InHealth PLLC
Sport Injury & Performance

www.inhealthseattle.com
4915 25th AVE NE, Suite 104 West, Seattle, WA 98105

New Patient Form – Please fill out completely and clearly. Please let us know if you have any questions.

Personal Information

Name: _____

Street Address: _____

City/State/Zip: _____

E-Mail Address (optional): _____

(H) Phone: (_____) _____ - _____(W) Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Birthdate: _____ / _____/ _____ Age: _____ Sex: M ____ F____

Social Security #:_____*
*This will only be used for processing insurance claims and will be kept secure, confidential, and compliant with HIPPA privacy standards.

Name of Employer: _____Occupation:_____

Marital Status: Single Married Divorced Widowed Domestic Partnership

Name of Spouse/Significant other (if applicable): _____

Name of Spouse/Significant other employer: _____

Work phone: (_____) _____ - _____ Cell phone: (_____) _____ - _____

Children: Yes ____ No ____ If yes, how many_____

Who referred you to our office: _____

Emergency Contact Information

Name: _____ Relation: _____

Day Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Insurance Information

Do you have insurance? ▫ Yes ▫ No Is there a secondary insurance? ▫ Yes ▫ No

Primary Insurance:
Insurance Company:_____

Member Name:_____ Identification #:_____

Policy/Group #:_____Employer:_____

Secondary Insurance:
Insurance Company:_____

Member Name:_____ Identification #:_____

Policy/Group #:_____ Employer:_____

Current Condition

1. What is your primary complaint or reason for seeking care in our office? _____
   _____
2. When did you first start to notice the onset of symptoms related to this condition?
   _____
   a. How did it occur?_____
   b. Has your condition gradually been getting better, worse, or staying the same?
      _____
3. If this is a recurrence of a chronic condition, when was the first time you experienced this problem?_____
   How does your primary complaint interfere with your daily life or the activities you enjoy (i.e. work, exercise, getting dressed, social life, sleep, etc.)?
   _____
   _____
4. How would you best describe the symptoms you are experiencing? (i.e. burning, stabbing, numbness, tingling, dull ache, sharp, etc.)_____
   _____
5. How frequent is this condition?
   _____ < 25% of day
   _____ 26-50% of day
   _____ 51-75% of day
   _____ 76-100% of day
   _____ Only at night
6. How long does it last?
   _____ A few Seconds
   _____ A few hours

_____ A few minutes _____ All night
_____ All day

7. What makes it Better? _____
   _____
8. What makes it Worse? _____
   _____
9. Have you seen any other health professional for this condition? _____
   If so, who? _____
10. Have you had any testing or imaging performed related to this condition (i.e. MRI, CT, X-Ray, etc.)? If so, when?_____
11. Have you had Chiropractic Care or Acupuncture before? If yes: when, where, with whom, and date of last
    visit:_____
12. Are there any other conditions or symptoms that may be related to your major symptom? If yes, what? _____
13. Have you ever been involved in an automobile collision or work related injury
    Within the past year ____ Past 5 years ____ Over 5 years ____ Never ____
14. What significant health problems have you had in the past?_____
    _____
15. What significant accidents, falls, or injuries have you had in the past? _____
    _____
16. Please list all surgeries you have had including date: _____
    _____

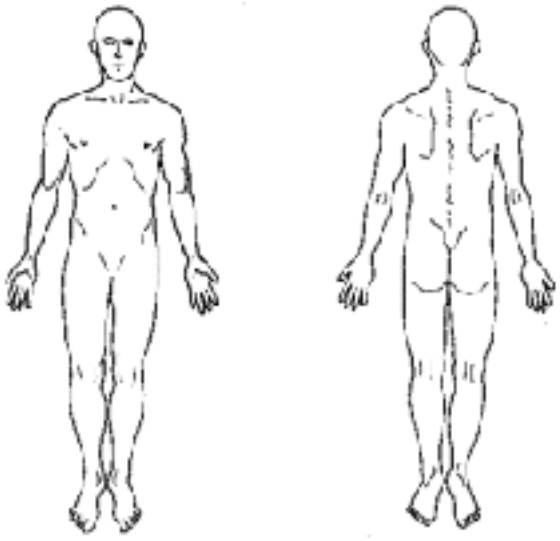
Symptom Diagram

Symptom Pattern Diagram

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > >
Numbness = = = = =
Pins & Needles o o o o
Burning x x x x
Stabbing / / / / /
Throbbing ~ ~ ~ ~ ~ ~
Other: _____ #######



