Lake Union Wellness

Date:_____

Patient Name: _____

Address:_____

City:_____State:_____Zip:_____

Sex: ☐M ☐F Age: _____ Birthdate:_____

E mail Address:_____

☐Single ☐ Married ☐Other

Patient SSN:_____

Employer: _____

CONTACT INFORMATION (check preferred contact number):

- Home Phone:_____
- Work Phone:_____
- Cell Phone:_____

EMERGENCY CONTACT:

Name: _____

Phone: _____ Relationship:_____

PRIMARY CARE PHYSICIAN:

Physician Name:_____

Clinic Name:_____

Phone: _____

Would you like us to send a Report of Findings to your Doctor?

- Yes
- No

HOW DID YOU HEAR ABOUT US? (check all that apply):

- Health Fair
- Flyer
- Walk By (work or live nearby)
- Event:_____
- Insurance:_____
- Internet (site):_____
- Doctor:_____
- Friend:_____
- Family:_____
- Other:_____

HOW WOULD YOU LIKE US TO SEND YOU REMINDERS FOR APPOINTMENTS? (SELECT ONE)

- Text Mobile Provider:_____
- Email
- I would not like to receive reminders for my appointments

ASSIGNMENT:

- I do not have medical insurance and am responsible for all charges.

X_____
(Responsible Party Signature)

OR

- I, the undersigned, certify that I (or my dependent) have insurance with _____

and I authorize direct payment to LAKE UNION WELLNESS for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges whether paid by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims.

X_____
(Responsible Party Signature)

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Care ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal Adjustment _____ Spinal X-ray _____

Circle "Yes" or "No" to indicate if you have had any of the following:

Alcoholism	Yes	No	Fever (prolonged)	Yes	No	Mononucleosis	Yes	No	Thyroid Problems	Yes	No
Aids/HIV	Yes	No	Frequent Colds	Yes	No	Multiple Sclerosis	Yes	No	Tiredness	Yes	No
Allergy Shots	Yes	No	Glaucoma	Yes	No	Mumps	Yes	No	TMJ (Jaw)	Yes	No
Anemia	Yes	No	Goiter	Yes	No	Numbness	Yes	No	Tremors	Yes	No
Anorexia/Bulimia	Yes	No	Gout	Yes	No	Osteoarthritis	Yes	No	Tuberculosis	Yes	No
Appendicitis	Yes	No	Hearing Loss	Yes	No	Osteoporosis	Yes	No	Tumors, Growths	Yes	No
Arthritis	Yes	No	Heart Attack	Yes	No	Pacemaker	Yes	No	Typhoid Fever	Yes	No
Asthma	Yes	No	Hemorrhoids	Yes	No	Parkinson's	Yes	No	Ulcers	Yes	No
Bed Wetting	Yes	No	Hepatitis	Yes	No	Pinched Nerve	Yes	No	Whooping Cough	Yes	No
Bleeding Disorders	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Vision Problems	Yes	No
Bronchitis	Yes	No	Herniated Disc	Yes	No	Polio	Yes	No	**Women Only:**		
Cancer	Yes	No	High Blood Pressure	Yes	No	Prostate Problem	Yes	No	Hysterectomy	Yes	No
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Prosthesis	Yes	No	Miscarriage	Yes	No
Chicken Pox	Yes	No	Infertility	Yes	No	Psychiatric Care	Yes	No	Menopause	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Rheumatic Fever	Yes	No	Premenstrual Syndrome	Yes	No
Difficulty Breathing	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No	Irregular Menses	Yes	No
Dizziness	Yes	No	Lowback Pain	Yes	No	Ringing in Ears	Yes	No	Cramps	Yes	No
Emphysema	Yes	No	Measles	Yes	No	Scarlet Fever	Yes	No	Breast Problems	Yes	No
Epilepsy	Yes	No	Midback Pain	Yes	No	Sinus Infections	Yes	No	Pregnant	Yes	No
Headaches	Yes	No	Migraines	Yes	No	STD's	Yes	No			
						Stroke	Yes	No	Due Date_____		

EXERCISE

☐ None
☐ 1-2 x week
☐ 3-4 x week
☐ 5+ x week

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

STRESS LEVEL

☐ Low
☐ Medium
☐ High
Causes_____

HABITS

☐ Smoking Packs/day _____
☐ Alcohol Drinks/Week_____
☐ Coffee/Soda Cups/Week _____

Type of Exercise:_____

Injuries / Surgeries you have had:	Description	Date
Falls / Head Injuries		
Broken Bones / Dislocations		
Surgeries		
Work Injuries		
Auto Accidents		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made in advance.

