



Dr. Travis J. Elliott

NATUROPATHIC PHYSICIAN

Confidential Personal Health Information

Full Legal Name _____
(Last Name) (First Name) (Middle Initial)

Preferred Name: _____ **Age:** _____ **Date of Birth:** _____ **SS#:** _____

Address: _____
(Street / P.O. Box) (City) (State) (Zip Code)

Telephone #: _____
(Cell) (Work) (Home)

Email address: _____ **Gender:** Female _____ Male _____

Are you (check one): Single _____ Married _____ Other _____ Partner's Name _____

Occupation: _____ (circle) Full time / Part time / Student / Retired

Employer / School: _____

Address: _____
(Street / P.O. Box) (City) (State) (Zip Code)

How did you hear about Dr. Elliott? _____

Emergency Contact: _____
(Name) (Relationship)

(Cell) (Other)

What is the best way to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).

Name: _____ Date of Birth: _____

Is there any place you do NOT want me to leave a message? _____

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May Dr. Elliott email you with a monthly newsletter and/or other educational material? Yes No

Insurance Information – Do you have any secondary or additional Insurance plans? (example, Medicare)

Yes No Name: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient: _____ Today's Date: _____

What are the concerns for which you are seeking care? (Primary concern first)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

Who is your primary care physician? _____

Name

Phone (if known)

Please write a short narrative describing the onset and development of your primary complaint(s). This could be emailed to contact@drtraviselliott.com (preferred) or brought in with this form.

For what concern did you last receive health or medical care? _____

When was your last bloodwork performed? _____ What was tested? _____

Do you have any known contagious diseases at this time? Yes No If yes, what? _____

Name: _____ Date of Birth: _____

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in **you, your parents, grandparents, brothers, sisters or children.**

Cancer _____ Diabetes _____ Epilepsy _____
Heart Disease _____ High Blood Pressure _____ Stroke _____
Anemia _____ Kidney Disease _____ Glaucoma _____
Allergies _____ Asthma _____ Mental Illness _____
Arthritis _____ Tuberculosis _____ Alzheimer's Dz _____

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever _____ Diphtheria _____ Rheumatic fever _____ Mumps _____ Measles _____ German measles _____

Have you had any immunizations? Yes No Negative Reactions?

Hospitalizations, Surgery, X-Ray and Special Studies

Please list the parts of your body for which you have been hospitalized, had surgery, x-rays, or other special studies?

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:



Name: _____ Date of Birth: _____

GENERAL

Weight _____ lbs. Height _____ Weight 1 year ago _____ lbs.

Maximum (non pregnant) Weight _____ lbs. When _____

LIFESTYLE HABITS

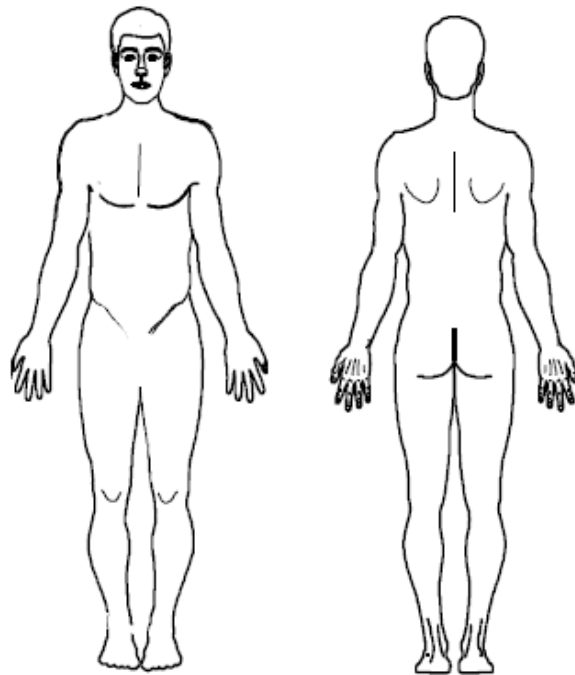
Main interests and hobbies? _____

___ Exercise, what kind? _____

How often do you exercise? _____

Please shade in areas where you are experiencing pain on figures (if applicable).

