

*Jonathan Collin, M.D.*

## INFORMATION FOR PATIENT'S CASE HISTORY

Please Print and Answer All Questions

Patient Name \_\_\_\_\_  
FIRST INITIAL LAST

Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Home Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Email Address \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_

Spouse/Partner or Parent's Name \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_

Who should be notified other than husband or wife in case of emergency?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Name of Previous Physician \_\_\_\_\_

Referred to this office by \_\_\_\_\_

Date \_\_\_\_\_

# Medical History Form

DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_  
Last First Middle

PRESENT OCCUPATION \_\_\_\_\_

PREVIOUS OCCUPATIONS \_\_\_\_\_

NAME OF SPOUSE / AGE \_\_\_\_\_ CHILDREN/AGES \_\_\_\_\_

WHY ARE YOU SEEING THE DOCTOR? \_\_\_\_\_

LIST ALL PRESENT SYMPTOMS, COMPLAINTS, OR ILLNESS, AND LENGTH OF TIME YOU HAVE BEEN AWARE OF THEM \_\_\_\_\_

HAVE YOU EVER HAD? (Leave blank if “no”. If “yes”, give approximate year it began.)

- |                            |                               |                             |
|----------------------------|-------------------------------|-----------------------------|
| Scarlet Fever .....        | Diabetes .....                | Bursitis .....              |
| Malaria .....              | Cancer .....                  | Artery Blockage .....       |
| Rheumatic Fever .....      | Epilepsy .....                | Neuritis .....              |
| Polio .....                | Stroke .....                  | Syphilis .....              |
| Meningitis .....           | Asthma .....                  | Gonorrhea .....             |
| Mumps .....                | High Blood Pressure .....     | Rectal Disorder .....       |
| Migraine .....             | Nervous Disease .....         | Prostate Trouble .....      |
| Anemia .....               | Mental Disorder .....         | Arthritis .....             |
| Blood Disease .....        | Skin Disease .....            | Rheumatism .....            |
| Heart Trouble.....         | Hearing Loss .....            | Varicose Veins .....        |
| Multiple Sclerosis .....   | Sinusitis .....               | Slipped Disc .....          |
| Psoriasis .....            | Pleurisy .....                | Sciatica .....              |
| Cataracts .....            | Stomach Ulcers .....          | Gout .....                  |
| Glaucoma .....             | Liver Disease .....           | P.M.S. ....                 |
| Thyroid Disorder .....     | Diverticulitis .....          | Yeast Syndrome .....        |
| Bronchitis .....           | Colitis .....                 | Chronic Fatigue Syndrome... |
| Emphysema .....            | Kidney Infections .....       | Epstein Barr Virus .....    |
| Gall Bladder Trouble ..... | Kidney Stones .....           | Herpes .....                |
| Diphtheria .....           | Phlebitis .....               | HIV .....                   |
| Typhoid .....              | Coronary Artery Disease ..... | Environmental Illness ..... |
| Tuberculosis .....         | Circulation Disorder .....    | Chemical Sensitivity .....  |
| Cirrhosis .....            | Kidney Disease .....          | Depression .....            |
| Pancreatitis .....         | Drug Dependency .....         | Suicide Attempt .....       |
| Alcoholism .....           | Drug Overdose .....           | Addiction Disorder .....    |
| Chemical Poisoning .....   | Biological Poisoning .....    | Covid-19 .....              |

## Medical History Form, continued

OTHER SERIOUS ILLNESS \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

LIST ALL OPERATIONS OR SURGERY, AND APPROXIMATE YEAR \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

LIST ANY OTHER HOSPITALIZATIONS – REASON AND YEAR \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

LIST ANY SERIOUS ACCIDENTS – INJURY AND YEAR \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

DATE OF LAST COMPLETE CHECKUP \_\_\_\_\_ GI SERIES \_\_\_\_\_

DATE OF LAST CHEST X-RAY \_\_\_\_\_ BARIUM ENEMA \_\_\_\_\_

OTHER X-RAYS \_\_\_\_\_ GALL BLADDER \_\_\_\_\_

CHECK HOW OFTEN YOU USE THE FOLLOWING (Check which):

	NEVER	OCCASIONALLY	FREQUENTLY	DAILY
ALCOHOL				
LAXATIVES				
SLEEPING PILLS				
ANTACIDS				
ANTIBIOTICS				
ASPIRIN				
PAIN PILLS				

