T: (360) 833-2868
F: (360) 833-2866
2115 SE 192nd Ave, Ste. 108
Camas, WA 98607
www.mindandbodynaturalhealing.com

New Patient Intake Form

Patient Information:

Name____ DOB_________________ Sex__________

Address_____________________________ City________________ State_______ Zip Code___________

Home Phone__________________ Cell Phone___________________ Work Phone__________________

Email ____SSN_____________________________

Emergency Contact_______________________________________Phone__________________________

How did you hear about us so we can thank them? ____

Marital Status? Single Married Divorced Widowed Other Spouses Name_____________________

Spouses Name_________________________________ Spouses Occupation______________________

Employed? F/T Emp. P/T Emp. Retired F/T Student P/T Student Retired Unemployed Self Emp.

Employer Name_____________________________________Occupation___________________________

Policy Holder's Information:

Policy Holder's Name ____ Sex_____________

Policy Holder's DOB__________________ Policy Holder's phone__________________________________

Patient's relationship to Policy Holder: Self Spouse Child/Dependent Other

Address_____________________________ City________________ State_______ Zip Code___________

Patient's medical I.D. #_________________________________ Group # ____________________________

Do you have dual-coverage insurance? YES NO **If yes please fill out the information below…**

Policy Holder's Name ____ Sex_____________

Policy Holder's DOB__________________ Policy Holder's phone__________________________________

Patient's relationship to Policy Holder: Self Spouse Child/Dependent Other

Address_____________________________ City________________ State_______ Zip Code___________

Patient's medical I.D. #_________________________________ Group # ____________________________

Area(s) of Chief Complaint____

How would you rate the discomfort right now?(0=no pain, 10= most intense pain ever experienced)_________

What is the frequency of the discomfort you are feeling? (10%-100%)________________________________

How bad is the discomfort at its worst? (0=no pain, 10=most intense pain ever experienced)_______________

How would you rate the discomfort at its best? (0=no pain, 10=most intense pain ever experienced)_________

What makes the problem worse (please list)____

What makes the problem better (please list)____

Do these conditions disrupt?
__Career/Productivity __Family Life __Ability to Exercise __Sleeping Pattern __Social Life

What methods have you tried to relieve the pain?
__Chiropractic __Acupuncture __Physical Therapy __Massage __Exercise __Prescription Drugs __Nothing

Have any methods been effective? YES NO

What do you think is causing your health concerns?
___Accident ___Injury ___Accumulated stress ___Lifestyle ___Don't know

Check off any additional symptoms that affect you and *CIRCLE* the items that bother you most.

__Headaches/Migraines
__Neck Pain
__Shoulder/Arm Pain
__Arm/Wrist/Hand Pain
__Upper Back Pain
__Mid Back Pain
__Low Back Pain
__Disc Problems
__Scoliosis
__Hip, Leg, or Knee Pain
__Sciatica
__Ankle/Foot/Toe Pain
__Arm Numbness/Tingling
__Leg Numbness/Tingling
__Memory Trouble/Brain Fog

__Frequent colds/flu
__Low Energy/Tired
__Dizziness
__Sinus/Allergies
__Snoring
__Ear Aches
__Thyroid
__Asthma
__Anxiety
__Insomnia
__Heart Palpitations
__Emotional Instability
__Heart Burn/Need Antacids
__Chest Pain
__Gas/Bloating/Indigestion
__Bowel Problems

__Constipation
__Low Immune Function
__Swollen Ankles
__Puffy Eyelids
__Kidney/Bladder Issues
__Prostate/Uterus Problems
__PMS/Painful Menstruation
__Compulsive Disorders
__Impotence
__Infertility
__Epilepsy
__Hyperactivity
__Depression
__Attention Disorders
__Sensitivity to Light

