Name:______________________ DOB:______________ Date:__________

Confidential Intake Form

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply will all federal privacy standards. Please print clearly in BLACK or BLUE **INK**.

Reason for visit (mark circle)
○ A worsening long-term problem
○ An interest in: ○ Wellness and prevention ○ Annual check-up ○ Other: ____________________
○ An accident or injury:○ Work ○ Auto ○ Other:______________________________ Claim #:__________
____

________________ Today's Date (mm/dd/yyyy)
________________ Date of Injury (If applicable)
________________ Who referred you/how did you find out about us?

○ No ○ Yes Previous chiropractic?
________________ Where?
________________ Date of last visit (approx.)

________________ Your full name
________________ Preferred Name
○ Male ○ Female ○ M2F ○ F2M **Gender**

____
________________ Birth date (mm/dd/yyyy)
_____ Age
○ Single ○ Married ○ Divorced ○ Widowed **Marital Status**

________________ Mailing address
________________ Home phone

________________ City
________________ State/Province
________________ ZIP/Postal Code
________________ Cell phone

________________ E-mail address

________________ Emergency contact
________________ Telephone

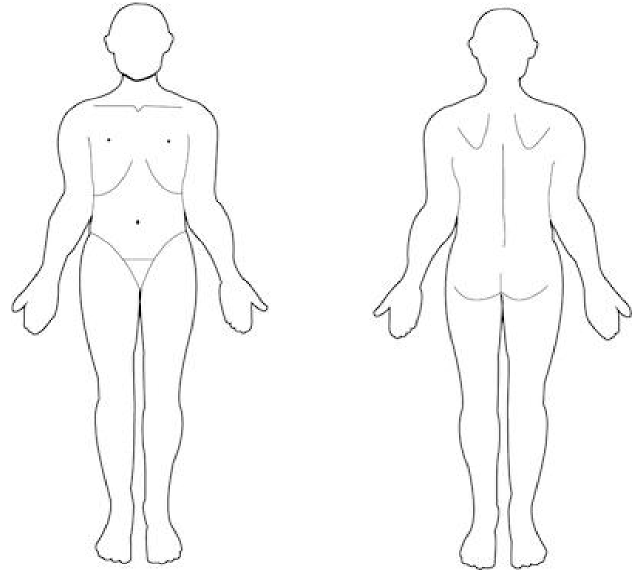
Do you have a Health Savings Account yes ☐ no ☐ or do you have a Flex Benefits program yes ☐ no ☐

Family/Specialist Doctor (if applicable)

________________ Primary care physician (Family doctor)
________________ Clinic
________________ Telephone
________________ Fax

Name:______________________________ DOB:__________________ Date:____________

● **2.Location** (Where does it hurt?)
Mark the area(s) on the illustrations.



● **1. List your current conditions/complaints**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Improved, Gotten Worse, = stayed same, D=Daily, C=Constant, F=Frequent, O=Occasional, I=Intermittent

What makes it better?___________________________
What makes it worse?
____

4. Have you ever suffered from your current symptoms in the past?			○No○Yes If yes, describe below:
Year	Cause	Tests done?	Problem resolved completely?
			○No ○Yes
			○No ○Yes
			○No ○Yes

● **6. Activities of Daily Living** How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○	Grocery shopping	○	○	○	○
Rising out of chair	○	○	○	○	Household chores	○	○	○	○
Standing	○	○	○	○	Lifting objects	○	○	○	○
Walking	○	○	○	○	Reaching overhead	○	○	○	○
Lying down	○	○	○	○	Showering or bathing	○	○	○	○
Bending over	○	○	○	○	Dressing myself	○	○	○	○
Climbing stairs	○	○	○	○	Love life	○	○	○	○
Using a computer	○	○	○	○	Getting to sleep	○	○	○	○
Getting in/out of car	○	○	○	○	Staying asleep	○	○	○	○
Driving car	○	○	○	○	Concentrating	○	○	○	○
Looking over shoulder	○	○	○	○	Gardening/Yard work	○	○	○	○
Caring for family	○	○	○	○	Exercising/Recreation	○	○	○	○
Work duties	○	○	○	○	Athletics	○	○	○	○

Name:________________________ DOB:________________ Date:____________

Past personal, family and social history Please identify your past health history, including accidents, injuries, illnesses and treatments.

7. Have you ever been hospitalized or had surgery? ○No ○Yes If yes, describe:

Year	Reason	Surgery	Outcome

8. Have you ever had any traumas or accidents?(Falls, car accidents, work injury, sports injury, fractures) ○No ○Yes If yes, describe:

Year	Trauma	Treatment	Outcome

9. Do you take any medications or supplements (including over the counter eg.Tylenol?) ○No ○Yes If yes, describe:

Name	Reason	x/day	Dose	Since when?