HOW MUCH DO YOU SMOKE? (Packs per day) \_\_\_\_\_

LIST ALL MEDICINES OR PILLS YOU TAKE (EXCEPT FOR VITAMINS OR SUPPLEMENTS)

(Include prescription, over-the-counter, and 'recreational' drugs)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

LIST ANY CHEMICALS, METALS, SPRAYS, FUMES, TO WHICH YOU HAVE BEEN EXPOSED FOR PROLONGED PERIODS

\_\_\_\_\_  
 \_\_\_\_\_

## Medical History Form, continued

### MALES

Prostate Trouble \_\_\_\_\_

Swollen Testicles \_\_\_\_\_

Discharge from penis \_\_\_\_\_

Venereal disease \_\_\_\_\_

Trouble with erection or ejaculation \_\_\_\_\_

### FEMALES

Irregular menses \_\_\_\_\_

Painful menses \_\_\_\_\_

Cysts or tumors of female organs \_\_\_\_\_

Vaginal infections \_\_\_\_\_

Bleeding between periods \_\_\_\_\_

Pain with intercourse \_\_\_\_\_

Age menses began \_\_\_\_\_

Last menstrual period (date) \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

Miscarriages \_\_\_\_\_

Current Weight \_\_\_\_\_

Height \_\_\_\_\_

What is the most you have ever weighed? \_\_\_\_\_ When \_\_\_\_\_

What is the least you have ever weighed as an adult? \_\_\_\_\_ When \_\_\_\_\_

How much weight have you gained or lost in the past year? \_\_\_\_\_

What times are you most hungry? \_\_\_\_\_

Do you often find that you can't stop eating? \_\_\_\_\_

LIST ALL VITAMINS (include strength) AND SUPPLEMENTS YOU TAKE REGULARLY \_\_\_\_\_

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How many hours do you sleep at night? \_\_\_\_\_

Do you have trouble getting to sleep? \_\_\_\_\_ Staying asleep? \_\_\_\_\_

Any other comments about your past or present health \_\_\_\_\_

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List all sports, exercise, or hobbies you engage in regularly \_\_\_\_\_

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## Medical History Form, continued

HAVE YOU EVER HAD AN ALLERGY OR BAD REACTION TO:

Penicillin _____	Other medicines _____
Serums _____	or injections _____
Vaccines _____	Other Antibiotics _____
Foods _____	Pollens _____

FAMILY HISTORY:

IF ALIVE

IF DEAD

	AGE	ILLNESS	AGE	CAUSE OF DEATH
FATHER				
MOTHER				
SISTER				
BROTHER				

NOTE WHICH MEMBER OF YOUR FAMILY HAS EVER HAD:

Diabetes _____	Migraines _____
High blood pressure _____	Epilepsy _____
Cancer _____	Arthritis _____
Asthma _____	Nervous disorder _____
Ulcers _____	Mental Disorder _____

CHECK IF YOU ARE HAVING ANY OF THE FOLLOWING:

Hives .....	Burning of urine .....	Numbness or tingling .....
Eczema .....	Weak bladder .....	Weakness of muscles .....
Ringling ears .....	Frequent urinating .....	Excessive Fatigue .....
Bleeding gums.....	Shortness of breath .....	Loss of ambition .....
Hay fever .....	Heart murmur .....	Loss of sex drive .....
Chronic rash .....	Vomiting spells .....	Difficulty concentrating....
Hearing loss .....	Jaundice .....	Poor memory .....
Sore tongue .....	Easy bruising .....	Crying spells .....
Frequent headaches..	Skipped heartbeats .....	Frequent depressed spells...
Double vision.....	Spitting blood .....	Frequent suicidal thoughts..
Frequent colds .....	Diarrhea .....	Unusual fears .....
Goiter .....	Flatulence (gas) .....	Sexual problems .....
Chest pains .....	Bleeding tendency .....	Irritability .....
Palpitations .....	Back trouble .....	Nervousness .....
Wheezing .....	Joint pains .....	Frequent loneliness .....
Constipation .....	Fainting .....	Nervous breakdown .....
Heartburn .....	Dizzy spells .....	Trouble sleeping .....
Bloody urine .....	Spasms or fits .....	Bad dreams .....
Sugar in urine .....	Tremors of hands or feet .....	Halitosis (bad breath) .....
Pus in urine .....	Cold hands or feet .....	Body odor .....
Gravel in urine .....	Hair loss .....	Skin: Oily or Dry .....

