REGISTRATION FORM

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /		Age:	Sex: ❑ M ❑ F	
Street address:					Home phone no.: ( )	
P.O. box:	City:		State:		ZIP Code:	
Occupation:	Employer:				Employer phone no.: ( )	
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )	
Is this person a patient here?	❑ Yes	❑ No				
Occupation:	Employer:	Employer address:			Employer phone no.: ( )	
Is this patient covered by insurance?	❑ Yes	❑ No				
Please indicate primary insurance	❑ Kaiser Permanente	❑ Cigna	❑ Regence	❑ Aetna	❑ United Health Care	
❑ Premera	❑ Lifewise	❑ First Choice Health	❑ Other			
Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )			
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Edmonds Wellness Clinic or insurance company to release any information required to process my claims.						
Patient Signature:						
Date:						

Health History Form

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

Describe briefly your present symptoms:

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Patient initials _____

SYSTEMS REVIEW

Have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

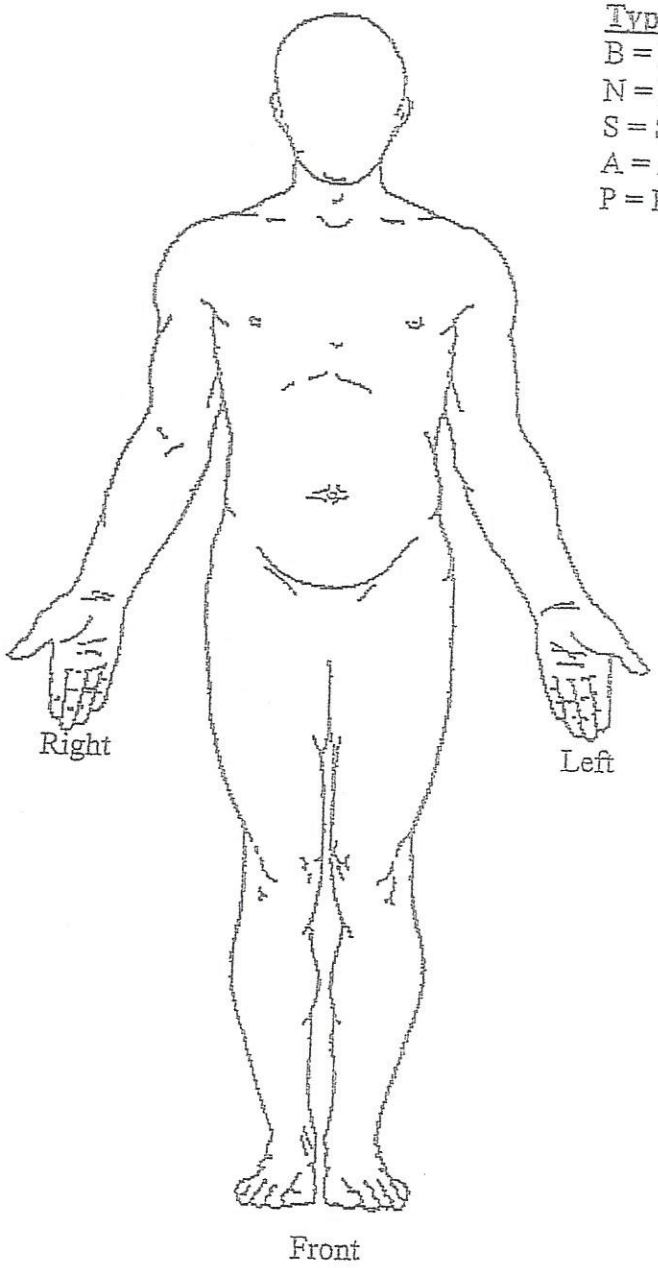
Patient initials _____

PAIN DIAGRAM

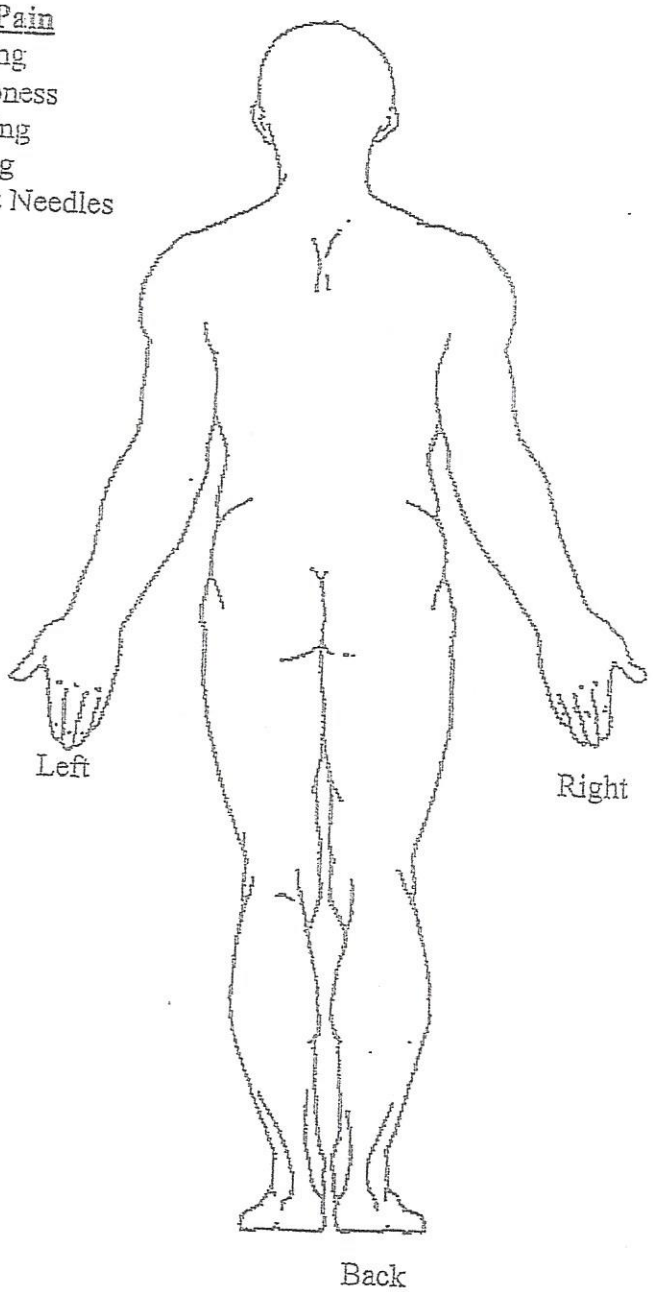
Please fill this out as carefully as possible. The information you provide on this form will be useful to the consultant(s) you will be seeing today and will help your exam to go as smoothly and as quickly as possible.

If you have any of the symptoms shown in the diagram, indicate where they are by writing in the appropriate letter on the affected body part.

<u>Types of Pain</u>
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles



Front



Back

Your name _____ Today's date _____

Height _____ Weight _____ Date of Birth _____

If you are in pain <u>NOW</u>, how bad is it?
Put a circle around the appropriate number on this scale.
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Late Cancel/No Show Policy

Our policy at Edmonds Wellness Clinic requires that all patients notify us 24 hours prior to their appointment if cancellation is necessary. Failure to do so could result in a $50.00 charge. By signing below you agree that you have read and understood the terms and will pay any charges that apply.

X_____ **Date**_____

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Birthdate_____

Signature _____

For a copy of the privacy notice please ask the front desk, we are happy to provide you with one!