X_____ _____

Signature *Date*

Lake Union Wellness

Pain Location And Rating Scale

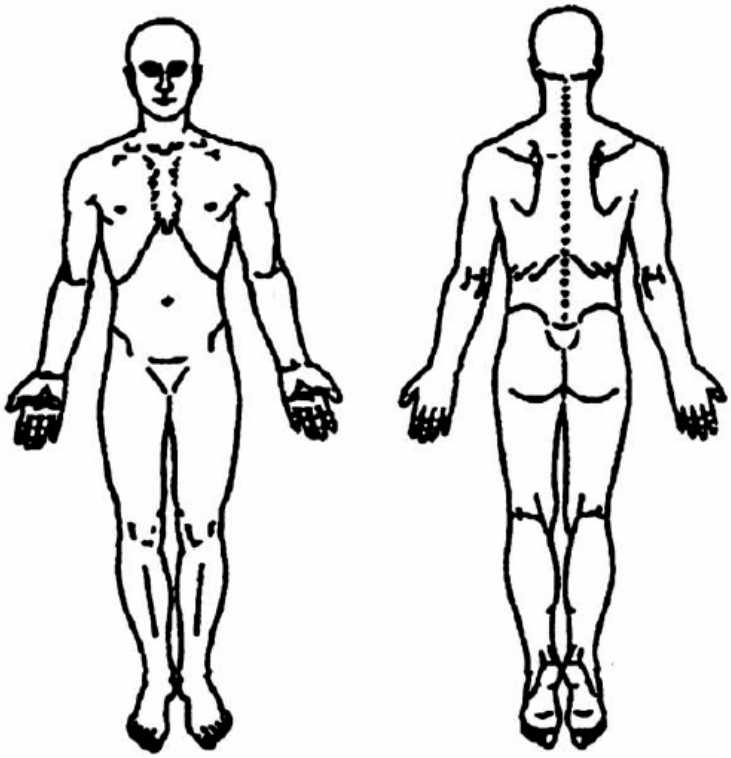
NAME: _____ DATE: _____

MY CHIEF COMPLAINT IS: _____

2ND COMPLAINT: _____

3RD COMPLAINT _____

Please draw the location and type of pain on the body outlines:



Ache	Burning	Numbness
MMM	– – –	OOOO
M	– –	OO

Pins and Needles	Stabbing	Other
••••••••••••••	////////	XXXX
••••••••••	////	XXX

Functional Rating Index

For use with Neck and/or Back problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

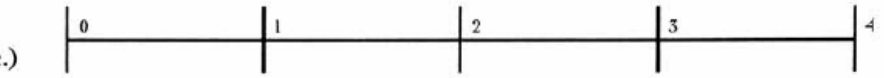
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

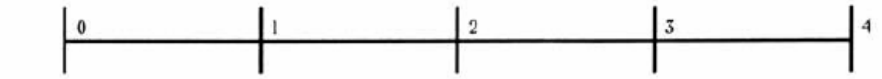
Please Turn Over

3. Personal Care
(washing, dressing, etc.)



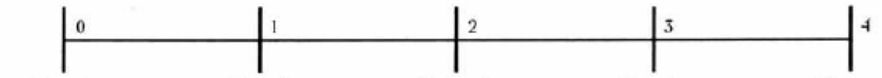
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel
(driving, etc.)



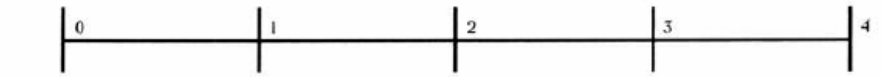
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



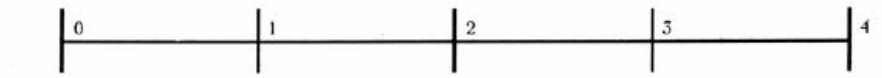
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



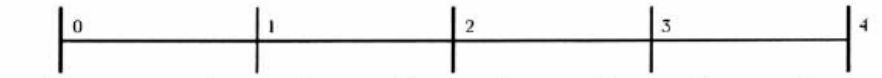
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain



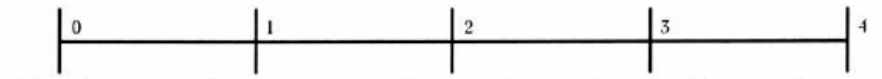
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

8. Lifting



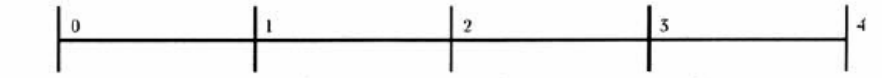
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 miles	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

_____ _____

Patient's Signature **Date**

Lake Union Wellness

HIPAA Rights:

Personal Health Records Privacy/Access Policy

This notice, effective immediately, describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully. Our office is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices as it relates to your protected health information. All patients are required to sign this consent form by state law so that we, Lake Union Wellness, may use or disclose health information to all authorized entities as well as provide treatment.

Disclosure of Your Health Care Information:

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment and/or healthcare operations.

Payment: We may disclose your health care information to your insurance company provider for the purpose of payment and/or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary in order to remain in compliance with: State Workers Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Military or national security (when necessary to prevent a health or safety issue), for government benefit purposes and if there is a change of ownership.

Access: You have the right to review and amend your personal health care records. Fees for copying your personal health information are set by state regulators annually.

I understand and have been provided with Lake Union Wellness's Personal Health Records Privacy/Access Policy which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing this consent and I had the right to object to the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment and/or health care operations.

Patient Signature: _____ Date: _____