



CENTER FOR  
ENVIRONMENTAL  
MEDICINE  
LLC

*Integrating the best of  
conventional and complementary medicine*

Dear Patient,

Welcome to the Center for Environmental Medicine. Your appointment is scheduled with Dr. Chris Hatlestad. Attached you will find New Patient Forms. Please fill out the entire Intake Form & Extended Medical History Form. The doctor will want to discuss your history with you at the time of your appointment. Sign the Business Agreement and Registration Form. If you take supplements, please list what you take.

Please fill out all forms before your appointment time assigned during our phone conversation. Medical history forms that are complete allow the doctor to review them and form a picture of what needs to be accomplished in the new patient interview. Also pertinent laboratory tests you can bring or release to us prior to your appointment may be helpful. Be sure to bring your insurance card. We will be happy to bill your insurance as a courtesy for you under the terms of our business agreement. Insurance co-payments are due at the time of service as well as all non-covered procedures or visits.

Attached are instructions of how to get to the Center. Allow 1.5 to 2 hours for your visit and orientation. Please call if we can answer any questions for you or can be of further assistance. Please be aware that we require a 48 hour cancellation on all patients. If you are unable to make your scheduled appointment, kindly give us adequate notice.

*Finally, for the comfort of all we ask that you not wear perfume, aftershave, or other scented products such as strong scented detergent, or clothes dried with dryer sheets. Many of our patients are chemically sensitive and may experience allergic-type reactions including headache, flu-like symptoms, mood swings and aggressive agitation, and the inability to think and process information. We look forward to serving you.*

Sincerely,

Cambor Wade  
Business Administrator

NAME \_\_\_\_\_

DATE \_\_\_\_\_

## PATIENT MEDICAL HISTORY

This is a confidential record of your medical history and will be kept in this office. Information will be released only with your written permission. Please complete the questionnaire as thoroughly as possible. Place a question mark by anything you do not understand.

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Primary Health Concerns:

When did your health concerns begin?

### MAJOR HOSPITALIZATIONS OR ILLNESSES:

<u>Operations</u>	<u>Year</u>	<u>Illnesses Requiring Hospitalization</u>	<u>Year</u>
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____
5. _____	_____	5. _____	_____

Description and date of any serious injuries or accidents you have had:

List the names of all medications and doses you are currently taking: (List on page 2)

List all vitamins, herbs or other supplements you are currently taking: (List on page 2)

Medications, supplements, foods or other things you are allergic to:

Please list any foods or tastes that you have particular craving or aversion to:

**MEDICATIONS**

NAME	DOSE	W/ FOOD	W/O FOOD	AM	MID	PM	BED

**SUPPLEMENTS**

NAME	DOSE	COMPANY	W/ FOOD	W/O FOOD	AM	MID	PM	BED

## REVIEW OF SYMPTOMS AND ILLNESSES

Please Mark C for current / recent or P if the problem was in the past. Circle the correct option if more than one.

### HEENT

- Bleeding gums
- Eye infections
- Far / Near sighted
- Grinding teeth / Jaw pain
- Mercury fillings / root canal
- Hay fever
- Sinusitis
- Hearing loss
- Recurrent ear infections
- Ringing in ears
- Sores in mouth / lips

### RESPIRATORY

- Asthma
- Chronic cough
- Recurrent bronchitis
- Emphysema
- Pneumonia
- Shortness of breath

### CARDIAC / CIRCULATION

- Angina / Chest Pain
- Cold hands / feet
- Edema or swelling
- Fainting
- Leg pain with exercise
- High / Low blood pressure
- Palpitations

### ABDOMINAL / DIGESTIVE

- Difficulty swallowing
- Abdominal bloating / pain
- Irritable before meals
- Pain before / after eating
- Tired after eating
- Distress from fatty foods  
(Nausea, dizziness, headaches, etc.)
- Food allergies
- Hypoglycemia
- Heartburn / reflux

- Ulcers
- Gallstones
- Hepatitis / Liver disease
- Hemorrhoids
- Bleeding from rectum
- Colitis
- Constipation / Diarrhea
- Change in bowel habits
- Belching / Flatulence (gas)

### GENITOURINARY

- Bladder infections
- Frequent urination
- Kidney disease / stones
- Venereal disease

### HORMONAL

- Diabetes
- Goiter / Thyroid problems
- Temperature sensitivity
- Abnormal hair growth
- Reduced sex drive

### NEUROLOGIC

- Childhood hyperactivity
- Dizziness / Vertigo
- Epilepsy / seizures
- Weakness
- Memory loss
- Migraines / Headaches
- Neuralgia / Neuritis
- Concussions

