RED-ROSE CHIROPRACTIC CLINIC, P.S.

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

PATIENT INTAKE FORM **DATE:**

First Name: _____ Last Name:_____ M:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: ____-_____-_____ Work Phone: ____-_____-_____ Home Phone: ____-_____-_____

Email _____ Date of Birth ____ / ____ / _____ Gender: M / F

Height: _____ Weight: _____ Status: (circle one) Single Married Separated Divorced Widowed

Number of Children _____ Spouse's Name _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____-_____-_____ Relation To You: _____

INSURANCE INFORMATION

Do you have Insurance? (Circle one) Yes No Insurance Name _____

ID/Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's Date of Birth: ____ / ____ / _____

REFERRAL INFORMATION

How did you hear about us? Existing Patient/ Friend Physician Insurance Drive by/ Walk In Internet

Referring Physician: _____ Contact information:. _____

Referring Patient: _____ Are you working with an attorney? ☐ Yes ☐ No

Attorney:_____ Contact Information:_____

Please continue on back of page

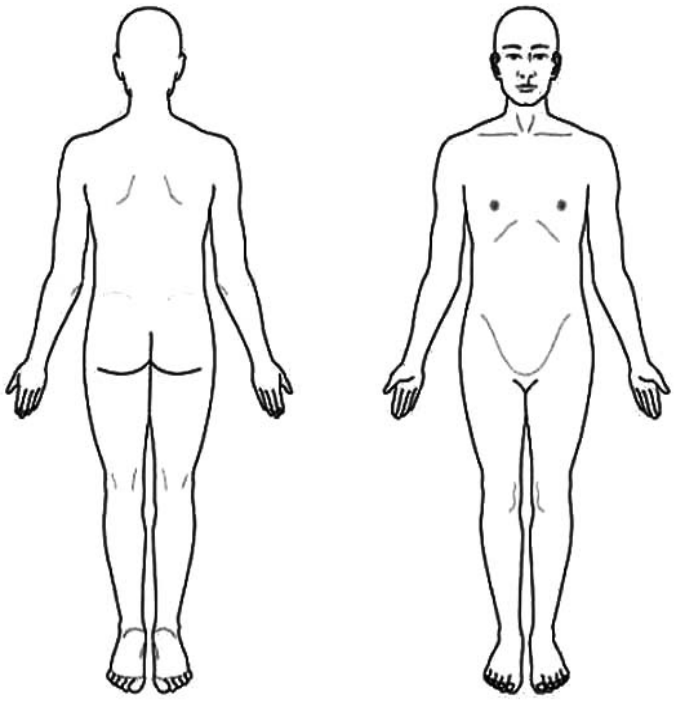
RED-ROSE CHIROPRACTIC CLINIC, P.S.

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

REASON FOR VISIT

How long have you had this complaint? (Please circle one)

Less than 5 days (Acute) Between 5-30 days (Sub Acute) More than 30 days (Chronic)



On the body diagrams to the left, please indicate you areas of symptoms by drawing in the appropriate symbols.

P-Pain

N-Numbness

W- Weakness

S-Shooting

A-Aching

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What caused this condition: _____

What term(s) describes your discomfort best? (Circle)

Aching	Annoying	Burning	Deep	Dull	Heavy	Pulling
Sharp	Stabbing	Stiffness	Throbbing	Tightness	Tingling	

Other: _____

On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How often do you feel this discomfort? (circle) Constant Frequent Occasional Intermittent

How has this complaint changed since the onset? (circle) Worsened Remained the same Improved

Please continue on back of page

RED-ROSE **CHIROPRACTIC CLINIC, P.S.**

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

What activity is most significantly affected by this discomfort? (circle)

Employment	Homemaking	Lifting
Personal Care (washing, dressing, etc.)	Sitting	Sleeping
Social Life	Standing	Traveling and/or Driving
Walking	Other:_____	

What aggravates this condition? (Circle all that apply)

Almost any movement	Applied pressure	Prolonged sitting
Coughing/ sneezing	Chiropractic Care	Medication
Ice	Heat	Bending
Carrying/Lifting	Driving/travel	Lying down
Standing	Turning/ Twisting	Yard Work
Work		

What improves this condition or gives you relief? (Circle all that apply)

