



2946 Eastlake Avenue East • Seattle, WA 98102
206.632.5500 • 206.632.5601 fax
www.alliancehealingarts.com

Alliance New Patient Form

Today's Date _____

Date of Birth _____ Age _____
Gender **M** or **F**

Name _____

Address _____

City, State, Zip _____

Home Phone # () _____ Email Address _____
 Work Phone # () _____
 Cell Phone # () _____ Driver's License # _____ SSN # _____

(Please check preferred communication method)

Emergency Contact _____
Relationship _____

Home Phone # () _____
Work Phone # () _____
Cell Phone # () _____

Referred By _____

Your Employer Name _____
Address _____
City, State, Zip _____

Occupation _____
Type of Work _____

Marital Status _____
Spouse/Partner Name _____
Spouse/Partner Age _____

Spouse/Partner Employer _____
Type of Work _____

Spouse/Partner Home Phone # () _____ # of Children, if any _____
Contact Info Cell Phone # () _____ Names of Children (age) _____
(Please check if child has _____
posture problems or scoliosis) _____

If you are currently under the care of a health care practitioner for any condition/injury, please provide:

Practitioner Name _____
Description _____ Phone # () _____

Please list any concurrent therapies: _____

Insurance information (private, group, automobile, or worker's comp):

Insurance Company _____
Address _____ Phone # () _____
City, State, Zip _____
Claim/Policy/ID# _____

Medicare information (if applicable):

Insurance Company _____
Address _____ Phone # () _____
City, State, Zip _____
Claim/Policy/ID# _____

Tell me about the purpose of this visit: (Please provide as much information as you can)

Reason for this visit:

If related to an accident or work injury, please describe:

If this visit is related to an accident or injury, please provide date of accident/injury: _____

If this visit is related to an automobile accident, please provide, if applicable:

Attorney Name _____

Phone # () _____

When did this condition first begin/when did you first notice it?

Circle the locations of symptoms, labeling pain, stiffness/tightness, scars, swelling, spasms, etc. Also label injuries (previous or present):

What activities aggravate your symptoms?

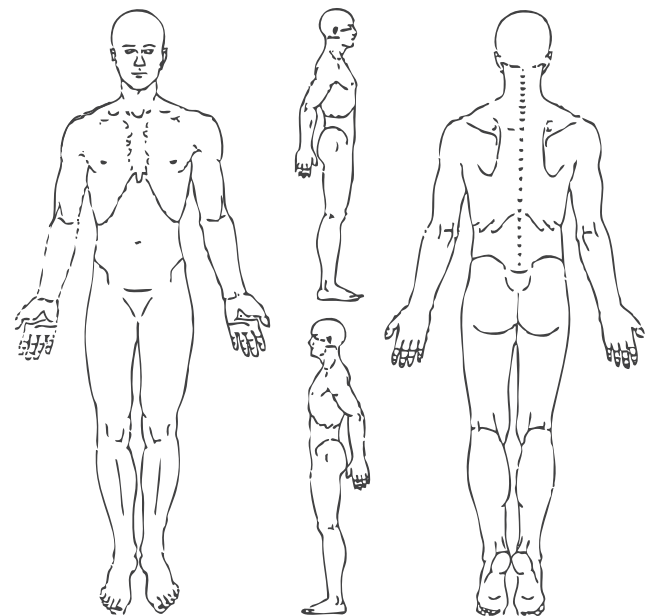
Is there anything that relieves your symptoms?

Have you experienced this condition before?

Who have you seen for this condition?

What did they do?

How did you respond?