- ___Y ___ N Have a religious/spiritual practice
- ___Y ___ N Average 6-8 hrs. of sleep
- ___Y ___ N Have a supportive relationship
- ___Y ___ N History of abuse
- ___Y ___ N Major traumas
- ___Y ___ N Use recreational drugs
- ___Y ___ N Treated for drug dependence
- ___Y ___ N Drink coffee
- ___Y ___ N Drink black or green tea
- ___Y ___ N Drink cola or other sodas
- ___Y ___ N Add salt to your food
- ___Y ___ N Eat refined sugar
- ___Y ___ N Enjoy your work
- ___Y ___ N Take vacations
- ___Y ___ N Spend time outside
- ___Y ___ N Watch TV? How much? _____
- ___Y ___ N Read? How often? _____
- ___Y ___ N Use alcoholic beverages
per week _____
- ___Y ___ N Treated for alcoholism
- ___Y ___ N Use tobacco currently
- ___Y ___ N Used tobacco in the past
How many years? _____
How many packs per day? _____



DIET:

List the three healthiest foods you've eaten in the last week: _____

List the three least healthy foods you've eaten in the last week: _____

How often do you eat fish? _____

Name: _____ Date of Birth: _____

MEDICATION/SUPPLEMENT LIST

Date Started	Medication/Supplement	Problem	Dose	Is it effective? (Scale 1-10)





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Metabolic Assessment Form

Name _____ Age _____ Sex _____ Date _____

PLEASE CIRCLE THE APPROPRIATE NUMBER "0-3" ON ALL STATEMENTS BELOW.
0 AS THE LEAST/NEVER TO 3 AS THE MOST/ALWAYS.

Category I /10

Feeling that bowels do not empty completely 0 1 2 3

Lower abdominal pain relief by passing stool or gas 0 1 2 3

Alternating constipation and diarrhea 0 1 2 3

Diarrhea 0 1 2 3

Constipation 0 1 2 3

Hard, dry or small stool 0 1 2 3

Coated tongue or "fuzzy" debris on tongue 0 1 2 3

Pass large amount of foul smelling gas 0 1 2 3

More than 3 bowel movements daily 0 1 2 3

Use laxatives frequently 0 1 2 3

Category II /6

Excessive belching, burping, or bloating 0 1 2 3

Gas immediately following a meal 0 1 2 3

Offensive breath 0 1 2 3

Difficult bowel movements 0 1 2 3

Sense of fullness during and after meals 0 1 2 3

Difficulty digesting fruits and vegetables; undigested foods found in stools 0 1 2 3

