NEW PATIENT REGISTRATION & HISTORY

How did you hear about us: ☐ Website ☐ Referral, if so, whom may we thank: ☐ Other:

Patient Information

Last Name:	First Name:	Sex: ☐ M ☐ F	DOB:
Street Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email:			

Employment Information

Occupation:	Employer:
Employer Address:	
Employer Phone:	

Emergency Contact Information

Contact Name:	Relationship to Patient:
Phone:	

Insurance Information

Subscriber Name:	Subscriber DOB:	
Relationship to Patient:	Insurance Co:	
ID #:	Group #:	Is patient covered by additional insurance? ☐ Yes ☐ No

Exercise	Work Activity	Habits
☐ None	☐ Sitting	☐ Smoking, Packs/Day________________________
☐ Moderate	☐ Standing	☐ Alcohol, Drinks/Day or Week_________________
☐ Heavy	☐ Light Labor	☐ Coffee/Caffeine Drinks, Cups/Day_____________
	☐ Heavy Labor	☐ High Stress Level, Reason_____________________

Medications & Purpose (list)	Allergies	Supplements

Health History (check all that apply)

☐ AIDS/HIV	☐ Chronic fatigue	☐ Herniated disc	☐ Psychiatric care
☐ Alcoholism	☐ COPD/Emphysema	☐ Kidney Disease	☐ Rheumatic Fever
☐ Allergies (shots?)	☐ Depression/Anxiety	☐ Liver Disease	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Measles	☐ Skin Conditions
☐ Anorexia	☐ Epilepsy	☐ Miscarriage	☐ Stroke
☐ Appendicitis	☐ Fractures	☐ Mononucleosis	☐ Suicide Attempt
☐ Arthritis	☐ Glaucoma	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Asthma	☐ Goiter	☐ Mumps	☐ Tonsillitis
☐ Bleeding disorders	☐ Gout	☐ Osteoporosis	☐ Tuberculosis
☐ Breast lump	☐ Headaches	☐ Pacemaker	☐ Tumors/Growths
☐ Bronchitis	☐ Heart Disease	☐ Parkinson’s Disease	☐ Typhoid Fever
☐ Bulimia	☐ Herpes	☐ Pinched nerve	☐ Ulcers
☐ Cancer	☐ High blood pressure	☐ Pneumonia	☐ Urinary Tract Infections
☐ Cataracts	☐ High blood cholesterol	☐ Polio	☐ Vaginal Infections
☐ Chemical dependency	☐ Hepatitis	☐ Prostate problems	☐ Venereal Disease
☐ Chicken pox	☐ Hernia	☐ Prosthesis	☐ Whooping Cough
			☐ Other

Females Only: Are you pregnant? ☐ Yes ☐ No Due Date:

Do you have any skin conditions today? ☐ Skin Rash ☐ Cuts/Scrapes/Bruises ☐ Burns

List injuries/surgeries including dates and description:

Family History (check all that apply to immediate family members)

☐ Asthma	☐ Circulation Problems	☐ Heart Disease	☐ Stroke
☐ Arthritis-Rheumatism	☐ Diabetes	☐ High Blood Pressure	☐ Thyroid Disease
☐ Back Problems	☐ Emphysema	☐ HIV Positive	
☐ Cancer	☐ Headaches	☐ Ulcer/Stomach Problems	

Primary Care Physician (PCP):____

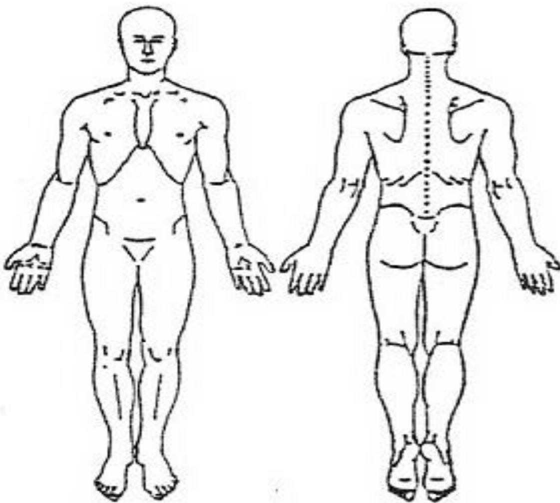
Address:____

Phone:______________________________ Date Last Seen:__________________________

I give Kirkland Whole Life Clinic permission to contact my PCP for medical history/treatment plan: ☐ Yes ☐ No

Patient Condition

Reason for Visit and Goals:	
What treatment, if any, have you received for this condition? ☐ Medical ☐ Physical Therapy ☐ Massage ☐ None ☐ Other (please describe):	
Name/address of other doctor(s) who have treated you for this condition:	
Is condition due to an accident? ☐ Yes ☐ No If yes, date:	Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other
Have you reported the accident? ☐ Yes ☐ No	If yes, to whom? ☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other
Attorney Name & Phone # (if applicable)	



How often are symptoms occurring?

