NORDQUIST
Integrated Medicine

Patient #: _____

Date: ___/___/___

New Patient Intake Form

Always Confidential

YOUR INFORMATION

Name _____

Preferred Name_____

Address _____

City_____State_____Zip_____

Date of Birth___/___/___Sex: ☐Male ☐Female

Social Sec#_____ Age_____

Spouse _____

Referred by:_____

Google☐ Existing patient☐ MD☐ Attorney ☐

Facebook ☐ Other ☐ _____

Occupation _____

Employer _____

CONTACT INFORMATION

Cell Phone:(____) _____

Would you like text reminders for future appts?

Y☐ N☐

Email:_____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: _____

Number: _____

Relationship: _____

Would you like your Chiropractic records sent to another health professional?

☐MD ☐PT ☐ND ☐Other_____

Name:_____

Office:_____

INSURANCE INFORMATION

Insurance Coverage: _____

Group #: _____

Insurance ID #: _____

Relationship to Patient: _____

DOB: ____/____/____

Insured's Name: _____

CURRENT COMPLAINTS

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

STIFF=S

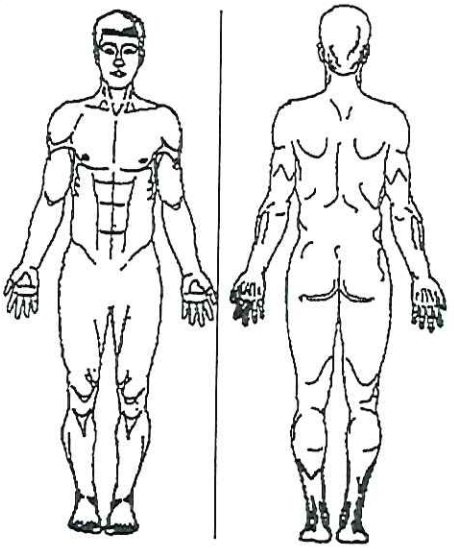
BURNING=B

TINGLING=T

PAIN=P

NUMB=N

ACHY=A



Pain Level: *(none)* 1 2 3 4 5 6 7 8 9 10 *(worst)*

Have you been treated for this before? ☐Yes ☐No

When was your last Chiropractic Treatment?

ACTIVITY INTOLERANCE

Are there any activities that you are having a hard time with because of your symptoms?

_____

_____

Previous Accidents / Surgeries

1. _____
2. _____
3. _____

Women Only

Is there any chance you are pregnant? Y☐N☐

If NO; I understand that x-ray can be harmful to a fetus. However, I believe that I am not pregnant, and my health concerns warrant the risk for any necessary x-rays.

Signature:_____

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Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

Location: _____ Severity on scale 1-10: _____

How long have you had this pain/problem? _____

Does the pain/problem occur at a specific time? _____

Context: where were you at the onset of this pain/problem? _____

Associated signs/symptoms: _____

What makes it worse? _____

What makes it better? _____

Any Radiating Pain? If yes, where? _____

Extremity complaints? _____

Past Medical History

Check "P" if you deal with the issue, check "F" if someone in your family deals with the issue.

P	F		P	F		P	F	
		Alcoholism			Diabetes - on insulin			Joint Pain
		Allergies/hay fever			Dialysis			Kidney Infection
		Anemia			Epilepsy or Seizures			Kidney Stone
		Anxiety			Fracture			Lung Disease
		Arthritis			Gastrointestinal Disease			Migraine
		Asthma			GERD			Multiple Sclerosis
		Bleeding Tendency			Glaucoma			Obesity
		Blocked Blood Vessels			Headaches			Osteoporosis
		Blood Transfusion			Heart Attack			Pneumonia
		Cancer			Heart Disease			Rheumatic Fever
		Chronic Kidney Disease			Heart Murmur			Rheumatoid Arthritis
		Cirrhosis or Liver Disease			Hernia			STD
		Colitis			High Blood Pressure			Stomach Ulcer
		Congestive Heart Failure			High Cholesterol			Stroke
		COPD or Emphysema			Hyperlipidemia			Suicide Attempt
		Crohn's Disease			Hyperthyroidism			Thyroid Disease
		Depression			Hypothyroidism			Other:
		Diabetes - not on insulin			Irregular Heart Rhythm			

Medications: (include non-prescriptions)

_____

_____

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs: Never: _____ Type/frequency: _____

Patient Signature: _____ **Date:** _____

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DR. JON NORDQUIST, D.C, DAAMLP

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email: dmordquist@hotmail.com
www.nordquistchiropractic.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

By signing this form, I authorize you (Nordquist Integrated Medicine) to release confidential health information about me, by releasing a copy of my medical records or a summary/narrative of my protected health information for the purpose of insurance appeals, requests from my attorney, another requesting physician's office, the Department of Labor and Industries or a personal request from myself.

Patient Name (Printed):_____ Date of Birth:

The information you may release subject to this release form is as follows: _____

- ☐ Complete Records
- ☐ History and Physical
- ☐ Care Plan
- ☐ Appeal
- ☐ Progress Notes
- ☐ Treatment Record
- ☐ Other (please specify): _____

Our clinic will not release your protected healthcare information other than that stated above.

Patient Signature:_____ Date: ____/____/____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Nordquist Integrated Medicine** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

(The Notice of Privacy Practices provided by **Nordquist Integrated Medicine** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Nordquist Integrated Medicine** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Nordquist Integrated Medicine, 9909 168th ST E # 102, Puyallup, WA 98375**

With this consent, **Nordquist Integrated Medicine** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Nordquist Integrated Medicine** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, **Nordquist Integrated Medicine** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Nordquist Integrated Medicine** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Nordquist Integrated Medicine** to use and disclose my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Nordquist Integrated Medicine** may decline to provide treatment to me.

Patient Name _____ Signature _____ Date _____

Assignment of Benefits

I hereby irrevocably assign and convey to **Nordquist Integrated Medicine,** as my designated authorized representative, all insurance benefits, if any, to which otherwise are payable to me for services rendered by the provider listed above. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to **Nordquist Integrated Medicine** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.
I intend by this assignment and designation of authorized representative to convey to **Nordquist Integrated Medicine** all my rights to claim (or place a lien on) the medical benefits related to services provided by them, including rights to any settlement, insurance or applicable legal or administrative remedies. **Nordquist Integrated Medicine** or their representative is given the right, by me to: (1) obtain information regarding the claim to the same extent as me. (2) submit evidence. (3) make statements about facts or law. (4) make any requests including providing or receiving notice of appeal proceedings. (5) participate in any administrative or judicial action and pursue claims or actions against any liable party.

Authorization to Release Information
I hereby authorize **Nordquist Integrated Medicine** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from **Nordquist Integrated Medicine** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

Patient Name _____ Signature _____ Date _____