



Virginia A. Oram, N.D.

Naturopathic Physician

Phone (541) 343-2384

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358 Blair Boulevard

Eugene, Oregon 97402

www.DrOram.com

Dear

We want to take this opportunity to welcome you! We are honored that you have decided to work with us in your efforts to obtain optimum health.

Our practice is committed to quality, competent, and compassionate Naturopathic healthcare. We provide all phases of primary health care, blending centuries-old knowledge of natural non-toxic therapies with current advances in the understanding of health and human systems. The full range of services provided includes:

- Family health care including physical exams and laboratory analysis for all family members from young to old, male and female
- Full women's health services including annual exams and PAPs
- Full pediatric care, including advice about immunizations
- Individualized metabolic detoxification programs
- Physical medicine: Ortho-Bionomy, Maya Abdominal Therapy, spinal manipulation and electrical stimulation
- Specialty treatments: Heavy metal detoxification, chemical sensitivity treatment, allergy testing, etc.

We have reserved a First Office Call appointment for you on _____ at _____ am/pm. Our office staff extends the courtesy of a reminder call one business day prior to your appointment when we are able to reach you at the number that you have designated. At least 48 business hours notice is required in the event that you need to cancel or reschedule your appointment. Cancellations without 48 business hours prior notice will be charged for half of the cost of the visit, cancellations with out prior notice will be charged the full fee. For further information on policies and fee schedules, please see the enclosed paperwork.

We are located at 358 Blair Boulevard in Eugene. Our office is across from the Red Barn Natural Grocery. The clinic is in a green two-story renovated home with a white picket fence. You may park your car in our front or rear parking lot (recommended).

Please don't hesitate to call should you have any questions prior to your appointment. We look forward to meeting you.

Sincerely,

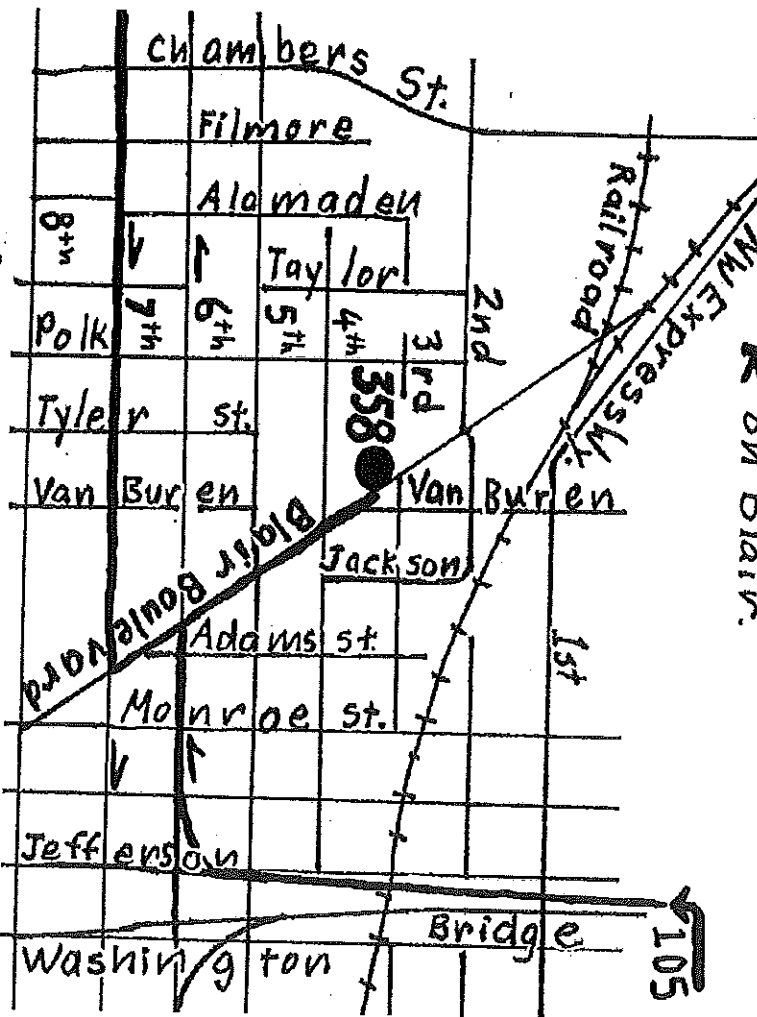
Virginia A. Oram, ND
and Staff

Vibrant Health is a Natural Path Away!

Dr. Oram
 Blair Centre for Natural Medicine
 358 Blair Boulevard
 Eugene, OR 97402



Directions:
 From the east, downtown, UO:
 Take 6th/Hwy. 99. R on Blair.
 From the west:
 Take 7th/Hwy. 99. L on Blair.
 From Hwy. 105:
 Exit to downtown. R on 6th.
 R on Blair.



Illustrated and designed by Tyler Burgess.

Printed in Eugene, Oregon

Our office is a FRAGRANCE-FREE ZONE

In response to health concerns we have developed a scent-free policy. Scented products such as soaps, lotions, hairsprays, deodorants, perfumes, incense, essential oils, patchouli, musks, etc. can trigger reactions such as respiratory distress and headaches.

Staff and visitors are asked not to use any fragrances when in our office.

Thank you for your consideration of others.

Sincerely, Dr. Oram & Staff

PATIENT REGISTRATION

Name _____ Age _____ Birthdate _____ Sex _____
Address _____ City _____ State _____ Zip _____
Phone (home) _____ (work) _____
Occupation _____ Full or Part Time _____ Retired _____
Employer (Name & Address) _____
Soc. Sec. # _____ Education _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Cohabiting _____

If patient is a child, please indicate the following:

Mother's name _____ Age _____ Marital Status _____ Child lives with you? _____

Father's name _____ Age _____ Marital Status _____ Child lives with you? _____

Are there other co-parents? _____

Name and Address of Relative or Friend in case of Emergency:

Name _____ Relationship _____

Address _____ Phone _____

How did you hear about this office? _____

Name of Family Doctor, if any _____

FAMILY HISTORY

Has any blood relative had any of the following? If so, please indicate their relationship to you and name the disease on the lines provided below:

Anemia	Eczema	Epilepsy	Stomach/Duodenal ulcer
Bleeding easily	Arthritis/Rheumatism	High blood pressure	Tuberculosis
Genetic disease	Cancer/Tumor	Heart disease	Alcoholism/Drug addiction
Allergies/Asthma	Diabetes	Stroke	Nervous breakdown
Hay fever	Glaucoma	Thyroid trouble	Suicide
		Venereal disease	Other

YOUR HEALTH HISTORY

Have you ever had any of the following? If so, indicate how old you were, in the blank next to the specific condition:

_____ Cancer _____ Herpes _____ Syphilis _____ Bad reaction to an immunization

_____ Tuberculosis _____ Gonorrhea _____ Other serious illness/injury _____

Have you ever had surgery or been hospitalized? If so, please indicate when and for what reason: (Do not include normal pregnancies) _____

Are you allergic to any medicines or other substances? If so, please indicate: _____

What medicines do you presently take, including supplements and nonprescription items? _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICES. THANK YOU.

