Lifestyle Medicine

INTAKE FORM

PATIENT INFORMATION

Name | Date of Birth | Gender

Health History + Medication List

Musculoskeletal
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Dislocations
- ☐ Fractures/Broken Bones
- ☐ Disc Herniation/Rupture
- ☐ Swelling
- ☐ Headaches

Change in Health
- ☐ Decreased Coordination
- ☐ Fever/Chills/Night Sweats
- ☐ Numbness/Tingling
- ☐ Nausea/Vomiting
- ☐ Appetite Changes
- ☐ Unexplained Weight Loss
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Fainting
- ☐ Hearing Loss
- ☐ Vision Changes
- ☐ Bowl/Bladder Changes
- ☐ Other: _____

Medical History
- ☐ Cancer
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Falling
- ☐ Stroke or ☐ TIA
- ☐ Seizures
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Gastrointestinal
- ☐ Angina/Chest Pain
- ☐ Pacemaker
- ☐ Thyroid Problems
- ☐ Communicable Disease (ie, HIV, Hep C)
  If yes, _____
- ☐ Under Stress
- ☐ Depressed
- ☐ Currently Pregnant
  If yes, due date: _____

List all current medications (including blood thinners):

_____

_____

_____

_____

List any previous injuries/surgeries in the past 3 years (ie, fractures, dislocations, surgeries):

_____

_____

Do you smoke?
☐ Yes ☐ No
If so, how much? _____

Would you like information on smoking cessation? ☐ Yes ☐ No

Do you drink alcohol?
☐ Yes ☐ No
If so, how much? _____

Injury date: _____
What makes your pain better or worse?
What treatments have you had for this injury? ☐ Chiropractor ☐ Massage ☐ Acupuncture ☐ Other: _____
Did they help? ☐ Yes ☐ No
Presently, are you getting: ☐ Better ☐ Worse ☐ Same
Have you had a similar injury before? ☐ Yes ☐ No
If yes, then when? _____
Is there anything else we should know about your medical history?

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Acknowledgement of Receipt of Privacy Practices (HIPAA)

I have read and fully understand Pinnacle Medical Wellness' Notice of Privacy Practices. I understand that Pinnacle Medical Wellness may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Pinnacle Medical Wellness will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Pinnacle Medical Wellness' Notice of Privacy Practices.

Responsible Party Initials _____

Insurance and Financial Policy

I hereby assign all medical benefits to which I am entitled to Pinnacle Medical Wellness in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. **I understand that Pinnacle Medical Wellness strongly encourages me to check my benefits with my insurance company.** Should I decide not to check my benefits, I understand that any fees accrued that the insurance company does not pay will be my responsibility. All balances are due within 30 days. A $25.00 fee will be charged to me for each incident that a check is returned to Pinnacle Medical Wellness with insufficient funds. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, all court costs, and balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said medical practices by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence. AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

Responsible Party Initials _____

Worker's Compensation Claims

Pinnacle Medical Wellness will bill your **open,** approved worker's compensation claim. Please be advised that in the event your claim is denied you are financially responsible for all charges. If you are receiving treatment at another facility at the same time you are being treated with Pinnacle Medical Wellness, you are responsible for keeping track of your authorized visits. In the event you exceed your authorized visits as a result of treatment at another facility, you will be financially responsible for any denied visits.

Responsible Party Initials _____

Scheduling & 24-Hour Notice

We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-hour notice. If you continually fail to attend your scheduled appointments and do not give us prior notification, you will be assessed a fee of **$40.00**. If you fail to show for two consecutive sessions, we will consider you discharged from our care at that time. If you are a L&I patient, your claim manager will be notified about the missed visits, and you will be discharged from care. A new referral from your referring physician will be required to reschedule any future appointments.

Responsible Party Initials _____

Non-Discrimination

Admission to our clinic is non-discriminatory for services rendered regardless of race, color, national origin, disability or age. Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 protect all clients who come to our clinic for services.

Responsible Party Initials _____

Patient's Name	Patient/Responsible Party's Signature	Date