

# Dr. Kaiten Rivers, ND

Naturopathic Physician  
1302 North I Street  
Tacoma, WA 98403  
(253) 572-0939

## Office Policies

### **TREATMENT PLANS**

Dr. Rivers' main goal is for you to be as healthy as you want to be and are willing to put the effort, time and resources toward. Treatment plans are designed to be comprehensive in nature. They often involve multiple types of treatment, testing, etc. Dr. Rivers realizes she is prescribing for personalities, life styles and budgets as well as health goals and conditions. Some people like to move fast, some slow. Some like to do several things at once and some one at a time; and everyone has a budget to consider. Your input is requested in designing your treatment plan for maximum success. We want you to be comfortable and confident with your commitment to health.

### **SUPPLEMENT REFILLS**

We have a relatively small dispensary. We recommend that you call ahead before coming by to pick up your supplements to make sure we have them on hand for you. This also allows us to have everything set aside for you when you get here.

### **POLICIES**

- Items are paid for at time of service: supplements, fees for services rendered, co-pays, or percentage for those with insurance coverage.
- After hour pages: Dr. Rivers is available for urgent needs via pager 24 hours a day. If you use this service between 6PM and 9AM Monday-Friday, anytime Saturday, Sunday, or holidays there will be a \$25.00 fee charged to your account. This fee generally cannot be billed to insurance companies.
- Cancellations and No-Shows: If you cannot keep your scheduled appointment, please notify us so we can reschedule your appointment. Appointments cancelled with less than 24-hour notice and no-shows are subject to a \$35.00 missed appointment fee. This charge cannot be billed to insurance companies.
- Collection Services: Any account that has not been satisfied in 60 days will be turned over to a collection agency.
- Returned Check Fees: There will be a \$25.00 charge per check for checks returned for insufficient funds. You are expected to make good on the charges or make payment arrangements within five (5) days of notification. Unpaid balances may be turned over to collection agencies.
- Methods of Payments: Cash, Check, VISA and Master Card
- Phone Consultation Charges: Return phone calls from the Doctor that are longer than five minutes will be subject to a telephone consultation fee. There is no charge for short phone calls clarifying questions regarding your treatment plan.

I have read, understood and agree to the policies listed above.

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Signature

Date

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Printed Name

Kaiten Rivers N.D.  
1302 North I Street  
Tacoma, WA. 98403  
(253) 572-0939  
Patient Profile

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Marital Status: S M W D

Cell phone \_\_\_\_\_ e-mail \_\_\_\_\_

May we contact you at any of the above numbers/addresses? Y/N Which are excluded? \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer (name & address) \_\_\_\_\_  
Occupation \_\_\_\_\_

Name in case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

What other health care are you presently receiving? \_\_\_\_\_

Where did you hear about our clinic? \_\_\_\_\_

Payment Information: Payment is due when services are rendered. Will you be making payment today? Y/N Will we be billing your insurance company? Y/N If so, have you verified your benefits? Y/N Please present insurance card and ID for photocopying.

A Note To Our Patients: Naturopathic, holistic & preventive health care are only possible when the physician has a complete picture of the patient physically, mentally & emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

Present Health Concerns: In your opinion, what are your most important health concerns in their order of significance? Please indicate the problem that motivated you to come in today.

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

Are you interested in preventive care ( as opposed to condition treatment)? Y/N

Your Health History:

Health as a child? \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_  
Childhood illnesses: \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ German Measles \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_

Hospitalizations (year & reason) \_\_\_\_\_

Surgeries (year & type) \_\_\_\_\_

Serious illnesses or injury (year & cause) \_\_\_\_\_

Vaccinations (year, type adverse reaction?) \_\_\_\_\_

Medications: prescription & non-prescription drugs, herbs, vitamins -- please include everything (pills, tablets, liquids, ointments, suppositories, etc) and indicate dosage.

1 _____	2 _____
3 _____	4 _____
5 _____	6 _____
7 _____	8 _____

Allergies: List any allergies you have to:

Drugs \_\_\_\_\_

Foods \_\_\_\_\_

Other \_\_\_\_\_

What happens when you have an allergy attack: \_\_\_\_\_

\_\_\_\_\_

Habits:

Substance use: Alcohol Y N Tobacco Y N Caffeine Y N Recreational Drugs Y N Soda Y N

Diet: Any diet restrictions or regimen? Describe: \_\_\_\_\_

Are you satisfied with your diet as it is now? Y N

Do you crave starches? Y N Sweets? Y N Salt? Y N Fats? Y N

Do you eat three meals daily? Y N

Do you: Sleep well? Y N Wake rested? Y N Average hrs of sleep \_\_\_\_\_

Exercise Y N What type? \_\_\_\_\_

How long? \_\_\_\_\_ How often? \_\_\_\_\_

Family History:

Check those applicable

	Father	Mother	Brothers	Sisters	Spouse	Child
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Age (if living) \_\_\_\_\_

Age (at death) \_\_\_\_\_

Cause of death \_\_\_\_\_

Health G-good P-poor \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Stroke \_\_\_\_\_

Epilepsy \_\_\_\_\_

Mental Illness \_\_\_\_\_

Asthma, hay fever, hives \_\_\_\_\_

Anemia \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Glaucoma \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Syphilis \_\_\_\_\_

Alcoholism/addiction \_\_\_\_\_

Thyroid Disease \_\_\_\_\_

Autoimmune Disease \_\_\_\_\_

Other \_\_\_\_\_

Your blood type A O AB B **Rh+ Rh-**

Your normal body temperature \_\_\_\_\_

Known toxic exposures: \_\_\_\_\_

Are you 'chemically sensitive'? (do you react adversely to medicines, solvents, fragrances, etc?) Y N

Review of systems: Y- a condition you have now, N=never had, P- a condition you have had in the past.