INSURANCE INFORMATION: If you have NO insurance, check here _____

PRIMARY INSURANCE (which co. we should bill first):

Subscriber's name (person's name the insurance is under) _____

Subscriber's address (if different than patient's) _____

Subscriber's Date of birth _____ Subscriber's employer _____

Address of Insurance Co. _____

Name of Insurance Company _____

ID Number _____ Group Number _____

Is there a second insurance company? _____

Subscriber's name _____

Subscriber's date of birth _____

Subscriber's employer _____

Name of Insurance Company _____

ID Number _____ Group Number _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party _____

Phone _____ Social Security # _____ Relationship to patient _____

Address (if different than patient's) _____

Date of birth _____

Please sign and return to receptionist.

I hereby authorize your office to release any medical records or other information necessary to secure medical benefits.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all expenses, including reasonable attorney fees.

Signature _____ Date _____

How Do I check my Insurance Benefits?

Patient Name _____ Insurance ID# _____

Our office will happily bill your insurance for your visit; however, it is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-7 when calling to find out your benefits and eligibility.

First, Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my coverage begin and when is it valid through?
Beginning Date of Coverage _____ End Date of Coverage _____

2. Do I need a referral from my primary care physician (PCP) for alternative services?
Yes _____ No _____

3. Is the doctor I want to see (Virginia Oram, ND) In-Network or a Preferred Provider with my insurance?
Yes _____ No _____

4. What are my benefits for the following services? **Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.*

Naturopathic: % Covered _____; Co-pay/Co-Insurance _____; Year Max _____

Labs: % Covered _____; Co-pay/Co-Insurance _____; Year Max _____

5. Do charges for Labs come out of Year Max for Naturopathic services:
Yes _____ No _____

6. Is there a Co-pay per visit or per specialty? Circle one.

7. What is my deductible for the year and has any or all of it been met?

Deductible: \$ _____ Amount of Deductible met so far: \$ _____ Date _____

Are any of the services listed above subject to this deductible? Yes _____ No _____

If so, which services? _____

7. What was the name of the representative you spoke with? _____
Date _____

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!

**Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.*

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name _____ Birthdate _____ Date: _____
 Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
 (Where is the pain/problem?)

Severity _____
 (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Timing _____
 (Does the pain/problem occur at a specific time?)

Associated signs/symptoms _____
 (What other associated problems have you been having?)

Quality _____
 (Example: normal versus abnormal color, activity, etc.)

Duration _____
 (How long have you had this pain/problem?, or, When did it start?)

Context _____
 (Where were you at the onset of this pain/problem?)

Modifying factors _____
 (What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	_____		
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes	_____		
Venereal Disease	no	yes				Stroke	no	yes	_____		

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____

Patient social history:

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
 Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
 Use of tobacco: Never: _____ Previously, but quit: _____ Current packs / day: _____
 Use of drugs: Never: _____ Type/Frequency: _____
 Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Air-borne Particles: _____ Noise: _____

Family medical history:

Age	Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____
Spouse _____	_____	_____
Children _____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good general health lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

Eyes

Eye disease or injury No Yes
 Wear glasses/contact lenses No Yes
 Blurred or double vision No Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problem or rhinitis No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

Cardiovascular

Heart trouble No Yes
 Chest pain or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath w/walking
 or lying flat No Yes
 Swelling of feet, ankles or hands No Yes

Respiratory

Chronic or frequent coughs No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

Gastrointestinal

Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements
 or constipation No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal pain No Yes

Genitourinary

Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of strain
 when urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male - testicle pain No Yes
 Female - pain with periods No Yes
 Female - irregular periods No Yes
 Female - vaginal discharge No Yes
 Female - # of pregnancies _____
 Female - # of miscarriages _____
 Female - date of last pap smear _____

Musculoskeletal

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

Integumentary (skin, breast)

Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

Neurological

Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Convulsions or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Head injury No Yes

Psychiatric

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

Endocrine

Glandular or hormone problem No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming dryer No Yes
 Change in hat or glove size No Yes

Hematologic/Lymphatic

Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

Allergic/Immunologic

History of skin reaction or other adverse
 reaction to:
 Penicillin or other antibiotics No Yes
 Morphine, Demerol,
 or other narcotics No Yes
 Novocain or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin
 or other serums No Yes
 Iodine, Merthiolate or
 other antiseptic No Yes
 Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

 Signature of Parent or Guardian

 Date

 Doctor's Review

 Signature of Doctor

 Date

PREPARING FOR YOUR HOMEOPATHIC CONSULTATION

This handout has been prepared to help you participate effectively in your homeopathic treatment. It contains instructions for preparing for your homeopathic consultation, and practical information about the course of treatment. Please read this material carefully and keep it to re-read occasionally, especially if you have not been in for some time.

THE HOMEOPATHIC CONSULTATION FOR CHRONIC DISEASE

The information that you provide the physician is *essential* for effective homeopathic treatment. The homeopathic consultation involves extensive questioning that may cover unfamiliar ground for those who are used to a few quick questions from a busy doctor. To better prepare you for the consultation, and the kinds of information the homeopathic physician requires are described below.

First, you will be asked to briefly list the conditions that have caused you to seek treatment and for how long you have had these problems. It is a good idea to mention these main problems in order of importance.

Next, you will be asked to describe each of these conditions in your own words, as fully as possible. Include everything that is characteristic of your problems. *Precise details are best*, but only if you can be definite about them. If applicable, your account should include, but not be limited to:

CHARACTER OF SENSATION or PAIN. Does it feel tingling, burning, numb, crawling, pressure, or itching, etc.? Is the pain cutting, dull, aching, or cramping? These are suggestions only.

LOCATION of the complaint as precisely as possible. For example, "pain in the left temple" is more helpful than simply "headache".

DISCHARGES or bleeding from any part of the body. Give color, consistency, quantity, and odor of the discharge.

AGGRAVATING OR AMELIORATING FACTORS. What makes your complaint better or worse? Does your condition vary with time of day or night or season of the year? Is it affected by your position (sitting, standing, lying, etc.) or by activity (motion of any body part, walking, vigorous exercise, rest, etc.)? How does temperature, weather, eating, and sleeping affect your condition? **ANYTHING** that clearly influences the intensity or pattern of your symptoms should be reported.

CONCOMITANTS. Does anything regularly occur in association with your symptoms? Are you always nauseated when you have a headache? Does your skin clear up during your premenstrual symptoms?

ONSET OF SYMPTOMS. Do you associate the onset of your condition with any emotional upset, prolonged or pronounced stress, lack of sleep, exposure to weather, an injury, drug use, or surgery, or any other factors? Does anything cause a recurrence of your symptoms?