☐ daily x ___ ☐ weekly x___ ☐ monthly x___ ☐ constantly

How long does each episode last?

☐ only as long as the activity lasts ☐ seconds ☐ minutes ☐ hours ☐ days ☐ constant

Rate severity of symptoms on graph below:

No Pain -- Severe Pain

List any activities that are inhibited by your symptoms:

Describe pain/symptoms as they are today: ☐ aching ☐ burning ☐ stabbing ☐ shooting ☐ sharp ☐ dull ☐ electric ☐ tingling/prickly ☐ numbness ☐ other:_____________________

Are there any questions, or other symptoms/concerns you want the practitioner to know about:

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage with above stated company/companies and assign directly to Kirkland Whole Life Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ________________________

Signature of Patient or Patient's Representative Date

Representative's relationship to patient: _______________________________

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form I authorize the *Kirkland Whole Life Clinic* to use and disclose my protected health information for the following purposes:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company); and
- Day-to-day healthcare operations of the Kirkland Whole Life Clinic such as quality assessments.

I have also been informed of and given the right to review and secure a copy of Kirkland Whole Life Clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

____
Patient Name (please print)

____
Patient/Guardian Signature

____
Date

Cancellation and Missed Appointments Policy

We understand there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least 24 hours in advance of the scheduled visit. Missed appointments or appointments cancelled less than 24 hours in advance can prevent us from serving others in need and disrupt our practitioner's schedules.

The fee for missed appointments/late cancellation is $50.

Please note that insurance does not pay for cancellation or missed appointment fees.

* * *

I, the undersigned, have been informed about the cancellation and missed appointment policy. I have further been informed that reminder calls are a courtesy and that I am responsible for remembering my appointment.

____

Name (please print)

____ ________________________________

Signature Date

INITIAL INTAKE NOTE

Name:	DOB:	Date:

SUBJECTIVE:

OBJECTIVE:

Restrictions to articular ROM noted in: ☐ Cx ☐ Thx ☐ Lx ☐ SI ☐ Other:

(HT=Hypertonic, TP=Trigger Point, ADH = Adhesions(s), INF = Inflammation, Palpatory Pain Scale of 0-4, tight and tender to blanching pressure)

Sub Occipital mm.___, *Cx Paraspinal* mm.____, L/R/Bi *Scm*____, L/R/Bi *Scalenes*____, L/R/Bi *Levator*____, L/R/Bi Up. Trap.____, L/R/Bi *SupraSpinatous*____, L/R/Bi *Teres/SubScrap* mm.____, L/R/Bi Mid. Trap.____, L/R/BI *Rhomboids*____, *Thx Paraspinal* mm.____, *Lx Paraspinal* mm.____, L/R/Bi *QL*____, L/R/Bi *Gluteal* mm.____, L/R/Bi *Piriformis*____, Other____________________

ASSESSMENT/DIAGNOSIS:

PROCEDURE/TREATMENT PLAN:

☐ Acux 97810	☐ Hot/Cold Pack 97010: _______minutes
☐ Acux+15m 97811	☐ Infrared 97026: _______minutes________________________________location
☐ Elec Acux 97813	☐ Electric Stim 97032: _______minutes______mA______________________location
☐ Elec Acux+15m 97814	☐ Myofascial Release 97140: _______minutes
☐ Herbs/Supplements 99070	☐ Massage Therapy 97124: _______minutes________________________________location
☐ Physical Therapy 97110: _____minutes	☐ Full Body ☐ Deep Tissue ☐ Stripping ☐ ROM ☐ ART ☐ Trigger Pt. ☐ Cross Fiber Fr.
☐ NMR 97112: _____minutes	
☐ Therapeutic Activities 97530:_____minutes	

LMP: ______________________________ Physician: ____________________________________ Date: _________________

Jessica Cortez, LMP *William Duarte, DAOM, LAc, EAMP*