Category III /7

Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3

Use antacids 0 1 2 3

Feel hungry an hour or two after eating 0 1 2 3

Heartburn when lying down or bending forward 0 1 2 3

Temporary relief from antacids, food, milk, carbonated beverages 0 1 2 3

Digestive problems subside with rest and relaxation 0 1 2 3

Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3

Category IV /9

Roughage and fiber cause constipation 0 1 2 3

Indigestion and fullness lasts 2-4 hours after eating 0 1 2 3

Pain, tenderness, soreness on left side under ribs 0 1 2 3

Excessive passage of gas 0 1 2 3

Nausea and/or vomiting 0 1 2 3

Frequent urination 0 1 2 3

Stool undigested, foul smelling, mucous-like, greasy or poorly formed 0 1 2 3

Increased thirst and appetite 0 1 2 3

Difficulty losing weight 0 1 2 3

Category V /10

Greasy or high-fat foods cause distress..... 0 1 2 3

Lower bowel gas and or bloating several hours after eating 0 1 2 3

Bitter metallic taste in mouth 0 1 2 3

Unexplained itchy skin 0 1 2 3

Yellowish cast to eyes 0 1 2 3

Stool color alternates from clay colored to normal brown 0 1 2 3

Reddened skin, especially palms 0 1 2 3

Dry or flaky skin and/or hair 0 1 2 3

History of gallbladder attacks or stones 0 1 2 3

Have you had your gallbladder removed? Y N

Category VI /9

Crave sweets during the day 0 1 2 3

Irritable if meals are missed 0 1 2 3

Depend on coffee to keep yourself going or started 0 1 2 3

Get lightheaded if meals are missed 0 1 2 3

Eating relieves fatigue 0 1 2 3

Feel shaky, jittery, or have tremors 0 1 2 3

Agitated, easily upset, nervous 0 1 2 3

Poor memory/forgetful 0 1 2 3

Blurred vision 0 1 2 3

Category VII /8

Fatigue after meals 0 1 2 3

Crave sweets during the day 0 1 2 3

Eating sweets does not relieve cravings for sugar 0 1 2 3

Must have sweets after meals 0 1 2 3

Waist girth is equal or larger than hip girth 0 1 2 3

Frequent urination 0 1 2 3

Increased thirst and appetite 0 1 2 3

Difficulty losing weight 0 1 2 3

Category VIII /8

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX /6

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X /12

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI /7

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats or sweating attacks	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII /3

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII /3

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males only) /5

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only) /13

Decrease in libido		Y		N
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating females only) /13

Are you perimenopausal?		Y		N
Alternating menstrual cycle lengths?		Y		N
Extended menstrual cycle, greater than 32 days?		Y		N
Shortened menses, less than every 24 days?		Y		N
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal females only) /12

How many years since menopause?	0	1	2	3
Any uterine bleeding since menopause?		Y		N
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3



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Informed Consent Form

I, _____, hereby authorize Dr. Travis Elliott to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- 🌿 Medical use of nutrition
- 🌿 Pulsed Magnet Field Therapy (PEMF Therapy)
- 🌿 Western Botanical/ Nutraceutical Prescription
- 🌿 Pharmaceutical Prescription
- 🌿 Homeopathic medicine
- 🌿 Lifestyle counseling
- 🌿 BodyTalk and other related hands-on medicine
- 🌿 Psychological counseling

I recognize the potential risks and benefits of the above treatments:

Potential risks: allergic reactions to prescribed herbs and supplements; side effects of oral and other prescribed medicines; inconvenience of lifestyle changes.

Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record and/or request a copy of it at any time.

Consent to Release of Information

I authorize Dr. Travis Elliott to release to my insurance carrier information about my identity, treatment, diagnosis, prognosis and/or services rendered as permitted by state and federal law which may be required or requested, thus releasing Dr. Travis Elliott for any liability for furnishing such information. I understand that information may be released through electronic or paper media. I acknowledge that I have received Notice of Information and Privacy Practices.

Consent to case study participation: I consent to the **anonymous** use of the information from my healing sessions in teaching and marketing materials created by Dr. Travis Elliott. _____ (initial here to **withdraw consent** for case study participation)

Signature of Patient

Date:

Signature of Legal Guardian

Date:



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Office Policies

Thank you for choosing my office for your health care. I am honored by your trust in my services. Please let me know if I can do anything to make your experience more rewarding.

Please read the following policies carefully.

INSURANCE INFORMATION

We share the concern of the patient regarding the increasing cost of medical care. When a patient's insurance provides acceptable coverage, we will accept insurance coverage on the date of service. Co-payments must be paid at the time of service. If you do not have insurance coverage for Dr. Elliott, payment is due at time of service unless other arrangements have been made.

Please note that coverage is not guaranteed based on a phone call that pre-verifies your insurance coverage.

APPOINTMENTS

Your appointments are your responsibility. It is not office policy to give reminder calls, and **missed appointments are subject to a \$30 missed appointment fee.** Some insurance plans do not allow the charging of this fee. Please ask me if yours is one of them. Please call the day before if you know that you will not be able to make it to your appointment.

REGULAR OFFICE HOURS AND LOCATION

Tuesday - Friday

1305 SW Stephenson St. Portland, OR 97219

9am-5pm

EMERGENCIES

If you have an emergency outside of office hours, please call 911 or go to your nearest emergency room. If you are in need of urgent care in this office, please call 503-206-7773 and you will be scheduled within 24 hours.

OFFICE FEES

Office fees will be charged based on complexity and length of consult. I offer a 35% "time of service" discount for anyone without insurance coverage, and am willing to work with anyone, regardless of ability to pay.

Thank you. Please call the office if you have any questions.