10. Do you have any allergies? ○No ○Yes If yes, list:

____

11. Family History **F=Father M=Mother H=Husband W=Wife K=Kid(s) S=Sibling G=Grandparent**

Place the appropriate letter(s) in the blank of someone in your family has/had any of the following:

__________ **Allergies** (Hay fever, Food Allergies, etc.)_______________ **Anxiety**_____________ **Arthritis/Joint Disease**

____________________ **Asthma/Breathing Problems**_______________ **Bed Wetting**___________________ **Bursitis** (Shoulder, Hip, etc.)________________

Cancer - type?_____________________________________ **Carpal Tunnel Syndrome**__________________ **Depression**___________________

Diabetes - type?___________________________________ __________ **Digestive Disorder** (GERD/Reflux, Ulcers, IBS, Crohn's, etc.)___________________ **Ear Infections**

(repetitive/chronic)_____________ **Fatigue/Low Energy**____________ **Fibromyalgia**

SOCIAL

What is your current occupation? ______________________________

Do you rest well at night? ○ Yes ○ No

Do you have trouble falling asleep? ○ Yes ○ No

Do you wake up frequently during the night? ○ Yes ○ No

Do you grind your teeth at night (bruxism)? ○ Yes ○ No

Do you snore heavily? ○ Yes ○ No

How many hours do you sleep at night? ○< 6h ○ 6-8h ○> 8h

Preferred sleep position? ○ Face up ○ Face down ○ Side

Rate your fatigue level (0-10) ____________

Approximate age of your mattress and pillow? ____________

How often do you exercise?: ○ Don't ○ Occasionally (<1x/week) ○ Frequently (2-3x/week) ○ Daily

Water intake: ○<33oz(1L) ○ 33-50oz (1-1.5l) ○>50oz(1.5L)

12. Social/Occupational History

SOCIAL

Alcoholic Drinks ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week

Caffeine use ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week Source of caffeine:____________________

Tobacco use ○ No ○<1x/day ○<½ pack/day ○>½ pack/day ○>1 pack/day Type of tobacco: ____________________

Soft drinks ○ Never a ○<1/day ○ Daily ○ 6-10/week ○>10/week

What vitamins/supplements do you take? ○ Not taking ○ Glucosamine ○ Chondroitin ○ Calcium ○ Multi-Vitamin ○ Fish Oils ○ Pro-biotics ○ Magnesium ○ Greens ○ B Complex ○ Vitamin C ○ Vitamin D ○ Vitamin E Others: ________________

Describe your eating habits: ○ Skip breakfast ○ Two meals per day ○ Three meals per day ○ Snacking between meals

Diet restrictions/intolerances: ______________________________

Rate your overall stress level (0-10): _______ What are your major causes of stress? ○ Work ○ Economic ○ Family/Kids/Relationships

Hobbies: ______________________________

Name:________________________ DOB:______________ Date:__________

13. Review of systems

Our integrative care focuses on the integrity of all body systems. Please mark the circle beside any condition that you've **HAD** or currently **HAVE:**

a. HEENT
- ○ Blurred Vision
- ○ Floaters in vision
- ○ Hearing Loss
- ○ Ringing in ears
- ○ Loss of taste
- ○ Loss of smell
- ○ Glaucoma
- ○ Ear infections
- ○ Sinusitis
- ○ Nasal Polyps
- ○ Strep Throat
- ○ Mononucleosis
- ○ **None**

b. Integumentary
- ○ Dry Skin
- ○ Psoriasis
- ○ Eczema
- ○ Acne
- ○ Hair Loss
- ○ Rash
- ○ Melanoma
- ○ **None**

c. Respiratory
- ○ Asthma
- ○ Apnea
- ○ Shortness of breath
- ○ Emphysema
- ○ COPD
- ○ Allergies
- ○ Pneumonia
- ○ Tuberculosis
- ○ **None**

d. Neurological
- ○ Anxiety
- ○ Depression
- ○ Pins and needles
- ○ Dizziness
- ○ Headaches
- ○ Numbness
- ○ Multiple Sclerosis
- ○ Parkinson's
- ○ Fibromyalgia
- ○ Chronic Pain
- ○ Mood Disorders
- ○ **None**

e. Digestive
- ○ Ulcer
- ○ Anorexia/Bulimia
- ○ Food Sensitivities
- ○ Heartburn
- ○ Constipation
- ○ Diarrhea
- ○ Crohn's Disease
- ○ Irritable Bowel Syndrome
- ○ Ulcerative Colitis
- ○ Celiac
- ○ diverticulitis/osis
- ○ Gas/Bloating
- ○ Gall Bladder disease
- ○ **None**

