MindBody MED REGISTRATION

How did you hear about us?____

Who is your primary physician?______________________**Clinic or hospital?**______________

PATIENT INFORMATION

Patient Name:______________________________ Date of Birth:____________________ Sex:__________

Home Phone:________________________ Cell:________________________Work:____________________

Email Address:____

Street Address: ________________________________ City, State, Zip:____________________

PLEASE PRESENT YOUR INSURANCE CARED AND ID FOR SCANNING

Insurance Carrier: ______________________ ID or Claim Number:______________________________

Group Number:________________________ Subscriber:__________________________________

Date of Birth:____________________________

Relationship to Subscriber: **Self** **Spouse** **Dependent**

Claims Address:____

For L&I and Auto Injury, Please specify date of accident:

Auto **Work** **Home** **Other**

To whom have you made a report of your accident?

Auto Insurance **Employer** **Work Comp** **Other**

What is their contact name and number? ____

Please read the following carefully before signing:

I, the undersigned, understand that payment is expected in full at the time of service, including all copay amounts for insurance billing. I authorize the treatment of the person named above to agree to pay all fees for such treatment. I hereby authorize my health care practitioner(s) to receive all benefits to which I and/or my dependents are entitled under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment of any of my charges. I also understand there is a $50.00 fee (per RCW 62A, 3-515 & 520) on all checks returned by my bank NSF.

I understand if I have an unpaid balance to MindBody Medicine PC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for MindBody Medicine PC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that MindBody Medicine PC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Signature: ______________________________________ Date:__________

GOALS OF CARE:

"If you don't know where you're going, any road will get you there." — Lewis Carroll

This section is important to read and fill out, so we have a clear understanding of what your goals are. This may change after we go through your patient history and physical exam or even as we progress through care, but it's important we establish targets. Having a goal will help us determine which tests to do, which treatment style will be most effective, and where we should focus our efforts, so we create the best results and highest satisfaction possible. Please circle as many of the goals as you like. If you have any questions, please let the doctor know. Our goal is to help you reach yours.

My main concern(s) is/are:____

____

My goal(s) is/are:

- ○ Pain Management: *"I'm tired of feeling uncomfortable. I recognize that pain is a symptom of a greater issue, but my immediate concern is getting rid of the pain."*

- ○ Functional Rehabilitation: *"I'm experiencing discomfort and realize it's because there is a deeper issue. I want to address the underlying cause of the pain so that I not only feel better now, but my body is more resilient in the future."*

- ○ Posture Correction: *"I recognize I have poor posture especially when I'm not paying attention. I would like better posture without having to constantly remind myself."*

- ○ Health and Wellness: *"I am concerned with my overall health and would like a plan that lowers stress and addresses nutrition."*

- ○ Maintenance: *"Currently I am feeling good, but I recognize the benefits to preventative care. Just like visiting the dentist for good oral health, I'm interested in regular care for the health of my body."*

- ○ Other (Please describe):____

  ____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name ______________________ ***Date*** ______________

1. *Describe your symptoms* ______________________

____

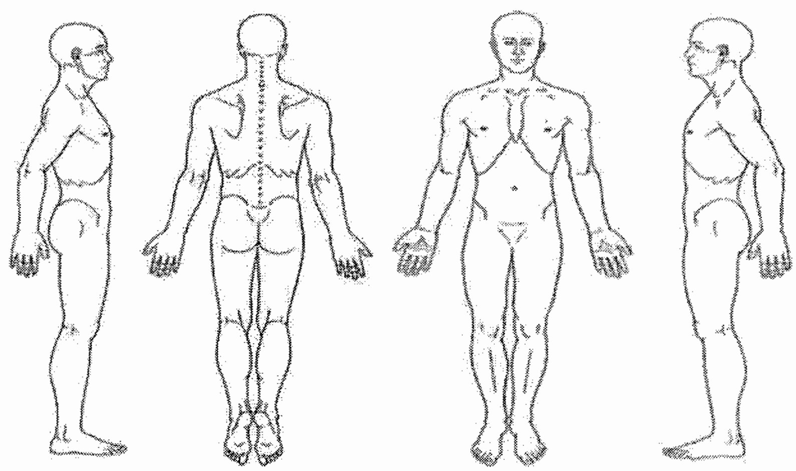
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. *How often do you experience your symptoms?*