### PSYCHOLOGICAL

- Depression / SAD
- Anxiety
- Mania
- Nervous breakdown
- Nightmares / Vivid dreams
- Restless sleep / Insomnia
- Sleep Apnea

### MUSCULOSKELETAL

- Arthritis / Joint pain
- Osteoporosis
- Sciatica / Low back pain
- Muscle pain / fibromyalgia
- Tendonitis / Bursitis
- Fractures

### DERMATOLOGIC

- Brittle nails
- Dandruff/dry scalp
- Eczema or rash
- Hives
- Recurrent sores

### INFECTIOUS

- Candida
- Chickenpox / Shingles
- Herpes I / II
- Malaria
- Measles / Mumps
- Meningitis
- Mononucleosis
- Polio
- Rheumatic / Scarlet fever
- H. pylori
- Tuberculosis

### OTHER

- Alcohol or drug abuse
- Anemia
- Bed wetting
- Bruise / Bleeding tendency
- Cancer / Leukemia
- Weight problems / changes
- Fatigue
- Chemical sensitivities
- Known toxic exposures

**FEMALES ONLY**

Date of your last menstrual period: \_\_\_\_\_ Age of menopause? \_\_\_\_\_  
How many days do your periods last? \_\_\_\_\_ Days between monthly cycles? \_\_\_\_\_  
Age you first began to menstruate? \_\_\_\_\_  
Did you breast feed?  
Do you perform self-breast exams? Yes No  
Date of last mammogram: \_\_\_\_\_  
Do you get a pap smear annually? Yes No Date of Last exam \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_ / abortions \_\_\_\_\_ / still-births \_\_\_\_\_ / children \_\_\_\_\_  
Current Ages of your children: \_\_\_\_\_  
Any difficulty getting pregnant or complications of pregnancy (explain)?

Do you currently take birth control pills? YES NO  
Did you ever take birth control pills? YES NO for how long \_\_\_\_\_  
Current contraception used? \_\_\_\_\_

Current (C) or Past (P) Symptoms:  
\_\_\_\_\_ vaginal dryness / itching \_\_\_\_\_ abnormal Pap smears \_\_\_\_\_ decreased sex drive  
\_\_\_\_\_ vaginal discharge \_\_\_\_\_ problem periods \_\_\_\_\_ night sweats / hot flashes  
\_\_\_\_\_ pain with intercourse \_\_\_\_\_ PMS \_\_\_\_\_ breast discharge  
\_\_\_\_\_ breast tenderness \_\_\_\_\_ irregular bleeding \_\_\_\_\_ breast lumps or fibrocystic



**MALES ONLY**

**Please check any problem that you now have or have ever had. Mark C for current or P if the problem was in the past.**

\_\_\_\_\_ Urine stream weak/slow \_\_\_\_\_ Nocturnal urination  
\_\_\_\_\_ Dribbling after urination \_\_\_\_\_ Premature ejaculation  
\_\_\_\_\_ Burning on urination \_\_\_\_\_ Swelling/lumps on testicles  
\_\_\_\_\_ Frequent or nocturnal urination \_\_\_\_\_ Loss of sexual interest function  
\_\_\_\_\_ Prostate problems \_\_\_\_\_ Loss of sexual function  
\_\_\_\_\_ Discharge from penis \_\_\_\_\_ Low sperm count or impotency

**SOCIAL HISTORY**

<u>Do you eat:</u>	<u>Yes</u>	<u>No</u>	<u>Serv./wk</u>		<u>Never</u>	<u>How Much / Often / Long</u>	<u>Quit</u>
Meat	_____	_____	_____	Cigarettes	_____	_____	_____
Fish	_____	_____	_____	Chewing tob.	_____	_____	_____
Fowl	_____	_____	_____	Cigar	_____	_____	_____
Dairy	_____	_____	_____	Pipe	_____	_____	_____
Eggs	_____	_____	_____	Marijuana	_____	_____	_____
Refined Sugar	_____	_____	_____	Rec. drugs	_____	_____	_____
Margarine	_____	_____	_____	Liquor	_____	_____	_____
Grains	_____	_____	_____	Beer	_____	_____	_____
Veggies	_____	_____	_____	Wine	_____	_____	_____
Fruit	_____	_____	_____	Coffee	_____	_____	_____
Water (# of glasses per day?)	_____			Soft drinks	_____	_____	_____
Time of day you eat:	Breakfast:	_____					
	Lunch:	_____					
	Dinner:	_____					
	Late snack:	_____					

**Travel History**

Have you traveled/lived outside the USA? Yes\_\_ No\_\_ If Yes, where: \_\_\_\_\_  
 Did you develop an illness as a result of your travels? \_\_\_\_\_

**FAMILY HISTORY**

**Please list any family history of illness:**

**Adopted** \_\_\_\_\_

Father:

Mother:

Paternal Grandfather:

Paternal Grandmother:

Maternal Grandfather:

Maternal Grandmother:

Siblings:

Aunts, Uncles, Cousins:

Children:



## EXTENDED ALLERGY HISTORY

**Do you have a family history of allergy?**  Food  
 Inhalant  Mold/ Dust etc.  Pollen  
 Hives  Itching  Asthma  Chemical  
 Sensitivity  Other \_\_\_\_\_

**Does any member of your family have celiac (gluten sensitivity) or inflammatory bowel disease?** \_\_\_\_\_

**Are you currently receiving allergy injections?** \_\_\_\_\_

**For How long?** \_\_\_\_\_

**Are you under the direct care of an allergist?** \_\_\_\_\_

**Direct care of another provider for allergies?** \_\_\_\_\_

**Do you have any allergies not under treatment?** \_\_\_\_\_

**Have you suffered from asthma in the past?** \_\_\_\_\_

**Do you have wheezing now?** \_\_\_\_\_

**Do you suffer with gastro-intestinal problems?** \_\_\_\_\_

**Do you have food allergies? Please list:** \_\_\_\_\_

**Do you follow a special diet?** \_\_\_\_\_

**Describe:** \_\_\_\_\_

**PREVIOUS ALLERGY TESTING:**

Exposed to: <input type="checkbox"/> foods <input type="checkbox"/> chemicals <input type="checkbox"/> mold/dust/pollen <input type="checkbox"/> pets <input type="checkbox"/> other	Testing Method: <input type="checkbox"/> skin test (RAST) <input type="checkbox"/> intradermal <input type="checkbox"/> blood panel <input type="checkbox"/> elimination diet <input type="checkbox"/> other
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**DISCRIBE YOUR HOME ENVIRONMENT:**

<input type="checkbox"/> House	<input type="checkbox"/> Residential	<input type="checkbox"/> Clean air
<input type="checkbox"/> Apartment	<input type="checkbox"/> Industrial	<input type="checkbox"/> Polluted air
<input type="checkbox"/> Mobile Home	<input type="checkbox"/> Freeway	<input type="checkbox"/> Mold
<input type="checkbox"/> Other	<input type="checkbox"/> Busy street	<input type="checkbox"/> Central
<input type="checkbox"/> Urban	<input type="checkbox"/> Old construct	<input type="checkbox"/> Filter units
<input type="checkbox"/> Suburban	<input type="checkbox"/> New construct	<input type="checkbox"/> Sunny
<input type="checkbox"/> Rural	<input type="checkbox"/> Insulation type	<input type="checkbox"/> Window

**HEATING/AIR CONDITIONER AT WORK AND HOME:**

natural gas  electric  solar  good ventilation  
 oil heat  fireplace  pellet  poor ventilation  
 filters changed  ducts cleaned

**PETS:**  dog  cat  bird  other \_\_\_\_\_

Do you know if you react to animals? \_\_\_\_\_

Which animals? \_\_\_\_\_

How? \_\_\_\_\_

**HOME FURNISHINGS**

**Upholstery**  cotton  leather  synthetic  wool  
**Flooring**  wood  linoleum  carpet, kind  tile  
**Bedroom**  Carpet  Natural  Synthetic  Feather  
**Cookware**  stainless  enamel  glass  aluminum  
 crock pot  non-stick or teflon

Do you rotate foods:  yes  no

Do you use dietary supplements?  yes  no

**DAILY / FREQUENT EXPOSURES:**

gas  asphalt  computer  fluorescent lights  
 auto exhaust  diesel exhaust  heavy equipment  
 fly frequently  new building  pesticides  
 make-up  lotions  perfumes/aftershave  
 nail products  new fabrics  molds

**TRANSPORTATION:**  car  bus  walk  bike

**DO CHEMICALS OR ODORS MAKE YOU SICK?**

**How?** \_\_\_\_\_

**Which?** \_\_\_\_\_

Have you ever had an anaphylactic reaction?  yes  no

If yes, what where you reacting to? \_\_\_\_\_

**POSSIBLE ALLERGY RELATED CONDITIONS**

*(Please check any that apply to you)*

Unexplained fatigue or malaise  
 Atopic Eczema  
 Arthritis  
 Ankylosing spondylitis  
 Malnutrition  
 Neuropsychiatric symptoms  
 Carbohydrate Intolerance  
 Abdominal Pain  
 Flatulence  
 Diarrhea  
 Constipation  
 Irritable Bowel Syndrome  
 Crohn's, or Ulcerative colitis  
 Other inflammatory or autoimmune disorders

List your favorite, craved, or particularly enjoyed foods/beverage:

List foods that disagree with you and the symptoms they cause:



Date \_\_\_\_\_

PATIENT REGISTRATION FORM

To provide you with the best service and to update our records, please complete both pages of this form in its entirety at the time of your visit. This information is for our use only unless released by your permission. Thank You.

Patient's Last Name First Name M.I.

By what name do you prefer to be called? Drivers Lic.

Date of Birth Age Gender: M F SSN

Address Email

City State Zip

Phone Home Work Cell Pager

Employer/School Occupation PT FT

I am: Living with:

Spouse/Partner's: Last Name First Name M.I.

Phone Home Work Cell Pager

Employer/School Occupation PT FT

Emergency Contact: Name Relationship

Address

City State Zip

Phone Home Work Cell

Financially Responsible party: Name Relationship

Would you like to get personal medical information, e.g. test result, appt. reminders by email? YES NO

Would you be interested in a clinic newsletter, blog or general medical information sent by email/Website? YES NO

How did you hear about us? Yellow Pages Advertisement Website Other

Friend Relative Physician

Please provide a copy of your insurance card.

**Primary Insurance:** \_\_\_\_\_  
 Company Name Policy # Plan # Group #

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

\_\_\_\_\_  
 Insured Name: Relationship DOB SSN

\_\_\_\_\_  
 Deductible: \$ Copay: \$

**Motor Vehicle, Work related injury or Secondary Insurance: Claim # \_\_\_\_\_ DOI# \_\_\_\_\_**

\_\_\_\_\_  
 Company Name Policy # Plan # Group #

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

\_\_\_\_\_  
 Insured Name: Relationship DOB SSN

\_\_\_\_\_  
 Agent or Attorney Phone

**Credit Card Authorization**

I, (print name) \_\_\_\_\_ authorize Center for Environmental Medicine , located at 10748 Halsey Street, Suite A, Portland, OR 97220 to bill my credit card as listed below for services or products received.

**Credit Card Details:** Visa Card # \_\_\_\_\_ Exp date \_\_\_\_\_ Code \_\_\_\_\_  
 MasterCard Card # \_\_\_\_\_ Exp date \_\_\_\_\_ Code \_\_\_\_\_  
 Discover Card # \_\_\_\_\_ Exp date \_\_\_\_\_ Code \_\_\_\_\_  
 American Express # \_\_\_\_\_ Exp date \_\_\_\_\_ Code \_\_\_\_\_

**Card Billing Information:**  Same as registering patient  Other

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Authorization:** Card Holder's Signature \_\_\_\_\_ Date \_\_\_\_\_

- This authorization may be revoked at any time when the following stipulations have been performed:
1. Patient has made a new financial arrangements to cover any services or products received.
  2. The card holder/patient has submitted to our office a written request to stop using this credit card (signed and dated).
  3. Patient's account is paid in full and no further care is anticipated.

The Center for Environmental Medicine (CEM) will bill my medical or accident insurance as a courtesy. It is my responsibility to provide accurate and complete insurance information. Failure to do so will result in the inability to file a claim with my insurance carrier in a timely manner and could result in no paid benefits. This would make me entirely financially responsible for all services provided. I understand that it is my responsibility to provide payment for all copays and non-covered benefits at the time of service. I grant CEM permission to release to my insurance carriers any information necessary to pursue any medical claim for services received. I have read, understand and agree to abide by the *Office Policies and Procedures* document in the initial patient registration packet. I hereby authorize Dr. Hatlestad to perform any diagnostic tests and therapeutic forms of treatment indicated and deemed necessary by mutual agreement for my care under the standards of medical and naturopathic care.