GENERAL INFORMATION. In addition to information about your primary problems, the homeopathic doctor needs to know a lot about you in general. This is important, and may be decisive when choosing the remedy.

How vital and energetic do you feel? How does your sense of well-being (not any particular symptom), change as a result of environmental or emotional factors? How are you affected, in general, by temperature, weather, time of day, activity level, eating and sleeping? What makes you feel better, what worse? This may be different from what makes a particular symptom better or worse. Please complete the questionnaire carefully.

The doctor will also want to briefly know your LIFE HISTORY, including any traumatic emotional events or significant patterns.

Finally, the homeopathic doctor will want you to discuss your MENTAL/EMOTIONAL NATURE. During what activities or in which situations do you feel most emotional? What are your most characteristic emotional patterns? What limits your ability to express yourself fully? What about your memory, clarity of thought, ability to create, and so on?

Feel free to think about these questions before hand and jot down some notes for yourself to use during the interview. How you say things is also important, so please don't be offended if the doctor asks you to put those notes aside for a while during the interview. There will be time later to get back to them.

PREVIOUS MEDICAL RECORDS are always helpful. Please bring copies along with you if possible.

PHYSICAL EXAMINATION AND LABORATORY

The first determination that the homeopathic doctor must make is an accurate diagnosis of your condition. For this reason a physical examination is done and laboratory tests and x-rays are ordered when they are deemed necessary.

HOMEOPATHIC CONSULTATION FOR ACUTE DISEASES

Acute diseases require a shorter visit, usually 20-30 minutes. During this type of visit chronic symptoms will be ignored and only those symptoms that have arisen at the time of the acute disease will be considered. You will still need to relate your symptoms with as precisely and with as much detail as possible. Physical exam is usually limited to those procedures necessary for that particular acute condition. Again, lab tests or x-rays will be ordered as required.

TREATMENT

Based upon the information you provide, as well as the results of physical examination and appropriate laboratory tests, you will be given a remedy to begin stimulating the healing process.

If you are being treated for a chronic condition you will usually be instructed to take a single dose of your remedy in the office. If you have used or taken something like coffee or camphor that day you may be given the remedy to take home and take later. This single dose will be all that you require for a month or more. Acute cases and certain chronic cases often require more frequent doses. A dose usually consists of three or four of the round white pellets in the vial you will receive.

Please follow the instructions you will be given about how to take and store your homeopathic medicine as well as what to avoid during treatment. If you have any questions about this please ask anyone on the staff.

WHAT TO EXPECT

During an acute illness you should notice improvement within the first 24 hours, though you will still require a normal, gradual convalescence.

While undergoing chronic treatment, each individual reacts to the remedy in a different way. Usually the effects are gentle and gradual, though at times more rapid or dramatic changes occur. Since the remedies work to improve your general health, you should not be concerned if local symptoms do not change immediately. Patience is a necessary ingredient you must add to the treatment.

Temporary minor aggravations of symptoms or recurrences of previously experienced symptoms sometimes occur. These are not side effects of the remedy, but an indication that the body is responding to the medicinal stimulus. If any reaction occurs that concerns you, do not hesitate to call the doctor.

People with chronic problems improve over widely varying periods of time, usually 3-24 months. This is the time necessary to complete the cure. You will, however, experience definite improvement in your symptoms within a few weeks of starting the correct remedy. During the whole of this time, regular follow-up visits are essential to nurture the healing process through the inevitable remedy changes and occasional setbacks that occur.

These follow-up visits are scheduled at varying intervals anywhere from three weeks to six months depending upon the individual characteristics of each person's progress.

FOLLOW-UP APPOINTMENTS Follow-up appointments are very important. Often they will be scheduled even when you are doing well or continuing to make progress. This sometimes seems unusual or unnecessary to patients unfamiliar with homeopathy. We're all used to the conventional idea of going to the doctor only when we are sick. However, our observation has been that those patients who return for their regularly scheduled follow-up appointments complete their homeopathic treatment in shorter time and with better results.

Although you may be taking homeopathic medicine and be under active care for as long as two or sometimes three years it is important to keep in mind that the ultimate goal of homeopathic treatment is to reach a high level of health without being dependent upon any medication.

COMPREHENSIVE CARE

Homeopathy can be used as a comprehensive medical system as well as for the treatment of specific complaints. Once the treatment of a specific disease is complete, the homeopathic remedies can be used to strengthen the person's emotional life. This will help to prevent disease in the future by increasing the person's resistance to emotional stress. After this, yearly or biyearly doses of their "constitutional remedy" will also act to prevent disease in the future by maintaining the body in its best possible condition. Of course, lifestyle and diet are also important in preventing disease.

REFERENCES: Readily available in Eugene

EVERYBODY'S GUIDE TO HOMEOPATHIC MEDICINE by Cummings and Ullman.

DISCOVERING HOMEOPATHY by Dana Ullman.

HOMEOPATHY: MEDICINE OF THE NEW MAN by George Vithoulkas.

THE PATIENT NOT THE CURE by Marjorie Blackie.

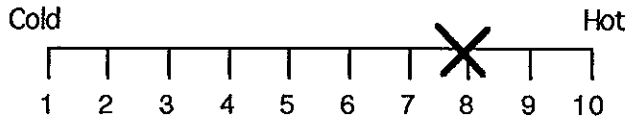
Please answer the following questions as carefully and thoughtfully as possible. Homeopathy individualizes each prescription to the person as well as to the disease symptoms. Many of the questions that follow may not seem directly related to your main complaint or reason for seeking homeopathic care. The answers to these questions, as well as the information that you provide in the office, will determine which homeopathic remedy we begin your treatment with. Please take enough time and answer carefully and accurately. ALL THE INFORMATION IN THIS QUESTIONNAIRE IS CONFIDENTIAL BY LAW.

This questionnaire has been designed to make this process easy. You can answer many of the questions by placing an X in the appropriate place on the line given. Some questions will ask you to decide between two opposite symptoms.

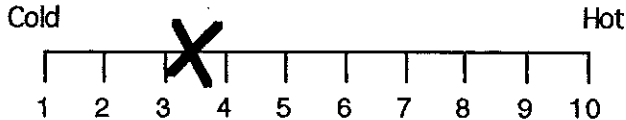
For example: If you are asked whether you are generally hot or cold. Place your mark along the line to indicate how hot or cold you are.

Placing an X closer to the hot end of the line means that you are more hot. Placing your X closer to the cold end means you are more cold.

For example: If you are hot, put an X in the appropriate place on the line to indicate how hot you are.

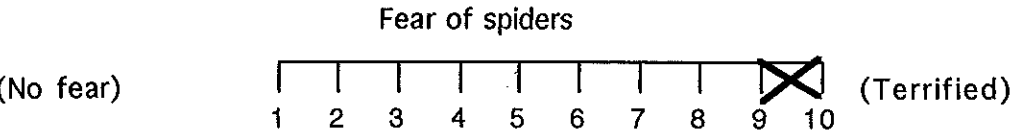


If you are cold, place an X on the line to indicate how cold you are.