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. *What describes the nature of your symptoms?*

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. *How are your symptoms changing?*

① Getting Better
② Not Changing
③ Getting Worse

5. *During the past 4 weeks:*

a. Indicate the average intensity of your symptoms

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

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. *During the past 4 weeks how much of the time has your condition interfered with your social activities?*
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. *In general would you say your overall health right now is...*

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. *Who have you seen for your symptoms?*

① No One ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* __________ ③ CT Scan *date:* __________
② MRI *date:* __________ ④ Other *date:* __________

9. *Have you had similar symptoms in the past?*

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. *What is your occupation?*

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height ___ ___ ___ (Feet, Inches) Weight ___ ___ ___ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	Condition
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	Condition
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

Past	Present	Condition
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

Past	Present	Condition
○	○	
○	○	
○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ____________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

____

____

List all the surgical procedures you have had and times you have been hospitalized:

____

____

Patient Signature ______________________________ ***Date*** ____________

Doctor's Additional Comments ______________________________

____

____

Doctors Signature ______________________________ ***Date*** ____________

If you are not experiencing any low back pain check the first box in each section (this form is required for all patients using insurance)

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

Patient's Name____ Number____________ Date____________________

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity
- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Section 6 – Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life
- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments____

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____________ %ADL

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

If you are not experiencing any neck pain check the first box in each section (this form is required for all patients using insurance)

Patient's Name____ Number_____________ Date_____________________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____________ %ADL______

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Informed Consent for Treatment at MindBody Med Seattle

Financial Policy
All patient balances are due at the time of service. This includes all deductibles, co-pays/co-insurance and cash balances.

Appointment Cancellations
Appointments are made in advance to accommodate your schedule. If you are unable to keep an appointment, notification is required at least 24 hours in advance so that another patient has the opportunity to use that appointment. If you do not give us at least 24 hours' notice for the missed appointment you will receive a charge as follows:

Massage: $85
Acupuncture: $45
Chiropractic: $20

Massage
Prescriptions and Referrals
Our office does require that the patient have a valid prescription or referral in order to bill insurances for massage therapy. If you do not have a valid prescription or referral at the time of service, full payment will be required at that time. You may be reimbursed some or all of the payment after we have received a valid prescription and billed your insurance.

Please read and sign the following: I will not withhold or delay payment if my insurance company denies payment for any of my charges. I will pay for the massage visit if I do not have a prescription for the massage at the time of service.

Guardian/Client Signature: __________________________________ Date: ____________

Chiropractic
The Material Risks Inherent in Chiropractic Adjustments:
As with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations and muscle strain, Horner's syndrome, diaphragmatic spasm, cervical myelopathy and costovertebral separations. Some types of manipulations of the neck have been associated with complications including stroke. Typically, the stroke is in progress and it is imperative to recognize the signs and symptoms, of which our practitioners have received extensive training to properly identify. In addition, some patients may feel associated stiffness and soreness following the first tew days of treatment.

The Probability of Those Risks Occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which is evaluated through the information in your history forms, your physical examination, and when necessary; x-ray studies. Stroke has been the subject of tremendous attention which has resulted in a thorough review of the risks; the retroactive 4-year study indicated that, at most, there is a chance of one per four million office visits to a health care office (including medical offices) of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination that help to identify whether you may be susceptible to that kind of injury.

Acupuncture
I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns an*d/o*r scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

By voluntarily signing below I agree that I have read, been read to, this consent to treatment. I have been told about the risks and benefits of the treatments provided. 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.

Patient Name (printed):____

Patient Signature:____Date:__________________

Parent/Guardian Signature:____Date:__________________