Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ ☐ **male** ☐ **female**

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Lenght of cycle: _____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mamogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: _____

_____

_____

_____

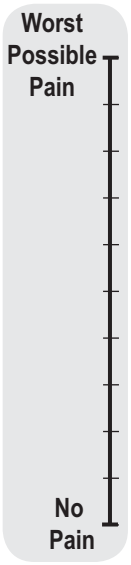
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

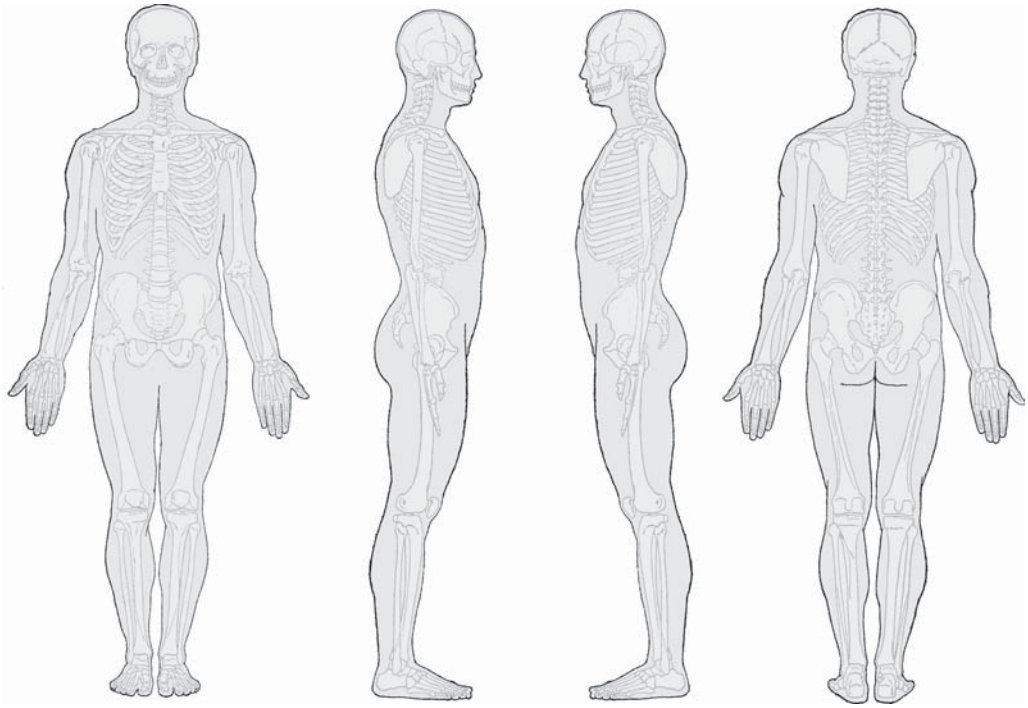
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your matress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Eagle Harbor Health & Chiropractic

Dr. Kirk Petheram

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working toward the same objective.

It is important that each patient understand both the objective and the method that will be used to attain improved spinal health. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific computerized adjustments and or gentle manual adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of symptoms.

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebra in the spinal column which can cause alteration of nerve function and transmission of nerve impulses resulting in a lessening of the body's ability to perform at it's optimal potential.

We only offer to diagnose either vertebral subluxations or neural-musculoskeletal conditions of the body, however, if during the course of the chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. We have a list of other professional health care providers for referral purposes if indicated. Any legal disputes with Eagle Harbor Chiropractic (E.H.C.), or employees of E.H.C. will be handled via arbitration.

I, _____ have read and fully understand the above statements. All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis, and understand that all charges incurred are my responsibility.

_____ _____

(patient signature) (date)

****Consent to evaluate and adjust a minor child**

I, _____ being the parent/legal guardian _____of have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care from Dr. Petheram.