Some questions will ask you to rate how much you are troubled by a single particular symptom or how much of this quality characterizes you in general. The number one means that you are troubled very little, or not much characterized in general, by that symptom. The number ten means you are troubled very much or characterized a lot in general by that symptom.

For example: You are asked whether you have a fear of spiders. Make an X on the line to indicate the degree to which you are troubled by that symptom.



Some questions ask you to circle the answer you think best fits you. For example:

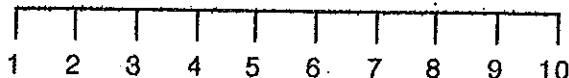
- Feeling toward disease/condition
- Optimistic
 - Doubtful of recovery**
 - Discouraged
 - Fearful
 - Despair of Recovery

NAME: _____
DATE: _____

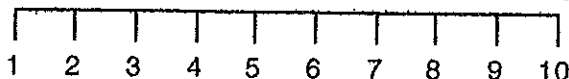
The following general symptoms pertain to you as a whole person.

Which weather conditions are you most troubled by?

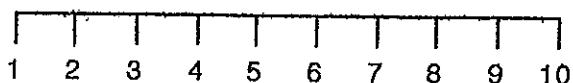
Cloudy Clear



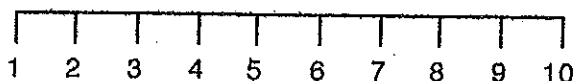
Wet Dry



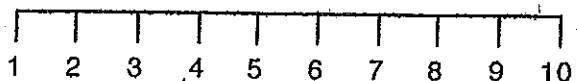
Damp cold Snow (Dry Cold)



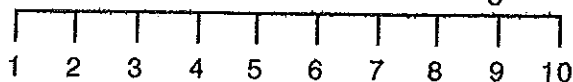
Storms



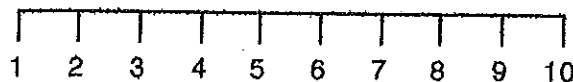
Wind



Fog



Hot Sun

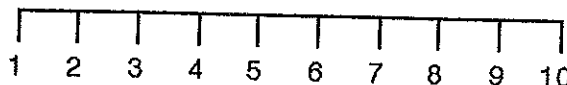


Circle which seasons cause you the most trouble ?

- Winter
- Spring
- Summer
- Autumn

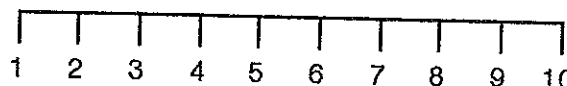
Are you more sensitive (worse) to being in the?

Mountains At the seashore

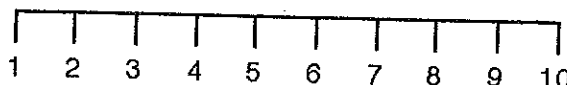


Are you generally sensitive to and/ or troubled by:

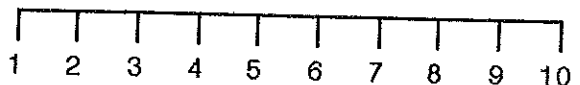
Bright light



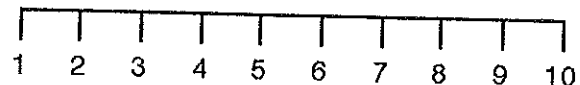
Darkness



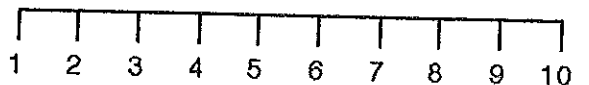
Open air



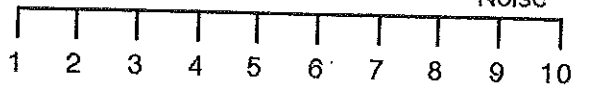
Stuffy rooms



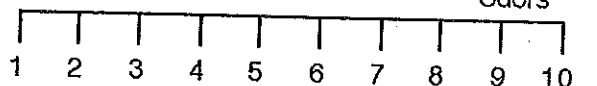
Tight clothing



Noise

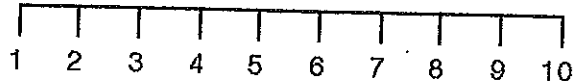


Odors

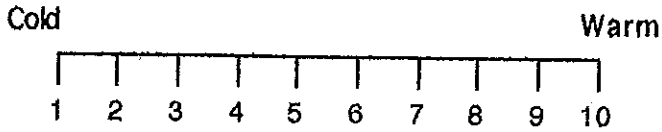


Are you generally chilly or warm ?

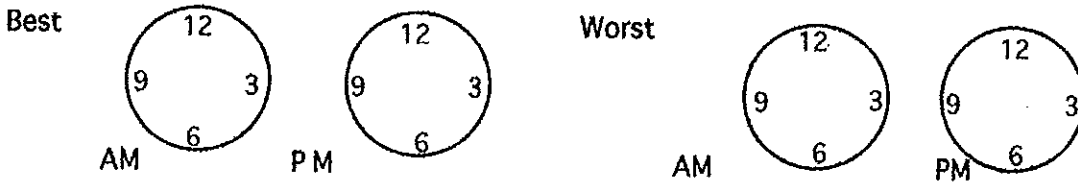
Chilly Warm



Which are you generally most sensitive to: warm or cold?



What times of day are you generally worst (mood, energy, symptoms, etc.) What times are you best?



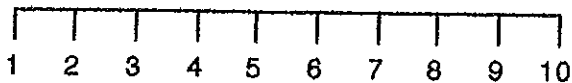
Symptoms during sleep. Circle which you have?

- tooth grinding
- restlessness
- talking
- perspiration
- frequent urination
- excess heat or cold
- laughing
- snoring
- nightmares

What position do you sleep in most often?

- Right side
- Left side
- On back
- On abdomen

How much do you perspire?



Food Desires and Aversions:

In the following questions you are asked to rate how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1.

