burien wellness

PATIENT INFORMATION

Date ____________________

Name _________________ _________________ _____
Last First Middle Initial

Address ____

City _________________ State _______ Zip _________

Home Phone ____________________________________

Cell Phone _____________________________________

Email ____

Sex ☐ M ☐ F Age ______ Birthday ___/___/___

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _________________________________

Occupation _______________________________________

Spouse's Name ____________________________________

Insurance Provider _________________________________

Prefix and ID# ____________________________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name ____

Relationship _______________________________________

Contact Number ____________________________________

Who may we thank for referring you? _______________

____

HOW CAN WE HELP YOU?

What brings you in today? ☐ Wellness ☐ Pregnancy ☐ Accident ☐ Physical Complaint

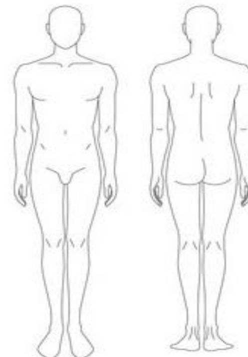
What brings you in today?____

How long has this been an issue?____

How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Aching ☐ Sharp
☐ Tingling ☐ Cramping ☐ Shooting
☐ Stiffness ☐ Nagging ☐ Burning
☐ Dull ☐ Stabbing ☐ Throbbing
☐ Swelling ☐ Other__________________

IMPACT OF YOUR SYMPTOMS

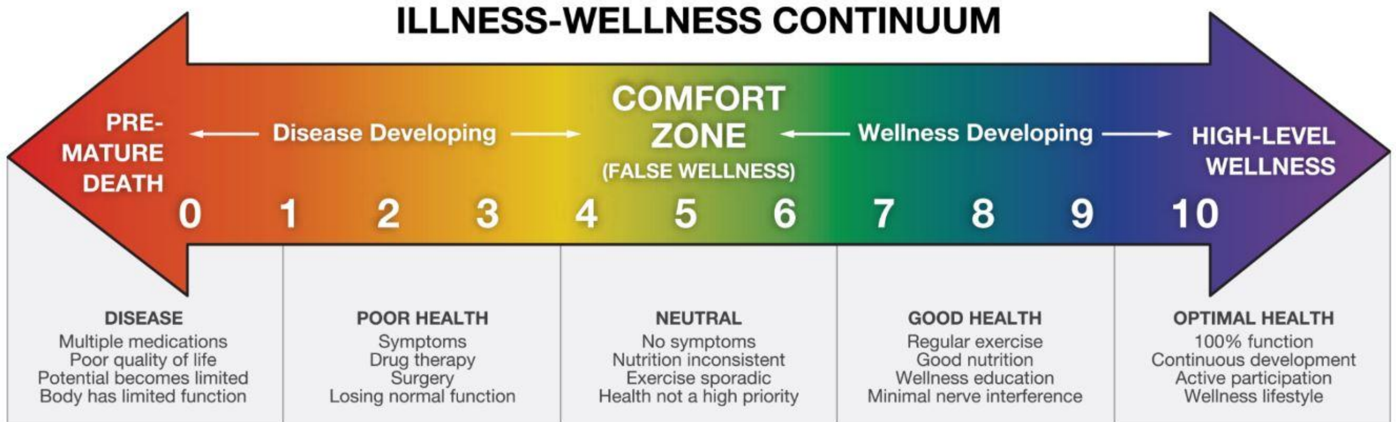
How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other__________	☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? ______________________________

B. In what direction is your health currently headed? ______________________________

What are your health goals?

Immediate ______________________________

Short Term ______________________________

Long Term ______________________________

CHILDREN & PREGNANCY

How many children do you have? ____________________

Childrens' ages? ____________________

Childrens' health concerns? ____________________

____

Are you currently pregnant? ☐ No ☐ Yes, due __________

Number of past pregnancies? ____________________

Health concerns regarding this pregnancy? ______________

____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you **have** or **have had**.

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma/Allergies
☐ Back Pain
☐ Cardiovascular Issues
☐ Cancer
☐ Circulation Issues
☐ Childhood Illness
☐ Depression
☐ Diabetes
☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
☐ Elbow/Wrist/Hand Issues
☐ Endocrine Issues (Thyroid)
☐ Foot/Ankle Issues
☐ Gout
☐ Headaches/Migraines
☐ Heart Disease
☐ Hepatitis
☐ Hip Issues
☐ Immune Issues
☐ Lymphatic Issues
☐ Multiple Sclerosis
☐ Neck Pain
☐ Reproductive Issues
☐ Ringing in Ears
☐ Scoliosis
☐ Shoulder Issues
☐ Stroke
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other______________

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Please list below.

ALLERGIES____________________
____
____

MEDICATIONS____________________
____
____

SUPPLEMENTS____________________
____
____

HIPAA (Health Insurance Portability & Accountability Act)

Re: Appointment Calls, Open Room Adjusting & Health Care Information

The doctors and staff at Burien Wellness may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member. **By signing this form, you are giving us authorization to contact you with these reminders and information.**

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

At Burien Wellness we believe it is important that all of your care professionals work together for your benefit. By signing this release you are authorizing us to release reports and information to your doctor(s) regarding your treatment at Burien Wellness.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvements or lack there of may be discussed during your office visits.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This authorization will expire seven years after the date on which you last received services at Burien Wellness.