f. Endocrine
- ○ Thyroid Issues
- ○ Hypoglycemia
- ○ Immune Disorders
- ○ Low Energy
- ○ Swollen glands
- ○ Frequent Infection
- ○ Polycystic Ovarian Syndrome
- ○ Diabetes
- ○ Hepatitis
- ○ Goiter
- ○ None

g. Genitourinary
- ○Kidney Stones
- ○Prostate Issues
- ○Erectile Dysfunction
- ○Bedwetting
- ○PMS Symptoms
- ○Infertility
- ○ Urinary Tract infections
- ○ Yeast Infections
- ○ Abnormal PAP
- ○ STD's
- ○ Decreased Libido
- ○**None**

h. Constitutional
- ○ Fainting
- ○ Low Libido
- ○ Poor Appetite
- ○ Difficulty losing weight
- ○ Weakness
- ○ Sudden Weight Change
- ○ Fever
- ○ Chills
- ○ Night Sweats
- ○ **None**

i. Cardiovascular
- ○ Angina
- ○ High-cholesterol
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Excessive Bruising
- ○ Poor Circulation
- ○ Stroke
- ○ Murmurs
- ○ A-Fib
- ○ Heart Disease
- ○ **None**

j. General
- ○ Cancer
- ○ Epilepsy
- ○ AIDS
- ○ Alcoholism/Drug dependence
- ○ Gout
- ○ Polio
- ○ Rheumatic fever
- ○ Scarlet fever
- ○ Typhoid
- ○ Malaria
- ○ Post-Nasal Drip

- ○ Other:
- ○ Other:
- ○ Other:

14. What would be the most significant thing that you could do to improve your health? ______________________________

____

Please check any of the following services you would like more information about:

- ✈ Medical Weight Loss
- ✈ Acupuncture
- ✈ Knee Regeneration Therapy
- ✈ Decompression Disc Therapy
- ✈ Migraine Therapy
- ✈ Peripheral Neuropathy
- ✈ Hormone Balancing Therapy
- ✈ Massage
- ✈ Allergy Testing

Height:

Weight: **Blood Pressure:** /

Side View:

Back View:

Left Side: **Right Side:**

Kingston Crossing Wellness

Agreement of Understanding

This ***'Agreement of Understanding'*** is presented to make certain that patients understand that health plans are constructed to reimburse only those services that their insureds are held responsible to pay, and how this office addresses that issue. It is important that you read this "agreement" carefully so there is no misunderstanding as to the type of services that are eligible for reimbursement, the type you can expect to be 100% financially responsible to pay, and the terms under which payment is expected.

_______Patient Responsibility for Payment

Patients (or *Custodial Parent* or *Authorized Persons*)**,** not insurance companies are considered the *party responsible* for payment of service rendered at this practice. The "***responsible party"*** is the only party eligible to receive discounts.

As the ***responsible party*** you acknowledge by your signature below that you understand, that standard fees apply to all services provided at this office and that discounts are only offered to patients who agree to make prompt personal payment at the time services are rendered, or agree to prepay for a clinical course of care they consent to receive, regardless of whether those services are a covered benefit of their health plan. **Patient balances are due at time of service and will be charged interest not to exceed 12% annually for all balances not paid by the 30th of each month**. Unless other arrangments have been made in advance. (payment plan)

Patients who wish to submit claims for personal reimbursement will, upon request, be given a receipt reflecting the discounted amount paid for all services provided, and all other information necessary to facilitate direct payment from their insurance company.

_______Discounted Fees for Services

Discounted fees are offered to any insured and non -insured patient (with the exception of those covered under Medicare and Workers Comp) who agrees to make prompt personal payment at the time services are rendered or pre-pay for a clinical course of care they consent to receive. Additionally those services that are **not a covered benefit** under an insured patient's health plan and those services that, due to policy limits, become ***non-covered*** may also be discounted in accordance with office policy and in compliance with state law.

In either **case** Patients who wish to submit claims for personal reimbursement will, upon request, be given a receipt reflecting the discounted amount paid for all services provided, and all other information necessary to facilitate direct payment from their insurance company.

_______Services Not Covered Under the "Care Plan"

Products, and after-hours urgent care, are services that are not included in any patient care plan – they are consider '***exclusions***'. Exclusionary items and services always represent an additional fee that patients are personally responsible to pay.