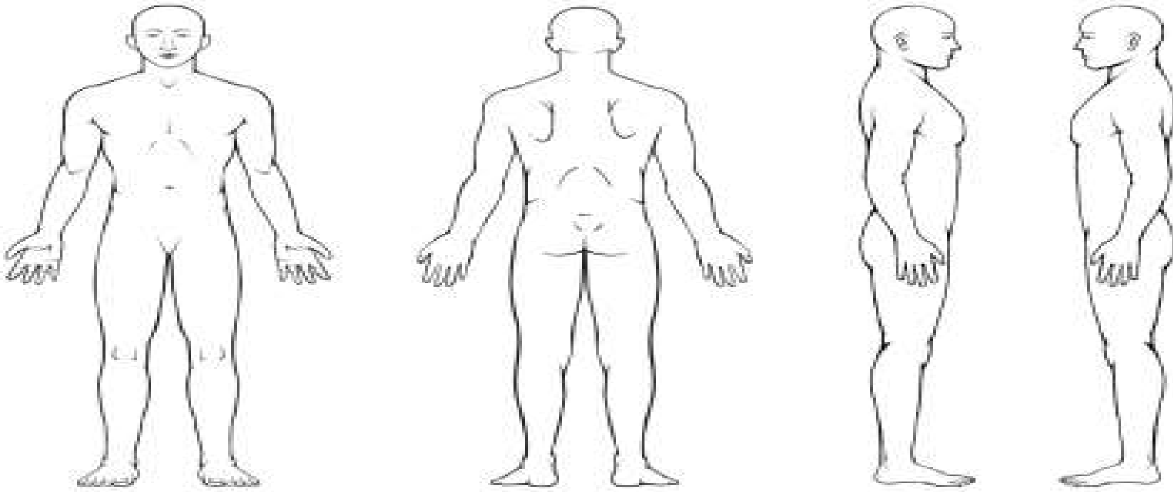
Please check off any stress that you have experienced and *CIRCLE* any stresses you are currently dealing with:

Physical stress
__Slips/Falls
__Car Accidents
__Hard Labor (ie: construction)
__Work Postures
__Difficult Pregnancy
__Difficult Birth (when you were born)
__Desk Job
__Sedentary Lifestyle
__Unhealthy Weight

Chemical stress
__Not Enough Water
__Unhealthy/Processed Foods
__Fast Food
__Lack of Fruit & Vegetables
__Pesticides/Hormones
__Prescription/Non-Prescription Medications
__Smoking/Drink Alcohol

Emotional stress
__Skip Meals
__Finances
__Relationships
__Loss of Loved One
__Poor Self Image
__Work
__Unhealthy Thoughts
__Depression
__Anger/Guilt/Resentment

Place an X in all the area(s) of Complaint



Past Injuries:

Injury/Accident: ____ Date:________________

Treatment if any: ____

Injury/Accident: ____ Date:________________

Treatment if any: ____

Please list all types of surgery:

Surgery: ____ Date:________________

Surgery: ____ Date:________________

Please list any related family health history: ____

____

____

Please list all types of medications you are taking (ie: Blood Pressure etc): _____________________

____

____

Please list all supplements you are taking:____

____

____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name ____Date_________________________

Signature of
Patient/Guardian____

Printed Name of Guardian _______________________________Relationship to Patient ___________________

PLEASE READ AND SIGN THE FOLLOWING

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Assignment of Benefits:
By signing below you assign benefits to Mind & Body Acupuncture & Herb Center. This designation directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from the insurance.

Release of Information:
If you're insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care:
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Cancellation of Appointment(s):
I voluntarily authorize the chiropractor to administer adjustments and/or other treatments of chiropractic medicine for relief of my conditions. I understand that appointment times are reserved especially for me and if for any reason you need to cancel or reschedule we do require a 24 hour notice. If not there will be a $45 fee charged to your account for no show/missed appointments or a $25 fee for same day cancellations. Payment is due prior to future treatments. I also understand that if I miss an appointment and/or cancel an appointment on the same day three times, that my future appointments will be canceled.

Copay-Coinsurance-Deductibles-Returned Checks:
I understand that payment is due at the beginning of each visit, unless otherwise arranged. (If we are not sure of your insurance co-pay or coverage, we ask for full payment until this is determined) There will be a $25.00 fee charged on all returned checks.

I have read and understand the above. Please sign below to authorize insurance payment, if billing medical insurance. I authorize Mind & Body Acupuncture & Herb Center to accept assignment for medical service(s) rendered.

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

I have read and agree to the above.

Signature____

Print Full Name ______________________________________Date____________________