Tastes:

Sweet

1 2 3 4 5 6 7 8 9 10

Sour

1 2 3 4 5 6 7 8 9 10

Salty

1 2 3 4 5 6 7 8 9 10

Bitter

1 2 3 4 5 6 7 8 9 10

Spicy (hot)

1 2 3 4 5 6 7 8 9 10

Smoked

1 2 3 4 5 6 7 8 9 10

Juicy

1 2 3 4 5 6 7 8 9 10

Refreshing

1 2 3 4 5 6 7 8 9 10

Pungent

1 2 3 4 5 6 7 8 9 10

Foods:

Alcohol

1 2 3 4 5 6 7 8 9 10

Apples

1 2 3 4 5 6 7 8 9 10

Bacon

1 2 3 4 5 6 7 8 9 10

Bread alone

1 2 3 4 5 6 7 8 9 10

Bread with butter

1 2 3 4 5 6 7 8 9 10

Butter alone

1 2 3 4 5 6 7 8 9 10

Cheese

1 2 3 4 5 6 7 8 9 10

Chocolate

1 2 3 4 5 6 7 8 9 10

Coffee

1 2 3 4 5 6 7 8 9 10

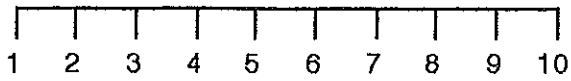
Pastries

1 2 3 4 5 6 7 8 9 10

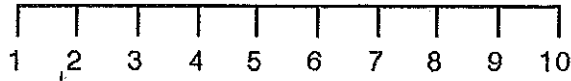
Eggs

1 2 3 4 5 6 7 8 9 10

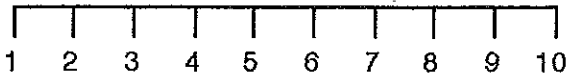
Fat (meat, chicken, pork, etc.)



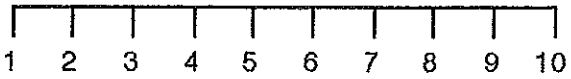
Fish



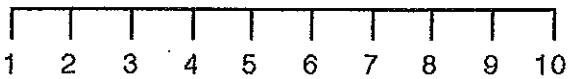
Fruit



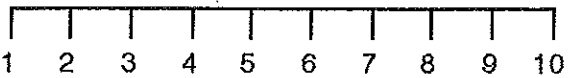
Fruit (sour)



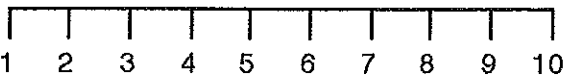
Grain products (pasta, bread, cereal, etc)



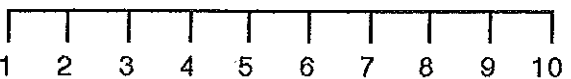
Ham



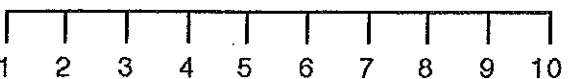
Ice



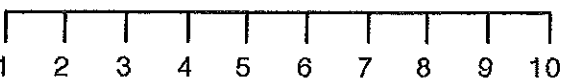
Ice cream



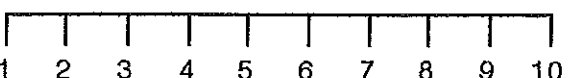
Indigestible things (chalk, clay, paper, etc)



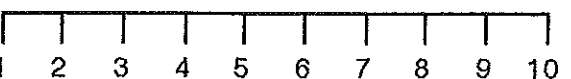
Lemonade



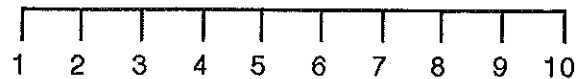
Meat



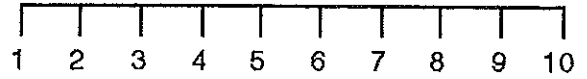
Milk



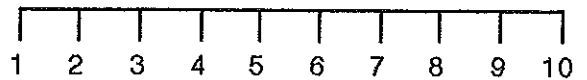
Nut butters



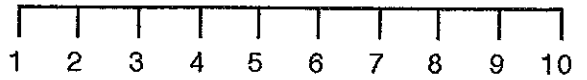
Oysters



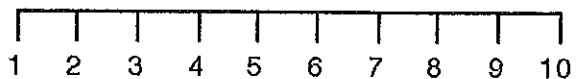
Pickles



Vegetables



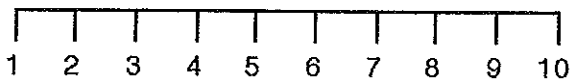
Vinegar



Temperature of food? (which do you prefer?)

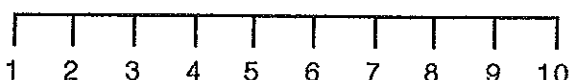
Warm food

Cold food



Warm drinks

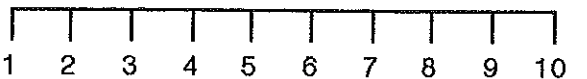
Cold drinks



How thirsty are you generally?

Not at all

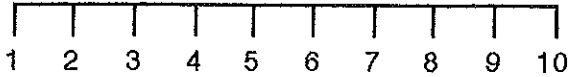
Very



How often are you troubled by any of the following emotional or mental symptoms? The most mark 10. The least mark 1.

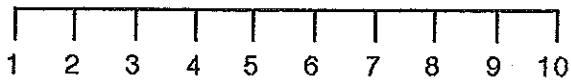
How strong in general are the following emotional symptoms?

Anxiety (worry and fear)

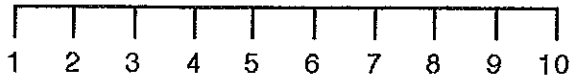


Do you worry about any of the following? 10 means the most 1 the least.

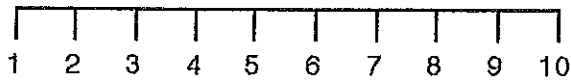
Creative activities



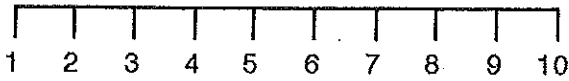
Emotions



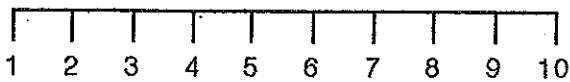
Financial security



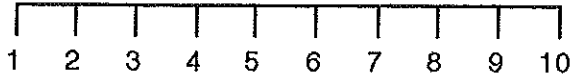
Health



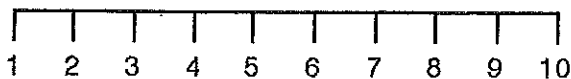
Mental functioning



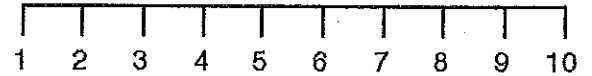
Morals/ past indiscretions



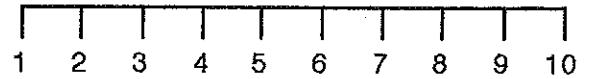
Others (family and close friends) well being



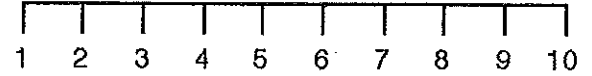
Religion



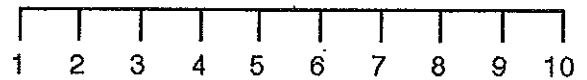
Social life



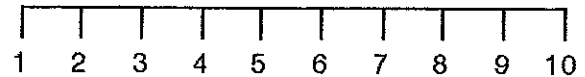
Social position



the Future

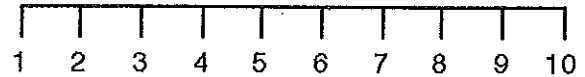


Work

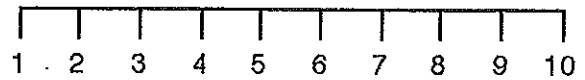


Again how often are you troubled by any of the following emotional or mental symptoms: The most mark 10. The least mark 1.