GENERAL

Weight \_\_\_\_\_  
 Weight 1-year ago \_\_\_\_\_  
 Maximum weight \_\_\_\_\_  
 When \_\_\_\_\_  
 Height \_\_\_\_\_  
 Night sweats Y P N  
 Fatigue Y P N  
 Date of last physical \_\_\_\_\_

SKIN

Rashes Y P N  
 Inflammation Y P N  
 Infection Y P N  
 Growths Y P N  
 Chng in hair/nail Y P N

HEAD

Headaches Y P N  
 Head injury Y P N

EYES

Impaired vision Y P N  
 Eye pain Y P N  
 Tearing or dry Y P N  
 Double vision Y P N

EARS

Impaired hearing Y P N  
 Ringing Y P N  
 Earache/itch Y P N  
 Dizziness Y P N

NOSE & SINUS

Frequent colds Y P N  
 Nose bleeds Y P N  
 Stuffiness Y P N  
 Sinus problems Y P N  
 Post nasal drip Y P N

MOUTH & THROAT

Freq sore throat Y P N  
 Sore tongue Y P N  
 Sores mouth/lip Y P N  
 Gum problem Y P N  
 Hoarseness Y P N  
 Dental problems Y P N

BLOOD

Anemia Y P N  
 Easy bleeding or bruising Y P N

RESPIRATORY

Cough Y P N  
 Spitting up blood Y P N  
 Wheezing Y P N  
 Difficulty breathing Y P N  
 Pain on breathing Y P N  
 Shortness of breath Y P N  
 " lying down Y P N  
 " at night Y P N  
 Positive TB test Y P N

HEART

Heart disease Y P N  
 High blood pressure Y P N  
 Rheumatic fever Y P N  
 Chest pain Y P N  
 Swelling in ankles Y P N  
 Palpitations, fluttering Y P N

DIGESTION

Trouble swallowing Y P N  
 Heartburn Y P N  
 Stomach pain Y P N  
 Change in thirst Y P N  
 Change in appetite Y P N  
 Nausea Y P N  
 Vomiting Y P N  
 Bowels move daily more less  
 Loose stools Y P N  
 Is this a change Y P N  
 Blood in stools Y P N  
 Belching or gas Y P N  
 Liver/gallbladder disease Y P N  
 Hemorrhoids Y P N

URINARY

Pain on urination Y P N  
 Increase frequency Y P N  
 Frequency at night Y P N  
 Inability to hold urine Y P N  
 Bladder infections Y P N

NECK

Swollen glands Y P N  
 Pain/stiffness Y P N

Review of systems: Y=a condition you have now. N=never had. P=a condition you have had in the past.  
Please circle the following:

**CIRCULATION**

- Deep leg pain Y P N
- Cold hands/feet Y P N
- Varicose veins Y P N

**NEUROLOGIC**

- Fainting Y P N
- Seizures Y P N
- Paralysis Y P N
- Muscle weakness Y P N
- Numbness Y P N
- Loss of memory Y P N

**ENDOCRINE**

- Thyroid problem Y P N
- Heat/cold intolerance Y P N
- Hypoglycemia Y P N
- Excessive thirst Y P N
- Excessive hunger Y P N
- Easy weight gain Y P N

**Female Reproduction**

- Age menses began \_\_\_\_\_
- # of days menstrual flow \_\_\_\_\_
- Length of cycle \_\_\_\_\_
- Bleeding betw. periods Y P N
- Are cycles regular Y P N
- Pain during intercourse Y P N
- Cramps Y P N
- Abnormal vag. discharge Y P N
- Excessive flow Y P N
- PMS Y P N
- Date of last Pap smear \_\_\_\_\_
- Abnormal results Y P N
- Date of last period \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- # of live births \_\_\_\_\_
- # of miscarriages \_\_\_\_\_
- Birth control \_\_\_\_\_
- What type? \_\_\_\_\_
- Difficulty conceiving Y P N
- Menopausal symptoms Y P N
- Are you sexually active? Y P N
- Sexual difficulties Y P N
- Venereal disease Y P N

(Following question is optional)

Sexual Preference:

Heterosexual \_\_\_\_\_ Bisexual \_\_\_\_\_ Lesbian \_\_\_\_\_

No. of Abortions \_\_\_\_\_

**BREASTS**

- Regular self-exams? Y P N
- Lumps Y P N
- Pain or tenderness Y P N
- Nipple discharge Y P N

**EMOTIONAL**

- Depression Y P N
- Mood Swings Y P N
- Anxiety/nervousness Y P N
- Tension Y P N

**MUSCULOSKELETAL**

- Joint pain/stiffness Y P N
- Broken bones Y P N
- Muscle spasms/cramps Y P N
- Weakness Y P N

**Male Reproduction**

- Hernias Y P N
- Testicular masses Y P N
- Testicular pain Y P N
- Are you sexually active Y P N
- Sexual difficulties Y P N
- Prostate problems Y P N
- Venereal disease Y P N
- Discharge or sores Y P N
- Difficulty starting or stopping urination Y P N
- Birth control Y P N
- What type? \_\_\_\_\_

Indicate on Diagram any problem areas:

