



**Karen Benton, N.D.**  
"Feel Better for Life – Naturally"  
Vancouver ~ Battle Ground ~ Ridgefield, WA.  
Phone: (360) 687-2799

**New Patient Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Parent/Guardian Name *if you are under 18* \_\_\_\_\_

Address \_\_\_\_\_

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

Home Telephone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_

Children? Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Most Important Health Concern(s) \_\_\_\_\_

What do you think causes your most important health concerns?  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact**  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Telephone Numbers** \_\_\_\_\_

**If you have INSURANCE, which covers naturopathic services, please provide your insurance card, so we can photocopy the important information.**

***If you are not the insured, please provide the insured's :***

Name \_\_\_\_\_ Birthdate \_\_\_\_\_.

Specifically, how did you choose Dr. Benton? \_\_\_\_\_

Yes, here's my e-mail address. \_\_\_\_\_ Please add me to your mailing list so I can receive information on upcoming classes, newsletters and promotions. (OVER)

**Please identify any symptom you currently experience or have experienced in the past six months:**

- Fever or chills     Hot flashes     Unusual hair growth     Weight change
- Skin eruptions     Joint pain     Numbness/tingling     Loss of libido
- Gas/bloating     Heartburn     Abdominal pain     Diarrhea/constipation
- Nausea/vomiting     Headache     Dizziness     Vision changes
- Sinus congestion     Hearing loss     Fainting     Chest pain
- Shortness of Breath     Heart Palpitations     Cough     Wheezing
- Frequent urination     Painful urination     Incontinence     Anxiety
- Depression     Insomnia     Appetite Change     Fatigue
- Other \_\_\_\_\_

**Sexually active?**     yes     no     \_\_\_\_\_

**It is helpful to understand how you feel/think about your current state of health. Please rate your current health on the following scales:**

<b>Mental/Emotional Health</b>	1	2	3	4	5	6	7	8	9	10
	Needs improvement									Optimum
<b>Physical Health</b>	1	2	3	4	5	6	7	8	9	10
	Needs improvement									Optimum
<b>Spiritual Health</b>	1	2	3	4	5	6	7	8	9	10
	Needs improvement									Optimum
<b>Sleep</b>	1	2	3	4	5	6	7	8	9	10
	Needs improvement									Optimum
<b>Stress Management</b>	1	2	3	4	5	6	7	8	9	10
	Needs improvement									Optimum
<b>Relationships</b>	1	2	3	4	5	6	7	8	9	10
	Need improvement									Optimum

**What are you willing to do to improve your overall health?**

- Not much, I'm too busy     I don't know     Maybe a few changes
- Please give me an herb or remedy    you tell me    just don't tell me to eliminate
- to fix me now    my favorite foods
- I'm willing to listen and     Anything
- make many changes

**TERMS AND CONDITIONS OF TREATMENT**

To be treated by Dr. Benton, she respectfully asks you agree to the following terms and conditions of treatment:

**Information Release.** If medical or other medically-related information is necessary to process an insurance claim, I authorize its release. I also request payment of government benefits to either myself or to the party who accepts assignment herein.

**Terms of Payment.** If you do not have naturopathic insurance coverage, payment in full is expected at the time of service. If you have difficulty with this, please discuss with your provider before your office visit. Our past due accounts are periodically turned over to a collection agency. If your account is assigned, I agree to pay all costs necessary to collect the amount due.

**Consent to Treat.** Naturopathic medical treatment relies primarily upon using natural remedies and I agree to relay any pertinent history which may impact selection of these treatments. I agree to be treated by Dr. Benton, a naturopathic physician licensed in the state of Washington.

**Receipt of Privacy Practices.** Dr. Karen Benton has provided me with a copy of her Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand I am entitled to receive updates upon request, if amendments or changes are made to this Notice. If I have questions or complaints I may contact Dr. Benton.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Patient

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent of Minor

AS A CONDITION OF DR.. BENTON'S MALPRACTICE INSURANCE, PLEASE READ AND SIGN THE AGREEMENT ON THE REVERSE SIDE OF THIS FORM.



**THANK YOU!**