**PLEASE LIST ALL SUPPLEMENTS AND MEDICATIONS**  
YOU ARE CURRENTLY TAKING, INCLUDING DOSAGE AND FREQUENCY

## FOOD ANALYSIS

PLEASE LIST AN EXAMPLE OF YOUR DAILY FOOD AND DRINK INTAKE  
Meals, snacks, beverages, including sizes: 8oz chicken, 12oz coffee w/cream

## Lab Work/Lab Testing

**Please provide copies of recent lab tests from the past two years.**

Dr. Collin is looking for lab tests from recent medical examinations and workups.

Additionally, if any tests have been done by naturopathic physicians or integrative clinics examining toxic metals, chemicals, comprehensive hormone profiles, food allergy testing, stool analysis, etc. please provide these reports.



## Medical Imaging Reports

*Please provide copies of recent imaging reports such as CT scans, MRIs, ultrasounds, etc. from the past two years.*

# *Jonathan Collin, M.D.*

12911 120TH AVE NE, STE #A-50

KIRKLAND, WA, 98034 U.S.A.

(425) 820-0547

Fax (425) 820-0259

## **HIPAA NOTICE –**

### **PLEASE NOTE:**

The full 8-page text of the HIPAA policy is provided by this office, and may be requested at any time via the contact information listed below. It may also be accessed or downloaded from our website, but most people don't want to print out extra pages of a policy that they probably don't even read, so it's not included in this 'short' set of forms.

To obtain a paper or email copy of the policy, or to report concerns, please contact:

JONATHAN COLLIN, M.D.

12911 120TH AVE NE, STE #A-50

KIRKLAND WA 98034

ATTN: PRIVACY OFFICER

The Privacy Officer can be contacted by telephone at 425-820-0547.

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## **Notice and Acknowledgement**

### **Acknowledgement**

I acknowledge that I have been provided access to the HIPAA - Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

\_\_\_\_\_

# Jonathan Collin, M.D.

DrJonathanCollin.com

## PORT TOWNSEND OFFICE

911 Tyler Street  
Port Townsend WA 98368  
(360) 385-4555  
Fax (360) 385-0699

## KIRKLAND OFFICE

12911 120<sup>th</sup> Ave NE Ste A-50  
Kirkland WA 98034  
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## Consent for Complementary and Alternative Medicine Diagnostics and Treatment

**Patient's Full Name** \_\_\_\_\_

I wish to consult with Dr. Jonathan Collin about complementary and alternative medicine in conjunction with conventional medicine to diagnose and treat my medical condition. I am providing Dr. Collin all medical information necessary for diagnosis and treatment.

I understand that complementary and alternative medicine has not yet been established as conventional medicine. However, based on the best available evidence, advised complementary and alternative medicine is appropriate for diagnosis and treatment of my condition in conjunction with conventional diagnosis and treatment.

Dr. Collin agrees to recommend conventional medicine in the diagnosis and treatment of my medical condition. He further advises undertaking all conventional diagnostics and treatments while undertaking complementary and alternative medicine. When conventional medicine has been unsatisfactory in managing my medical condition, Dr. Collin will suggest complementary and alternative medicine for diagnosis and treatment. Just like conventional medicine, complementary and alternative medicine do have medical risks and concerns. Dr. Collin agrees to inform me of such medical risks and concerns.

I understand that at any time I may choose not to proceed with advised complementary and alternative medicine diagnostic testing and treatment. I understand that at any time I may withdraw my consent for care by Dr. Collin.

**I have carefully read this consent form and hereby authorize administration of complementary and alternative medicine diagnostics and treatment by Dr. Collin.**

**Signature of patient** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Consent for Treatment and Billing Agreement for Phone Consult Appointment

*(signed consent is required to have telephone consultations with Dr. Collin)*

**Patient's Full Name** \_\_\_\_\_

During the 2021 legislative session, Washington State Substitute House Bill 1196 was passed, outlining terms for billing as it relates to 'Telemedicine', specifically 'audio-only' services. As per the terms of that Bill, we are required to obtain explicit patient consent for billing for telephone appointments.

**I agree to consult with Dr. Jonathan Collin by Phone Consult/Telephone to diagnose and treat my medical condition. Further, I understand there is a charge for each appointment and that payment is expected after the consultation.**

*I have carefully read this consent form, and indicate my agreement with the signature below:*

**Signature of patient** \_\_\_\_\_ **Date** \_\_\_\_\_