Your Habits

	Heavy	Moderate	Light	None
Alcohol	▫	▫	▫	▫
Tobacco	▫	▫	▫	▫
Drugs	▫	▫	▫	▫
Coffee	▫	▫	▫	▫
Soft Drinks	▫	▫	▫	▫
Fruits/Vegetables	▫	▫	▫	▫
Fast Food	▫	▫	▫	▫
Exercise	▫	▫	▫	▫
Sleep	▫	▫	▫	▫
Stress	▫	▫	▫	▫

Miscellaneous

Drugs or Medication(s) you take:

▫ Sleeping Pills ▫ Antidepressants ▫Blood Pressure ▫ Cholesterol
▫ Birth Control ▫ Other:

_____

Do you take nutritional Supplements? If so, please list:_____

Age of Mattress: _____ ▫ Comfortable ▫ Uncomfortable

Are you wearing: ▫ Heel Lifts ▫ Sole Lifts ▫ Arch Support/Orthotic

Allergies

List any allergies that you have, the nature of the reaction, and how long ago:

Health History

Please indicate for each of the questions below your experience by use of the following code: 1 = Presently have, 2 = Previously had

Musculo-Skeletal System

___Lower Back Problems ___Middle Back Pain ___Neck Problems
___Arm Problems ___Leg Problems ___Swollen Joints
___Painful Joints ___Stiff Joints ___Sore Muscles
___Weak Muscles ___Walking Problems ___Herniated Disk
___Hernia ___Broken Bones ___Teeth Grinding

Health History - Continued

Genito-Urinary System

___Bladder Trouble ___Excessive Urination ___Scanty Urination
___Painful Urination ___Discolored Urine ___Hard to Start Urination
___Testicular Pain ___Painful Ejaculation ___STD
___Kidney Stones ___Kidney Disease ___Urinary Tract Infection

Gastro-Intestinal System

___Poor Appetite ___Excessive Hunger ___Difficulty Swallowing
___Excessive Thirst ___Nausea ___Vomiting
___Abdominal Pain ___Diarrhea ___Constipation
___Bloody Stool ___Hemorrhoids ___Liver Trouble
___Gall Bladder Problems ___Weight Trouble ___Heart Burn

Nervous System

___Numbness ___Loss of Feeling ___Paralysis
___Dizziness ___Fainting ___Headaches
___Muscle Twitch/Spasm ___Concussion ___Depression
___Seizures ___Tingling in Hands ___Pain Down Legs/Arms

Eye, Ear, Nose, &Throat

___Vision Problems ___Eye Inflammation ___Ear Discharge
___Ear Pain ___Ear Ringing ___Hearing Loss
___Nose Pain ___Nose Bleeding ___Nose Discharge
___Sore Gums ___Dental Problems ___Sore Throat

Female

___Vaginal Discharge ___Vaginal Bleeding ___Vaginal Pain
___Breast Pain ___Lumps on Breast ___Painful Menstruation

Cardiovascular & Respiratory Systems

___Chest Pain ___Difficulty Breathing ___Persistent Cough
___Coughing Blood ___Rapid Heartbeat ___Blood Pressure Problem
___Heart Problems ___Lung Problems ___Varicose Veins

Family History

Please circle all that apply:

Grandparents: Heart Disease Cancer Stroke Diabetes High blood pressure Other:_____
Father: Heart Disease Cancer Stroke Diabetes High blood pressure Other:_____
Mother: Heart Disease Cancer Stroke Diabetes High blood pressure Other:_____
Siblings: Heart Disease Cancer Stroke Diabetes High blood pressure Other:_____

Additional notes on family history:

_____
_____
_____

Treatment

What Type of treatment are you looking for?