Nothing	Chiropractic Care	Cold Packs
Exercise	Heat Packs	Massage
Over-the-counter medication	Physical Therapy	Prescription medication
Re-direct attention	Rest	Stretching
Work		

What treatment, if any, have you received pertaining to this condition?: (Circle al l that apply)

Nothing	Chiropractic Care	Massage
Medical injection treatment	Surgical treatment	Over-the-counter medications
Prescribed medications	Natural or holistic treatment	Acupuncture
Physical therapy	Other:_____	

Have other health care provider(s) performed tests related to this condition? (i.e. x-rays/ CT scan):_____

_____

Please continue on back of page

RED-ROSE **CHIROPRACTIC CLINIC, P.S.**

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

Have you ever experienced this condition before? Yes No

If yes: When/Please explain:_____

What are your goals pertaining to this condition? (Circle al l that apply)

No functional limitations relieve pain Improve sleep Work w/o limitations Walk w/o need of assistance

Please provide an activity goal (Fill in the blank**)**:

I would like to be able to (ie; run 1 mile/ stand without pain) _____ without limitations.

What other goals do you have to improve your health? (i.e. diet change, exercise more):_____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following? (Please select all that apply)

Musculoskeletal -					
Osteoporosis:	__ have	__ had	Arthritis:	__ have	__ had
Scoliosis:	__ have	__ had	Neck Pain:	__ have	__ had
Back Problems:	__ have	__ had	Hip Disorders:	__ have	__ had
Knee injuries:	__ have	__ had	Foot/ankle pain:	__ have	__ had
Shoulder Problems:	__ have	__ had	Elbow/wrist pain:	__ have	__ had
TMJ issues:	__ have	__ had	Poor posture:	__ have	__ had

Neurological -					
Anxiety:	__ have	__ had	Depression:	__ have	__ had
Headaches:	__ have	__ had	Dizziness:	__ have	__ had
Pins & needles:	__ have	__ had	Numbness:	__ have	__ had

Head & ENT					
Blurred vision:	__ have	__ had	Ringing in ears:	__ have	__ had
Hearing loss:	__ have	__ had	Chronic ear infection:	__ have	__ had
Loss of smell:	__ have	__ had	Loss of taste:	__ have	__ had

Please continue on back of page

RED-ROSE CHIROPRACTIC CLINIC, P.S.

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

Cardiovascular -					
High Blood Pressure:	__ have	__ had	Low Blood Pressure:	__ have	__ had
High Cholesterol:	__ have	__ had	Poor circulation	__ have	__ had
Angina:	__ have	__ had	Excessive bruising:	__ have	__ had

Respiratory -					
Asthma:	__ have	__ had	Apnea:	__ have	__ had
Emphysema:	__ have	__ had	Hay fever:	__ have	__ had
Shortness of breath:	__ have	__ had	Pneumonia:	__ have	__ had

Gastrointestinal -					
Anorexia/bulimia:	__ have	__ had	Ulcer:	__ have	__ had
Food sensitivities:	__ have	__ had	Heartburn:	__ have	__ had
Constipation:	__ have	__ had	Diarrhea:	__ have	__ had
I.B.S.	__have	__had	Crohns:	__have	__had

Genitourinary-					
Kidney stones:	__ have	__ had	Infertility:	__ have	__ had
Bedwetting:	__ have	__ had	Prostate issues:	__ have	__ had
Erectile dysfunction:	__ have	__ had	PMS symptoms:	__ have	__ had

Endocrine-					
Thyroid issues:	__ have	__ had	Immune disorders:	__ have	__ had
Hypoglycemia:	__ have	__ had	Frequent infection:	__ have	__ had
Swollen glands:	__ have	__ had	Low energy:	__ have	__ had

Integumentary -					
Skin cancer:	__ have	__ had	Psoriasis:	__ have	__ had
Eczema:	__ have	__ had	Acne:	__ have	__ had
Hair loss:	__ have	__ had	Rash:	__ have	__ had

Allergies Or Sensitivities -	

Please continue on back of page

RED-ROSE **CHIROPRACTIC CLINIC, P.S.**

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

PERSONAL AND FAMILY HISTORY	
Please use the space provided to explain/ list	

Surgeries: (i.e. Left ACL Sept/2009)