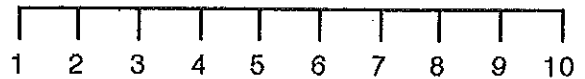
Irresolution (Not being able to decide or stick to a decision)



Capriciousness (Willfulness, changeable and erratic desires that are difficult to satisfy)

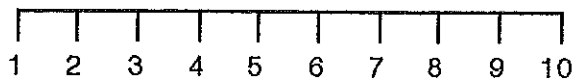


Selfishness



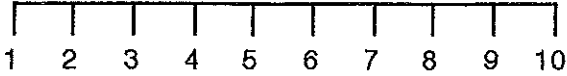
Frightened easily

Never Afraid

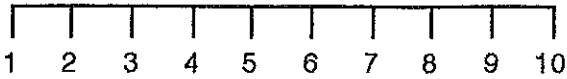


Answer as honestly as you can about your personality traits.

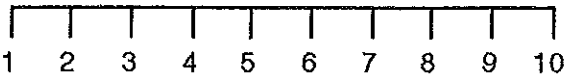
Stingy Overly generous



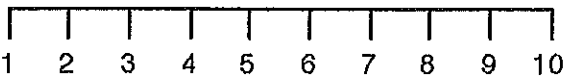
Thrifty Extravagant



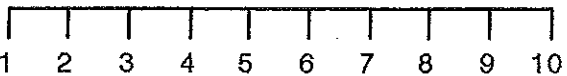
Hurried, impatient Slow



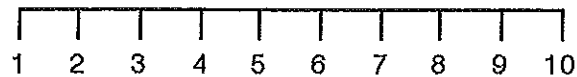
Messy Fastidious



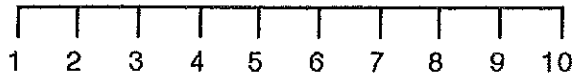
Restlessness



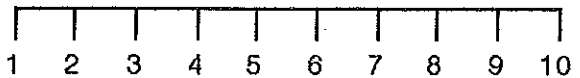
Indolence (Lazy) Always busy



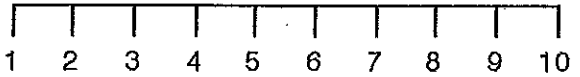
Shyness, Timid/ Bashful



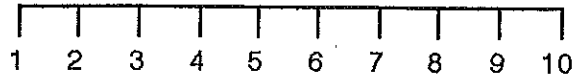
Anger Mildness



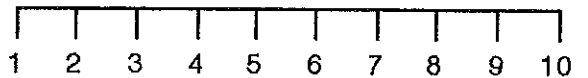
Lack of moral sense Guilty



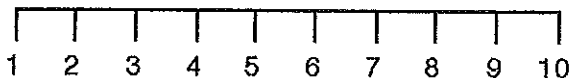
Religious feeling



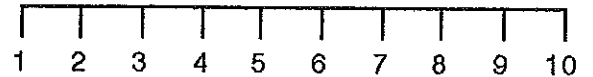
Obstinate (stubborn) Yielding



Heedless/Reckless Cowardice

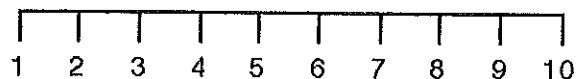


Envy



Social/Antisocial. In regard to being with other people or in company? —

Aversion Desire for



Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events.

- Resolved Grief
- Dwells on past
- Inconsolable
- Remorse
- Guilt

Feeling toward close others

- Loving
- Affectionate
- Indifferent
- Resentment
- Hatred

Feeling toward disease/condition

- Optimistic
- Doubtful of recovery
- Discouraged
- Fearful
- Despair of Recovery

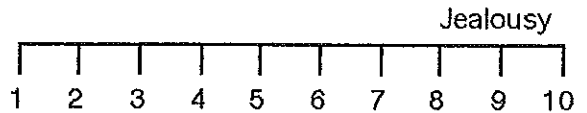
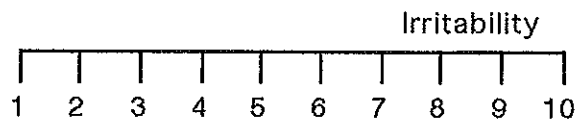
Feeling toward Life

- Love Life
- Indifferent
- Bored
- Weary of Life
- Loathing of Life
- Desires death
- Suicidal thoughts
- Suicidal disposition

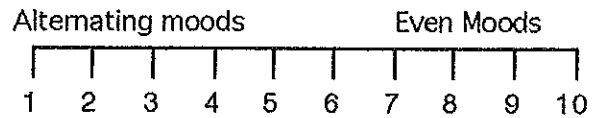
Feeling toward spouse/lover

- Loving
- Affectionate
- Dissatisfaction
- Disappointed
- Indifferent
- Resentment
- Hatred

How much do you have the following symptoms. 10 a lot, 1 hardly ever.



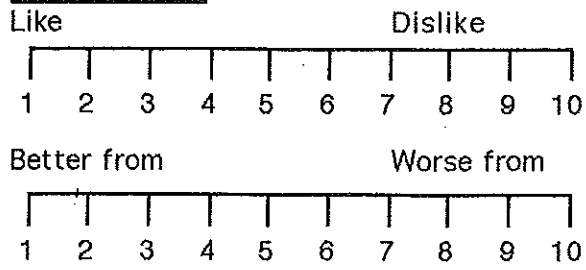
Mood



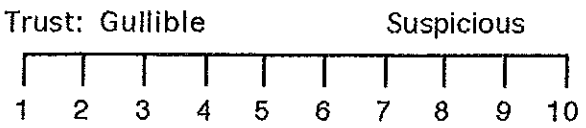
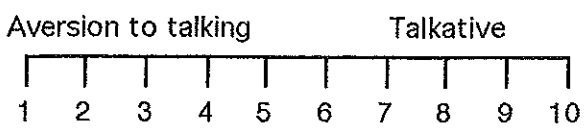
Circle which expression best expresses your general mood.

- Morose
- Sad
- Apathy/Indifferent
- Excitement
- Exhilaration

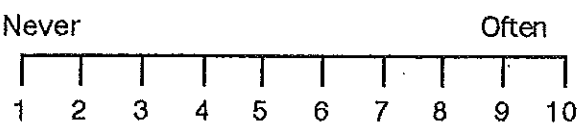
How do you experience sympathy or consolation?



