram and findings: ____Where? ____________________________

Male Reproductive

Do you do testicular self exams?	Y	N		Hernias	Y	N	P
Testicular pain	Y	N	P	Sexual difficulties	Y	N	P
Testicular masses	Y	N	P	Penile discharge	Y	N	P
Sexually Transmitted Infection	Y	N	P	Difficult urination	Y	N	P
Prostate pain	Y	N	P	Prostate disease	Y	N	P

Sexual Orientation Heterosexual Homosexual Bisexual

Sexually active Y N Birth control type ____

Last digital prostate exam and findings: ____________________________________By Whom? _______________________

Last Prostate Specific Antigen (PSA) measurement and value: ____

Musculoskeletal

Joint pain/stiffness	Y	N	P	Broken bones	Y	N	P
Joint swelling	Y	N	P	Muscle weakness	Y	N	P
Muscle cramps	Y	N	P	Arthritis	Y	N	P

Peripheral vascular

Deep leg pains	Y	N	P	Cold/Numb hands & feet	Y	N	P

Leg pain while walking	Y	N	P	Varicose veins	Y	N	P

Neurological

Dizziness	Y	N	P	Numbness/tingling	Y	N	P
Fainting	Y	N	P	Memory loss	Y	N	P
Seizures	Y	N	P	Paralysis	Y	N	P
Stroke	Y	N	P	Tremors	Y	N	P

Endocrine and Blood

Anemia	Y	N	P	Low libido	Y	N	P
Hypothyroid	Y	N	P	Easy bleeding/bruising	Y	N	P
Excessive hunger/thirst	Y	N	P	Heat/cold intolerance	Y	N	P
Excessive fatigue	Y	N	P	Insomnia	Y	N	P

Mental and Emotional

Excessive fears	Y	N	P	Anxiety/nervousness	Y	N	P
Mood swings	Y	N	P	Depression	Y	N	P
Tension	Y	N	P	Excessive anger	Y	N	P

Habits

Do you wake rested? Y N
Sleep well? Y N
Ave. hours sleep ____________

What are you main hobbies/interests?
____
____

Enjoy your job? Y N
Watch TV? Y N Hours/day _________
Read? Y N Hours/day _________
Take vacations? Y N

What forms of exercise do you get and how often
____
____

Have you ever been treated for alcohol dependency Y N Drug dependency? Y N
If yes, when and where? ____

Do you currently use recreational drugs? Y N Which ones, how often? ______________________

Do you consume alcohol? Y N How much & how often? ______________________

Do you currently smoke cigarettes? Y N Have you ever smoked? Y N
Age started? _________ How much per day? __________ When did you quit? _____________

Do you currently use chewing (smokeless) tobacco? Y N Have you ever used chewing tobacco? Y N
Age started? ________ How much per day? __________ When did you quit? _____________

Thank you for taking the time to fill out this form completely. During your office visit, we will discuss your responses in detail.

Consent to Naturopathic Treatment Provided by Breana Hauskins-McElgunn, ND

I. This is to acknowledge that I have been informed and understand that:
  i) Any treatment or advice provided to me as a patient of Breana Hauskins-McElgunn, ND is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
  ii) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider
  iii) I understand that Breana Hauskins-McElgunn, ND is not preventing me from seeking or following the advice of another licensed health care provider.
  iv) The treatment and therapies provided to me by Breana Hauskins-McElgunn, ND may be different from those offered by another licensed health care provider.

II. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees that are not covered by my insurance plan, at the time of the visit.

III. I hereby authorize and consent to treatment.

______________________________ Signature

______________________ Date

Gallatin Valley Natural Medicine

2002 North 22nd Ave. Suite 2 Bozeman, MT 59718
Phone: (406) 587-0858 Fax: (406) 586-0406

Dr. Breana McElgunn, Naturopathic Physician

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO HIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the Gallatin Valley Natural Medicine Clinic.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires our specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

GVNM Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records from Gallatin Valley Natural Medicine at the above address.

Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints and Further Information

If you would like to submit a comment or complaint about our privacy practices, or if you need any further information concerning privacy practices please contact Gallatin Valley Natural Medicine at the above address. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of you concern to this address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This notice is effective on or after 04/16/2003

I have read and understand the Privacy Practices For Protected Health Information.

____ _____________________________

Signature **Date**

Print Name _____________________________________