_______If Your Visits are Covered by Insurance

If you are insured under a health plan that covers chiropractic, like all plans, your coverage has limitations, and any services you consent to receive that are **not** covered, or become non-covered services due to a visit limit or dollar cap must be personally paid for by you   **1. in advance**   **2. at the time they are provided.**

In order for services and procedures to be eligible for insurance reimbursement, most plans require their insured to pay a deductible. All monies collected from you will be applied towards standard fees for services until your deductible has been satisfied. Once your deductible has been satisfied, any remaining amounts you have prepaid will be applied as co-payments and or co-insurance.

_______Early Termination of Care

Patients who prepaid for their care decide not to continue receiving care at this office before completing have prepaid for their care, and do not complete their care plan terminate treatment prior to completing their care plan, any sums

personally paid for service not yet received will be reconciled against fees charged for services the patient did received, and the difference will be refunded to the patient.

Insurance Payments Pending

If payment is received on any assigned claims after a patient terminates their care, and that payment results in a credit balance on the patients account, will be reconciled in favor of the patient and those sums will be refunded to the patient upon the office receiving a written request from the patient. If the practice receives duplicate payments from any insurance company, those sums will be refund the insurer or appropriate source.

Obtaining Refund

Patients are required to submit a written request for any overpayment that has resulted in a credit balance on their account. The 'Refund Overpayment' form is available at the front desk. All 'Refunds' requested, must go through Life Force Chiropractic's Accounting Department and that this process will take up to 30 days.

Changes in Status

Health Coverage

If your healthcare coverage changes or is terminated for whatever reason in the future, this office reserves the right to amend the terms of this 'Agreement' or any subsequent 'Agreements' that may be in effect at that time.

Any Accidents

If you are involved in a work related injury, auto or other accident, regardless of whether you are receiving active therapeutic or maintenance care it is of paramount importance that you notify the doctor before being treated at your next appointment. This will ensure a proper assessment is made at to the extent of you injury(s) and what if any other collateral sources are available to assist you with the costs involved in your care.

Chiropractic's standard fees for services will apply to all products, services and procedures utilized to treat conditions related injuries during this period. Patient may resume treatment under their '***initial care plan***' once they have recovered from their accident related injuries**/**conditions and their Doctor has released them from care without any residuals, impairment, or disabilities

Temporary Suspension of Care Plan

Injuries Due to Accident

In the event you are involved in a personal injury or workers compensation claim, this agreement will be suspended while you receive care for the resultant injury(s).

______________________________ ____________________________________ ___/___ /___

Printed name of Patient *Signature* of Patient or Responsible Party Date

______________________________ ____________________________________ ___/___ /___

Printed name of Witness *Signature* of Witness Date

Credit Card Notice/Approval

NOTICE: Filling out this Questionnaire will not add a credit card to your patient portal; the form serves only as your permission or lack thereof to hold the card on file. At time of check out, the card will be added on file.

Integrated Medical Solutions PLLC, dba Kingston Crossing Wellness reserves the right to keep credit cards on file to be used in the event of Account balances owed for services and products owed on your account. Please note that we do our best to estimate your insurance responsibility. Ultimately we have no control over how they process your claim. Per our financial agreement you are responsible for any unpaid amounts your insurance company does not cover.

Your account will be accessed monthly and any balance owed will be charged to your card on file to keep you account current. Unless you have made other financial arrangements to pre-pay for services or pay monthly installments. I authorize $________ to be automatically processed without prior notice monthly, anything above this amount I understand I will be contacted by phone to approve if my balance exceeds $_________ in any given month.

At any time a patient can choose to terminate a credit card on file.

_____ I understand the above stated policy and authorize Integrated Medical Solutions PLLC, dba Kingston Crossing Wellness to keep the credit card listed below on file.

Patient Printed Name:_______________________________________

Patient Signature:____ Date:_____________

Witness Signature:____

Kingston Crossing Wellness

8202 NE St Hwy 104, Suite 105

Kingston, WA 98346

360-297-0037

Name:________________________________ DOB:____________________ Date:______________

Acknowledgements

Notice of privacy practices acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature _______________________________________Date___________

Informed Consent

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy, massage therapy, diagnostic x-rays, diagnostic lab work including urine, blood, gynecological specimens and body cultures, medical doctor and/or chiropractic adjustments on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or licensed doctors who now or in the future treat me while employed by, work or are associated with, or are serving as back up, for Restart Chiropractic, PLLC, including those working at the center or office listed below or any other office or center.
I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.
I understand, and am informed that in the practice of medicine, and in the practice of chiropractic, naturopathy and physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and potential exacerbation of symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the same time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedure. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient

Signature of Patient ____ Date ____

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

Representative Name ______________________________ Signature of Representative __________________________________

Date Signed ______________________________________

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and Sign.

Notice of privacy practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Copy

Dr.Joshua Bailey