\_\_\_\_\_  
 Print Name Signature Date



## CONSENT TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION (HIPPA)

I, \_\_\_\_\_ authorize the Center for Environmental Medicine and Dr. Hatlestad to use and disclose my personal health information (PHI) for the following limited purposes:

- To carry out investigation, treatment, or other healthcare operations/procedures.
- The preparation of reports to other healthcare providers or facilities involved in your care with only the minimum amount of necessary information being disclosed for this purpose.
- The analysis of medical research projects without personal identification.
- To assist in the payment of any of my medical care or submission for insurance claims.
- The types of information that will be used or disclosed may include the following:
  - The health condition that I have.
  - The alternative modalities that I choose to use.
  - The types of healthcare products or prescriptions that I use.
  - The type of health insurance that I have.
  - Copies of clinic visit transcription including laboratory, pathology and/or xray results.

\_\_\_\_\_ I understand that once the information is disclosed to others, the recipients of that information  
initial may disclose it to other individuals or organizations that are not subject to HIPAA regulations and that the information may no longer be protected.

\_\_\_\_\_ I have been given a copy of the Notice of Privacy Practices and have had the opportunity  
initial to review it before signing the consent to treatment. I acknowledge that the Notice of Privacy Practices may change from time to time and patients may access the updated Notice by submitting a request in writing to this office.

\_\_\_\_\_ I understand that I have the right to restrict how my personal health information is used and what  
initial is shared or disclosed to carry out investigation, treatment, payment or medical research and that the Center for Environmental Medicine Dr. Hatlestad, has the right to refuse my request. If he agrees to my request, it will be bound by that agreement. I understand that I have the right to revoke this consent in writing as long as it has not already been relied upon.

\_\_\_\_\_ I understand that the Center for Environmental Medicine or Dr. Hatlestad will not condition  
initial treatment, payment, enrollment or eligibility based upon obtaining this authorization unless permitted by law or regulation.

\_\_\_\_\_  
signature of patient

\_\_\_\_\_  
date



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This is to authorize: \_\_\_\_\_ Fax: \_\_\_\_\_

(The Dr. with the records)

address

phone

To release copies my medical record to: For the purposes of continuing medical care.

Limited to time period of \_\_\_\_\_ years.

CENTER FOR ENVIRONMENTAL MEDICINE, LLC
CHRIS HATLESTAD, MD, PC
10748 NE HALSEY STREET, SUITE A
PORTLAND, OR 97220-3691
503-261-0966: PHONE
503-252-2691: FAX

Please send the records indicated below:

- \_\_\_ Clinician office chart notes
\_\_\_ Transcribed hospital records
\_\_\_ Most recent three year history
\_\_\_ Consultations
\_\_\_ Problem list
\_\_\_ Other:
\_\_\_ Emergency & urgent care records
\_\_\_ Diagnostic imaging reports
\_\_\_ Laboratory reports
\_\_\_ Pathology reports
\_\_\_ Medication list

\* The following items must be initialed by patient to be included in requested chart information (federal regulations require a description of how much and what kind of information is to be disclosed).

- \_\_\_ HIV/AIDS related records
\_\_\_ Genetic testing information
\_\_\_ Mental health information
\_\_\_ Drug/alcohol diagnosis, treatment or referral information

Describe: \_\_\_\_\_

I agree to waive the privilege of confidentiality and privacy of my medical record in order to gain insurance reimbursement. I understand that this is not a blanket authorization to release information. It is intended for one-time use and expires \_\_\_\_\_ or 3 months after signing. I must re-execute it should additional requests for information occur. I understand that this authorization has been prepared in accordance with OR 433.045 and OAR 333-12-270. I also understand that Oregon Law allows HIV test information to be entered in my medical record and to be seen by or shared orally with persons who must review the record for the purpose of delivering health care to me or for routine administrative purposes. I further understand Oregon Law requires my physician to report my identity and/or HIV antibody test result to Public Health Authorities under certain circumstances without my authorization. I understand that I may revoke this release at anytime in writing.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of lawful representative if patient is a minor or incompetent. \_\_\_\_\_

(Relationship) \_\_\_\_\_



## Directions to the Clinic

10748 NE Halsey Street  
Portland, OR 97220-3961

From I-205 North, take the Glisan exit, make a right off of the exit. Turn left at 102nd Street. Go to Halsey which is the street just beyond Fred Meyers, and turn right. Go to 107th, look for our large sign and turn into the parking area.

From I-84 East, take the Halsey exit and continue up to 107th. Look for our large sign and turn into the parking area.

From I-205 South and I-84 South, take the Glisan-Stark exit, turn left onto Glisan. Go to 102nd and turn left again. Go to Halsey which is the street just beyond Fred Meyers and turn right. Go to 107th, look for our large sign and turn into the parking area.

TriMet stops right outside of our building. The Max Station is approximately 9 blocks away. You may easily transfer to TriMet or take a brisk walk.

