# 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 …….. _____
Malaria …….. _____
Rheumatic Fever ……..…… _____
Polio ……. _____
Meningitis ……. _____
Mumps …….. _____
Migraine …… _____
Anemia ……. _____
Blood Disease ……..…. _____
Heart Trouble…… _____
Multiple Sclerosis …… _____
Psoriasis ……... _____
Cataracts …….. _____
Glaucoma …… _____
Thyroid Disorder …… _____
Bronchitis …… _____
Emphysema ……..…… _____
Gall Bladder Trouble ……. _____
Diphtheria ……. _____
Typhoid ……..…….. _____
Tuberculosis …… _____
Cirrhosis …….. _____
Pancreatitis …….. _____
Alcoholism …….. _____
Chemical Poisoning …… _____

Diabetes ……...……. _____
Cancer ……. _____
Epilepsy ….…….. _____
Stroke ……..…. _____
Asthma ……..... _____
High Blood Pressure …… _____
Nervous Disease ……..…….. _____
Mental Disorder ……..…. _____
Skin Disease …..……..…. _____
Hearing Loss …… _____
Sinusitis …… _____
Pleurisy ……..…… _____
Stomach Ulcers ……. _____
Liver Disease …… _____
Diverticulitis ……. _____
Colitis …… _____
Kidney Infections ……..… _____
Kidney Stones …… _____
Phlebitis ……. _____
Coronary Artery Disease ….... _____
Circulation Disorder ……... _____
Kidney Disease …….. _____
Drug Dependency …….. _____
Drug Overdose ……... _____
Biological Poisoning …….. _____

Bursitis ……..……..……. _____
Artery Blockage …… _____
Neuritis ……..…… _____
Syphilis …… _____
Gonorrhea …… _____
Rectal Disorder ……. _____
Prostate Trouble …… _____
Arthritis …… _____
Rheumatism ……..……. _____
Varicose Veins ……. _____
Slipped Disc ……. _____
Sciatica ……. _____
Gout …….. _____
P.M.S. …….. _____
Yeast Syndrome …… _____
Chronic Fatigue Syndrome… _____
Epstein Barr Virus …… _____
Herpes ……..…….. _____
HIV ……..……. _____
Environmental Illness ……... _____
Chemical Sensitivity ….……. _____
Depression ……. _____
Suicide Attempt ……. _____
Addiction Disorder ……... _____
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 _____

_____

_____

_____

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 _____

_____

_____

_____

List all sports, exercise, or hobbies you engage in regularly _____

_____

_____

_____

# 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 …… _____
Eczema …… _____
Ringing ears …… _____
Bleeding gums……. _____
Hay fever ……. _____
Chronic rash …… _____
Hearing loss …… _____
Sore tongue ……. _____
Frequent headaches.. _____
Double vision……... _____
Frequent colds ……. _____
Goiter …….. _____
Chest pains …….. _____
Palpitations ……. _____
Wheezing …… _____
Constipation …… _____
Heartburn …… _____
Bloody urine ……... _____
Sugar in urine ……. _____
Pus in urine ……. _____
Gravel in urine …… _____

Burning of urine …… _____
Weak bladder …… _____
Frequent urinating …….. _____
Shortness of breath …… _____
Heart murmur ……. _____
Vomiting spells …….. _____
Jaundice ……. _____
Easy bruising ……. _____
Skipped heartbeats ……. _____
Spitting blood …… _____
Diarrhea ……. _____
Flatulence (gas) ……. _____
Bleeding tendency ……. _____
Back trouble …….. _____
Joint pains ……. _____
Fainting ……. _____
Dizzy spells ……... _____
Spasms or fits …… _____
Tremors of hands or feet ……... _____
Cold hands or feet ……. _____
Hair loss …… _____

Numbness or tingling ……..____
Weakness of muscles ……. _____
Excessive Fatigue …….. _____
Loss of ambition …… _____
Loss of sex drive …… _____
Difficulty concentrating…. _____
Poor memory ……. _____
Crying spells …….. _____
Frequent depressed spells... _____
Frequent suicidal thoughts.. _____
Unusual fears ……. _____
Sexual problems …… _____
Irritability …….. _____
Nervousness …….. _____
Frequent loneliness ……... _____
Nervous breakdown …….. _____
Trouble sleeping …… _____
Bad dreams …… _____
Halitosis (bad breath) …… _____
Body odor …….. _____
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, !2oz 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.

911 TYLER STREET
PORT TOWNSEND WA 98368 U.S.A.
(360) 385-4555
Fax (360) 385-0699


# 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 provided 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.
911 TYLER STREET
PORT TOWNSEND WA 98368
ATTN: PRIVACY OFFICER

The Privacy Officer can be contacted by telephone at 360-385-4555

# Jonathan Collin, M.D.

911 TYLER STREET
PORT TOWNSEND WA 98368 U.S.A.
(360) 385-4555
Fax (360) 385-0699


## Notice and Acknowledgement

### Acknowledgement

I acknowledge that I have received the 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 120th Ave NE Ste A-50
Kirkland WA 98034
(425) 820-0547
Fax (425) 820-0259

## 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 _____**

# 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 120th Ave NE Ste A-50
Kirkland WA 98034
(425) 820-0547
Fax (425) 820-0259


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

*(Specific consent is required for having treatment/consult with Dr. Collin by telephone)*

**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 _____**