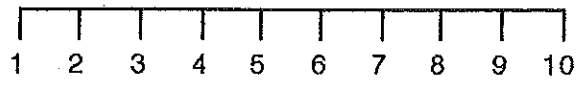
How talkative are you in general?



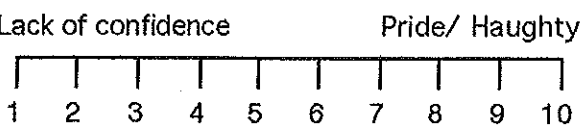
How often and easily do you weep?



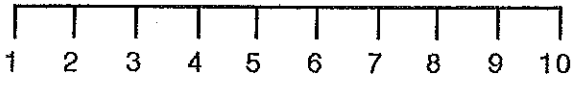
How often do you experience clairvoyance ?



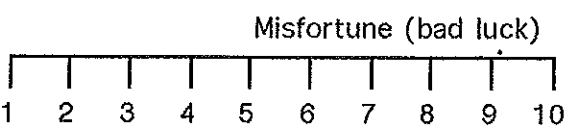
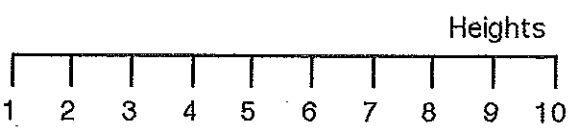
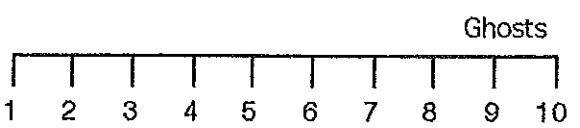
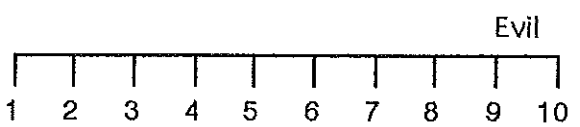
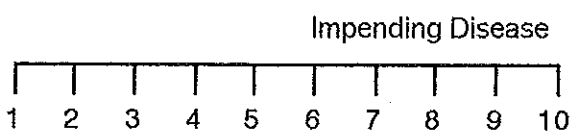
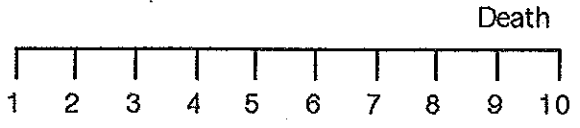
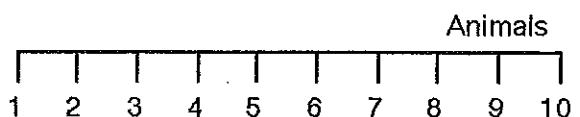
How is your level of self confidence?



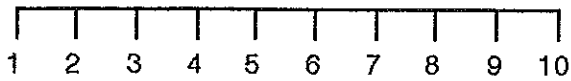
How impulsive are you?



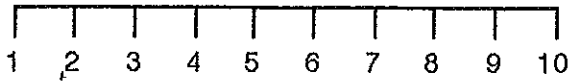
How afraid are you of the following?
Again, 1 means not at all and 10 means the most.



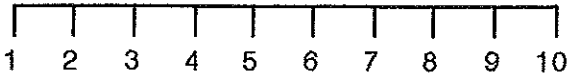
People



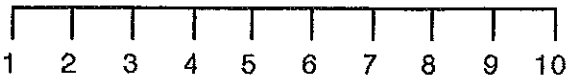
Robbers/ intruders



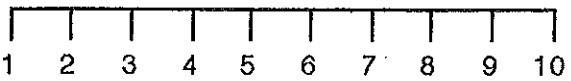
Snakes



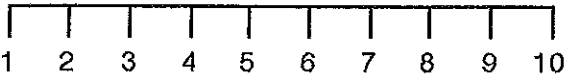
Spiders



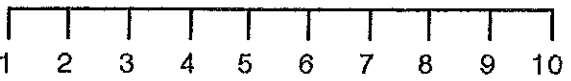
Strangers



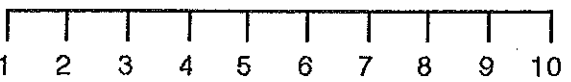
Having a stroke



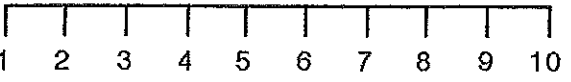
That something will happen



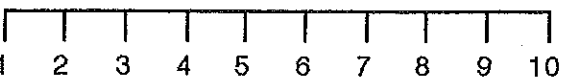
Darkness



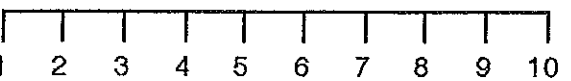
Thunderstorms



Water

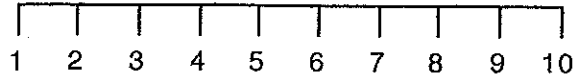


Wind

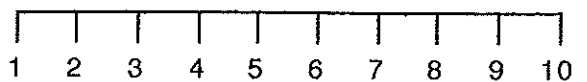


Are you forgetful for any of the following?
(1 not at all, 10 a lot)

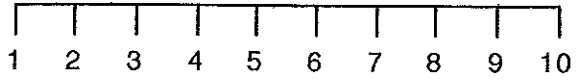
Dates



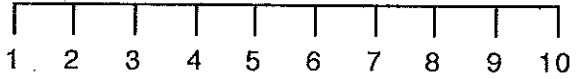
Names



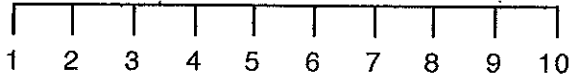
Numbers



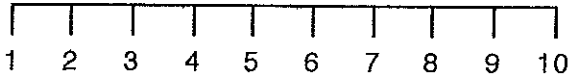
Of what someone else just said to you



Of what you just said

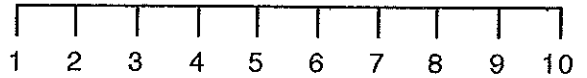


Of words

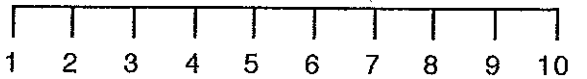


How often do you make mistakes with the following?