_____ _____

(authorized signature) (date)

****Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform, if needed, an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____

_____ _____

(patient signature) (date)

**if applicable

GENERAL INSURANCE AND FINANCIAL POLICY

Eagle Harbor Health & Chiropractic 701 B Winslow Way East Bainbridge Island, WA 98110

To our valued patients:

We regret that due to restrictions implemented by insurance companies, which dramatically limits the amount and accuracy of information available to our office, we are no longer able to verify insurance benefits for our patients. Both the inaccurate and overall lack of benefit information cited to our staff by the insurance companies leaves all of us frustrated. Therefore, we STRONGLY encourage our patients to call their insurance company to verify both chiropractic and rehabilitation benefits.

We STRONGLY recommend that you call your insurance company to verify your chiropractic and rehabilitation benefits.

Our **Financial Policy** is as follows:

1. As a patient of this office you are directly responsible for prompt payment of all charges incurred while under treatment.
2. **If your card lists a co-pay amount on it, then your co-pay is due at the time of each service.** (If our biller can verify that the services are not subject to co-pay, we will credit your account.)
3. All supports, supplements and supplies must be paid for at the time of service, as these items are not covered by insurance.
4. Overdue accounts past ninety (90) days will be assigned to a collection agency.
5. A late fee of 1.0% interest per month is charged on past due accounts. There is a $20.00 charge on all returned checks.
6. No Show Fees: Chiropractic - $20.00 Massage - $65.00
7. Please know that we bill insurance only as a convenience to our patients. Your insurance coverage is a relationship between you and your insurance company. Again, you are ultimately responsible for your bill.

Please read this supplemental information:

1. **MEDICARE ENROLLEES**: Medicare covers spinal manipulations only and does not pay for the initial exam, which costs $60. Most secondary or supplemental insurance does not pay for it either. You will be responsible for this charge.
2. In addition to chiropractic adjustments, our providers also provide services that are often processed under a separate therapy or rehabilitation benefit. Examples of these types of services include but are not limited to: Intersegmental Traction, Therapeutic Exercises, Manual Traction, Myofascial Release, Manual Massage, etc.
3. DRS (Lumbar Decompression) is not a covered benefit under any insurance plan.
4. Our providers can never know how your claim will be processed until the payment is received from your insurance company, therefore, all services rendered will be billed using the appropriate code(s) per insurance requirements, billing regulations, and codes/procedures set forth by the American Medical Association.
5. Our staff is always here to assist you in whatever way we can. Please do not hesitate to bring any questions or concerns to our attention. Our primary goal is that all of our patients have a great experience while under our care! Again, ***thank you*** for choosing our office for your chiropractic health care needs.

ULTIMATELY IT IS YOUR RESPONSIBILITY TO KNOW WHAT YOUR BENEFITS ARE. WE HIGHLY RECOMMEND THAT YOU CALL YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS!

_____ _____ _____

Patient Signature Date Witness (Staff Signature)

Eagle Harbor Health & Chiropractic

701B Winslow Way E Bainbridge Island, WA 98110
Phone: 206-842-2702 Fax: 206-842-2847

Office Policies

1. If you need to reschedule or cancel an appointment please call our office 24 hours in advance to do so. You will be charged for missed appointments or cancellations with less than 24 hours notice, this includes massage therapy appointments.
2. Please refrain from wearing strong colognes/perfumes to our office as many of our patients have highly sensitive allergies and/or respiratory problems.
3. Please notify the doctors of any changes in health status, regardless of the significance.

Privacy Policy

It is the policy of our office to keep your medical information strictly confidential. Unless authorized by you, or requested by your insurance company, your information will not be divulged to any one individual or any organization.
If you have read and understand the Privacy Policy of our office, please sign below. If we are authorized to release information to any one other than you, please list their names in the spaces provided.

_____ _____
Patient signature Date

Persons authorized to all medical information if applicable:

_____
Name Relationship Phone#

By signing this document I authorize this office to collect benefits, if any, from my primary insurance company and to release daily chart notes/information when necessary for the processing of claims.

Eagle Harbor Health & Chiropractic
701 B Winslow Way E
Bainbridge Island, WA 98110
206-842-2702

Date:_____

Patient: _____ SS#/ID#_____

Employer: _____ Claim/group#_____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Eagle Harbor Chiropractic

Or

If my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to any insurance company, attorney, or adjuster involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____ 20 ____

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant (if other than policyholder)