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

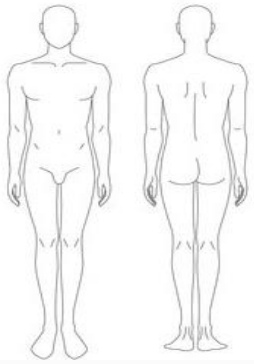
What brings you in today?_____

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_____

_____ _____ _____

_____ _____ _____

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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: _____