Procedure:_____ Date:_____

Procedure: _____ Date: _____

Illnesses: (i.e. Diabetes circa 1998, ongoing)

Illness: _____ Illness: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Injuries/Accidents/Traumas: (i.e. Broken wrist 6/15/12)

Injury: _____ Injury: _____

Date: _____ Date: _____

Injury: _____ Injury: _____

Date: _____ Date: _____

Are you presently taking any medication? –Please give list to front desk if applicable:_____

_____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? If yes please Explain:_____

_____

WORK SOCIAL HABITS

Current work habits: **(Circle all that apply)**

Please continue on back of page

RED-ROSE CHIROPRACTIC CLINIC, P.S.

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

Permanently fully disabled | permanently partially disabled | Cannot work due to current condition

Full-time (20-40+ hours/week) | Part-time (1-19 hours/week) | Retired

Student | Homemaker | Unemployed

Personal social habits: (Circle all that apply)

Smoke or use tobacco products | Drink alcohol | Drink caffeine | Use recreational drugs

Other:_____

Present exercise habits: (Circle all that apply)

No current exercises | Exercises daily | Exercises 3+ times per week

Cannot return to exercise due to current condition

Diet and nutrition habits : (Circle all that apply)

Vegan | Vegetarian | Daily supplements

Other:_____

INFORMED CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office. I authorize this office and its staff to examine and treat my condition as the doctor(s) see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I also agree to automatic appointment reminders sent by the clinic. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that denials or unapproved services through my health/ accident insurance, including preauthorization denials, will be my own financial responsibility. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I understand any payments due not tendered within 120 days from the initial statement date will be sent to out the collections agency we keep on retainer.

( ) I agree with this statement of authorization

Name of Insured (Print): _____ Date: _____

Patient Signature: _____ Date of birth: _____

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please continue on back of page

RED-ROSE **CHIROPRACTIC CLINIC, P.S.**

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

Please indicate the following and provide the best phone number for each:

Who receives appointment reminder text	[ ] Patient	[ ] Guardian	Phone: _____
Communications regarding care/condition	[ ] Patient	[ ] Guardian	Phone: _____
Communications regarding billing	[ ] Patient	[ ] Guardian	Phone:_____
Must Guardian be present to receive care?	[ ] No	[ ] Yes, Guardian must **ALWAYS** be present	

INFORMED CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I consent to the use or disclosure of my protected health information by **Red-Rose Chiropractic Clinic P.S.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Red-Rose Chiropractic Clinic P.S..** I understand that diagnosis or treatment of me by **Dr. Scott Harder** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Red-Rose Chiropractic Clinic P.S.** is not required to agree to the restrictions that I may request. However, if **Red-Rose Chiropractic Clinic P.S.** agrees to a restriction that I request, the restriction is binding on **Red-Rose Chiropractic Clinic P.S.** and **Dr. Scott Harder.**

I have the right to revoke this consent in writing at any time, except to the extent that **Dr. Scott Harder** or **Red-Rose Chiropractic Clinic P.S** has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to **review Red-Rose Chiropractic Clinic P.S's** Notice of Privacy Practices prior to signing this document. **Red-Rose Chiropractic Clinic P.S.'s** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **Red-Rose Chiropractic Clinic P.S..** The Notice of Privacy Practices for Dr. Scott Harder is also provided at the front desk of **Red-Rose Chiropractic Clinic P.S..**

This Notice of Privacy Practices also describes my rights and the duties of **Dr. Scott Harder** with respect to my protected health information. **Red-Rose Chiropractic Clinic P.S.** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please continue on back of page

RED-ROSE **CHIROPRACTIC CLINIC, P.S.**

12841 NE 85th Street • Kirkland, WA 98033 • (425) 893-9200 • fax (425) 893-8046

By signing below, you acknowledge receipt of the Notice of Privacy Practices of RED-ROSE Chiropractic Clinic. You are also authorizing our clinic to use and disclose the health and medical information for the purposes of treatment, payment, and health care operations.

May we leave a voicemail: ☐ YES ☐ NO

Name of Patient: _____

Signature of patient/guardian: _____ **Date**: _____

Please continue on back of page