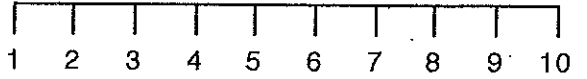
Numbers



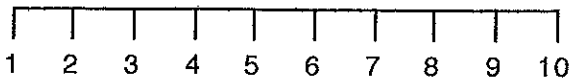
Words (reading)



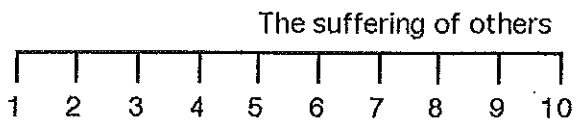
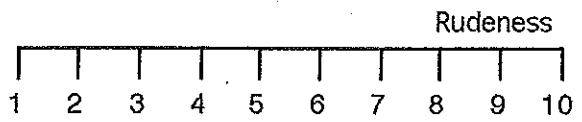
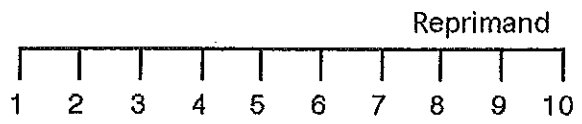
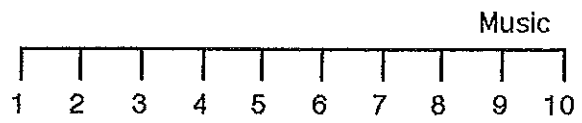
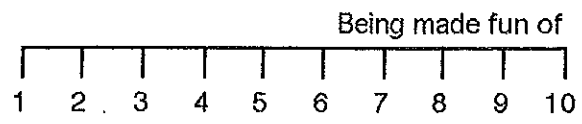
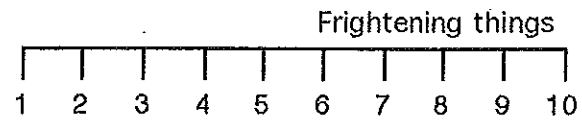
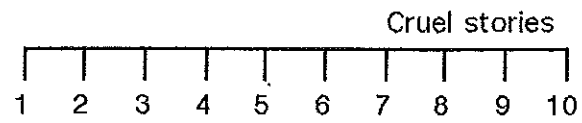
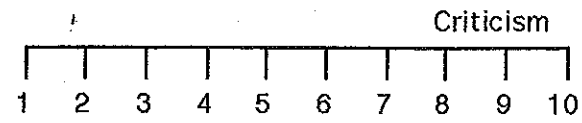
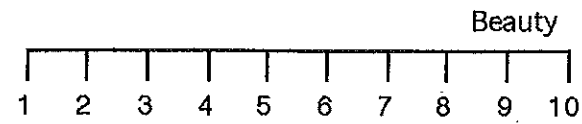
Words (speaking)



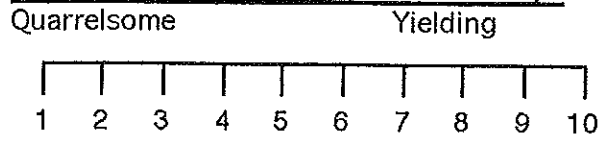
Words (writing)



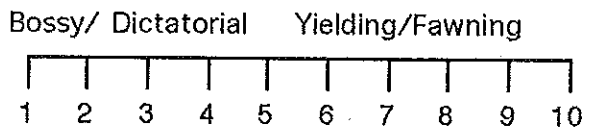
How sensitive are you to any of the following:



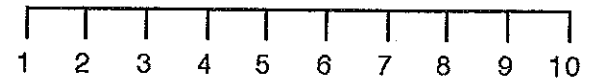
How do you handle conflict usually?



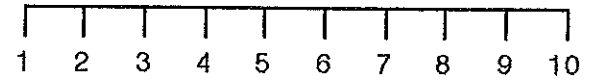
How are in regard to authority?



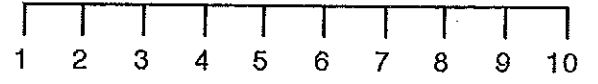
How critical are you of others?



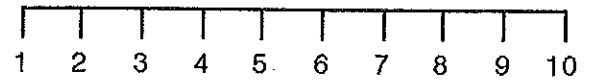
How critical are you of yourself?



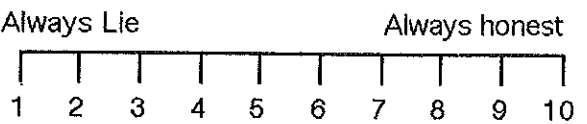
How often do you reproach others?



How often do you reproach yourself?

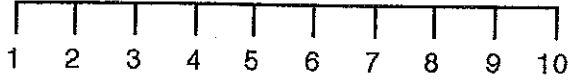


How honest are you?

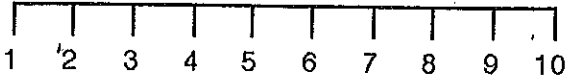


How often do you have the following behaviors?

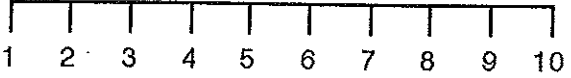
Abusive



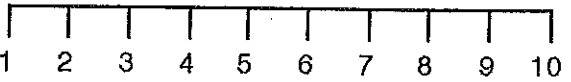
Biting



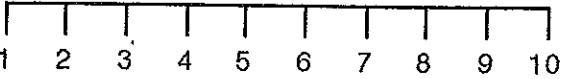
Breaks Things



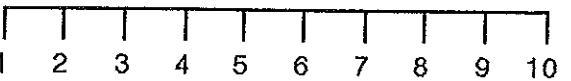
Contrary



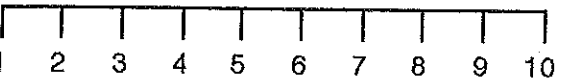
Cursing



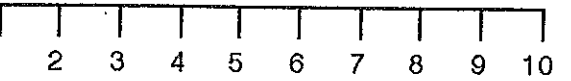
Disobedience



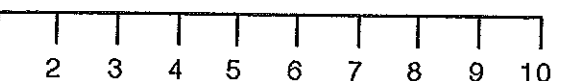
Insolent



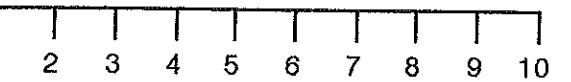
Rage



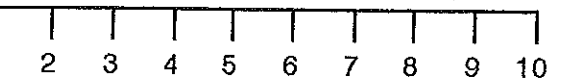
Rudeness



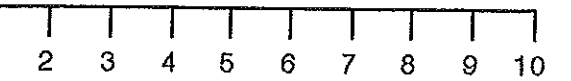
Striking others



Striking self



Violence



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www.DrOram.com

Fee Schedule

Revised 09/01/2011

Initial visit – chronic health concerns	\$ 327
Follow-up visit - brief	\$ 97
Follow-up visit – usual	\$ 127
Physical – new patient	\$ 127 - \$ 227
Physical – established patient	\$ 127 - \$ 187
Woman’s annual – new patient	\$ 227
Woman’s annual – existing patient	\$ 187
Phone appointments - usual	\$ 97 - \$ 187

All charges are decided by the doctor based on complexity, and are subject to change.

Labs, EKG, X-rays, imaging and all other tests are typically billed by the facility performing the test.

As a courtesy to our patients we do bill insurance. We will work closely with you and your insurer to facilitate payment of claims, but ultimately, the financial responsibility of all accounts lies with the patient.