I authorize Burien Wellness to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Name (print): ____

Patient Signature: ____

(*or parent/guardian if under 18*)

Parent/Guardian Name (please print) ____

Date: ____________________________

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Motor Vehicle Accident: Questionnaire

This questionnaire will allow you to describe your motor vehicle accident in detail. Please complete it carefully as the information provided will assist the doctors in evaluating and documenting your condition. Please choose any and all answers that apply.

PATIENT & INCIDENT INFORMATION

Today's Date ________________

Name ________________ ________________ _____
Last First Middle Initial

What was the date of the accident? ______________

In your own words, please briefly describe what happened:
____
____

What was your position in the vehicle at the time of the accident?

- ○ Driver
- ○ Front Side Passenger
- ○ Left Rear Side Passenger
- ○ Right Rear Side Passenger

What type of vehicle were you in? ____

What type of vehicle was the other party driving?
____

What type of restraint were you wearing at the time of impact?

- ○ Lap Belt
- ○ Shoulder Harness
- ○ Both
- ○ None

What was your vehicle doing at the time of impact?

- ○ Moving
- ○ Stopped
- ○ Slowing Down

How was the vehicle impacted?

- ○ From the Rear
- ○ Head On
- ○ From the Left Side
- ○ From the Right Side
- ○ Obliquely from the Front Left Side
- ○ Obliquely from the Front Right Side
- ○ Obliquely from the Rear Left Side
- ○ Obliquely from the Rear Right Side

How would you describe the damage to your vehicle?

- ○ Minimal
- ○ Moderate
- ○ Extensive
- ○ Totaled
- ○ Unsure

Right after the incident, did you feel any of the following? (please check all that apply)

- ○ Disoriented
- ○ Neck Pain
- ○ Low Back Pain
- ○ Confused
- ○ Mid Back Pain
- ○ Felt Fine

Were police called to the scene? Yes No

Immediately after the accident, what did you do?

- ○ Drove Home
- ○ Was Driven Home
- ○ Drove to Emergency Room
- ○ Was Driven to ER

When did the symptoms you are experiencing now begin?

- ○ Immediately
- ○ Next Day
- ○ A Week Later
- ○ A Few Hours Later
- ○ Several Days Later
- ○ 2 or More Weeks Later

Did you strike any of the following?

- ○ Steering Wheel
- ○ Side Window
- ○ None
- ○ Dashboard
- ○ Back of Front Seat
- ○ Other: _______________
- ○ Windshield
- ○ Not Sure

Did you experience any of these symptoms prior to the accident? Yes No

Have you sought any other medical treatment for your injuries? Yes No

If so, who have you seen?

- ○ Medical Doctor
- ○ Physical Therapist
- ○ Chiropractor
- ○ Acupuncturist
- ○ Massage Therapist
- ○ Other: ________________________

Clinic or Provider's Name: ____

Prior to the accident, had you ever experienced any of these symptoms before?

- ○ None
- ○ Neck Pain
- ○ Hip or Pelvic Pain
- ○ Headaches
- ○ Mid Back Pain
- ○ Upper Extremity Pain
- ○ Chronic Nausea
- ○ Low Back Pain
- ○ Lower Extremity Pain

Name (Print): ____

Signature: ____ Date: ______________________

Motor Vehicle Accident: Insurance Verification

In order to assist with the process of verifying your insurance so that we may begin your care in our office, we ask that you obtain all of this information for us prior to your second visit. This ensures that there is no financial barrier to receiving the necessary care in the aftermath of a car accident.

The first step is to call your insurance company to open a claim, if you have not already done so at the time of the accident. Their number can be located on your insurance card or on the company's website.

Insurance Company: ______________________________________ Phone: (____) _______-______________

Billing Address: __________________________________City_________________ State _____ Zip _________

Your Auto Policy #: _______________________________ Claim #: ____________________________________

When you open a claim, you will be assigned a claims adjuster to handle your case. Their job is to determine the extent of the company's liability. Many auto policies contain a provision for **Personal Injury Protection (PIP)**. Ask your adjuster or another representative from the company whether or not your policy has PIP coverage, and in what amounts. Typically, policies with PIP coverage will usually pay 100% of your expenses for chiropractic care. If your balance is paid in full by the insurance company, there will be no out of pocket expense to you.

Adjuster's Name: ____________________________________ Adj.'s Phone: (____) _______-______________

Adjuster's Email: ____

PIP on policy? YES NO PIP Coverage Limit: $__________________**Office Use Only**:______________

If you do not have PIP coverage on your auto insurance policy, and you were not at fault in the accident, you may choose to hire an attorney in order to seek a settlement from the other party's insurance. We **do not** bill the third-party insurance directly, so in order to hold a balance until a settlement can be reached, we must have a letter of representation signed by your attorney in order to begin a care plan in our office. If you do not already have an attorney, we are happy to recommend one.

Attorney's Name: _____________________________________ Att.'s Phone: (____) _______-______________

Attorney's Email: ____

If you have neither personal injury coverage nor an attorney, you will be on a cash basis.

Should the insurance company fail to pay, and reasonable efforts were made to collect, you will then be responsible for payment in full of any accrued balance.

Name (Print): ____

Signature: ____ Date: ___________________________