▫ I am looking for the most minimal amount of care to find relief of the symptoms I am experiencing.
▫ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
▫ I am looking to take care of my problem and then go on to ""performance and wellness care" to achieve my optimal level of health.

Please list any other treatment/health goals so that we can work together to best achieve your objective for seeking care at our office:

_____
_____
_____
_____

Office & Financial Policies

*****PLEASE READ & SIGN*****

Right to Modify Terms

InHealth PLLC reserves the right to modify the terms of this Agreement at any time at its sole discretion, and may post a notice of such changes. If and when the Agreement is modified, You will be subject to the terms of the modified Agreement, and by seeking services at InHealth PLLC, You agree to the terms of modified Agreement, without further notice.

We at InHealth, PLLC strive to provide excellent patient services. In order to run our scheduling and billing efficiently, we have implemented the following policy. There is a fee for missed appointments if 24 hour advanced notice is not given, or if you are more than 15 minutes late to your appointment.

New Patient no show or late cancellation fee: $80.00

No show or late cancellation fee: $45.00

Financial Policy

Please present your health insurance card today. We will submit your claims on behalf to your health insurance company. Please note that healthcare and accident insurance policies are an arrangement between the carrier and the subscriber/patient, and the patient is personally responsible for all services rendered. Our office will prepare any necessary reports and forms to assist in making collections from the insurance companies. However please be aware that sometimes insurance companies deny claims for various reasons, we will resubmit such claims if denial is based in an error on our part. If claims are denied for any other reasons, we will then bill the patient directly and let the patient collect reimbursement from the insurance company. If your insurance plan requires a PCP referral, it is your responsibility to provide that to us. Our office will not verify nor will we check your insurances benefits; it will be your responsibility to check and verify your benefits.

Deductibles/Coinsurances/Copays: If your insurance plan requires a calendar/plan year deductible and it has not been satisfied at the time of service, payment will be collected from the patient on the day services are rendered. Unless prior arrangements have been with the billing coordinator, all copays and deductibles are due at the time service is rendered.

Time of Service Rate: Our time of service discount rate is available only when payment is received within two business days from the day the service was rendered. Time of service patients who do not make payment on the services are rendered will be billed the regular rate.

Returned/Insufficient Funds: Returned and or/Insufficient checks that are issued will incur a $75 re-processing fee. If an alternative form of payment is not received further action will be taken to collect this debt. For further information or additional assistance regarding this matter, please contact our billing office at 425-712-3417.

Workers Compensation/Labor & Industries: You need to report your accident to your employer, bring in necessary documentation of the accident and insurance information (if applicable). Complete and sign accident report or the L&I Report of Industrial/Occupational Injury. **Until the claim is approved/denied you may be required to pay the acquired fees.**

Personal Injury: Please provide our office with the following information: **accident report, your car insurance policy information, the other party's insurance information, you attorney information, and the other party's attorney information (if applicable).** Until all of the necessary information is provided, you may be required to pay acquired fees. Patients with Personal Injury Protection (PIP) are not requires to pay all fees. **If InHealth PLLC files a Medical Lien for your case, you will be responsible for the fee required by the auditor's office to file the paperwork necessary to satisfy the lien.**

Ultimately you are fully responsible for any amount not paid my your insurance, even if your claim was denied. Neither InHealth, PLLC nor any of the Doctors, or staff can enter into any dispute with any insurance company and so it is your obligation and full responsibility to contact your health insurance and verify your eligibility and benefits. It is also your responsibility to see that your bill is paid.

By signing below, I permit InHealth, PLLC to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered are charged directly to my account and that I am personally responsible for payment. It is my understanding that if I suspend or terminate my care and treatment; any fees for professional services rendered will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors of InHealth, PLLC, and whomever they may designate as their assistants, to administer treatment as they so deem necessary. I also authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

I understand that the above information and statements made on this form are accurate to the best of my knowledge, and I understand it is my responsibility to inform the office of any future changes in medical status.

Patient Name: _____ Date: _____

Patient Signature: _____