Frequency of complaint:

- () 100% of the time () 75% of the time
() 50% of the time () 25% of the time

Intensity of complaint:

- () Annoyance but no effect on activity
() Tolerable with some impairment to activity
() Tolerable with marked impairment to activity
() Intolerable and can not perform any activities

Does the condition interfere with your () work () sleep () other, please describe: _____



2946 Eastlake Avenue East • Seattle, WA 98102
 206.632.5500 • 206.632.5601 fax
 www.alliancehealingarts.com

Alliance New Patient Form

Tell me about your lifestyle:

Appetite (check): () Low () Moderate () High

Thirst for water: _____ glasses per day

- | | |
|--------------------------------|---|
| () Coffee: _____ cups per day | () Alcohol: _____ glasses per day / week / month |
| () Soda: _____ cups per day | () Marijuana |
| () Artificial sweetener | () Other drugs |
| () Crave sugar | () Stress |
| () Salty foods | () Occupational Hazards |
| () Tobacco: _____ # per day | |

List any surgeries, injuries/accidents, major illnesses or other hospitalizations within the last 5 years or for conditions still affecting you:

Regular Exercise: (type and frequency)

List vitamins/supplements taken in the last 2 months:

Average Daily Menu

Morning: _____
 AM Snack: _____
 Noon: _____
 PM Snack : _____
 Evening: _____
 Evening Snack: _____

List pharmaceuticals taken in the last 2 months:

Tell me about your health:

- | | | |
|--|---|---|
| <p>General</p> <p>() Poor appetite
 () Heavy appetite
 () Strongly like cold drinks
 () Strongly like hot drinks
 () Recent weight loss/gain
 () Poor sleep
 () Heavy sleep
 () Dream-disturbed sleep
 () Fatigue
 () Lack of strength
 () Body heaviness
 () Cold hands or feet
 () Poor circulation
 () Shortness of breath
 () Fever
 () Chills
 () Night sweats
 () Sweat easily
 () Muscle cramps
 () Vertigo or dizziness
 () Bleed or bruise easily
 () Peculiar taste; describe:

 _____</p> | <p>Head, Eyes, Ears, Nose, Throat</p> <p>() Glasses/contacts
 () Eye strain
 () Eye pain
 () Red eyes
 () Itchy eyes
 () Spots in eyes
 () Poor vision
 () Blurred vision
 () Night blindness
 () Glaucoma
 () Cataracts
 () Teeth problems
 () Grinding teeth
 () TMJ
 () Facial pain
 () Gum problems
 () Sores on lips or tongue
 () Dry mouth
 () Excessive saliva
 () Sinus problems
 () Recurrent sore throat
 () Excessive phlegm; describe color: _____
 () Swollen glands
 () Lumps in throat</p> | <p>Head, Eyes, Ears, Nose, Throat (cont.)</p> <p>() Enlarged thyroid
 () Nose bleeds
 () Poor hearing
 () Earaches
 () Headaches
 () Migraines
 () Concussions
 () Other head or neck problems:

 _____</p> <p>Respiratory</p> <p>() Difficulty breathing when lying down
 () Shortness of breath
 () Tight chest
 () Asthma/wheezing
 () Cough: wet or dry, thick or thin; color of phlegm _____
 () Coughing blood
 () Pneumonia</p> |
|--|---|---|



2946 Eastlake Avenue East • Seattle, WA 98102
 206.632.5500 • 206.632.5601 fax
 www.alliancehealingarts.com

Alliance New Patient Form

Tell me about your health: (cont.)

Cardiovascular

- High blood pressure
- Blood clots
- Low blood pressure
- Fainting
- Chest pain
- Shortness of breath
- Difficulty breathing
- Tachycardia
- Heart palpitations
- Phlebitis
- Irregular heartbeat

Gastrointestinal

- Nausea
- Vomiting
- Acid regurgitation
- Gas
- Hiccup
- Bloating
- Bad breath
- Diarrhea
- Constipation
- Laxative use
- Black stools
- Bloody stools
- Mucous in stools
- Intestinal pain/cramping
- Itchy anus
- Burning anus
- Rectal pain
- Hemorrhoids
- Anal fissures
- Bowel movements:
 Frequency: _____
 Color: _____
 Texture/form: _____
 Odor: _____

Musculoskeletal

- Neck/shoulder pain
- Muscle pain
- Upper back pain
- Lower back pain
- Joint pain
- Rib pain
- Limited range of motion
- Limited use
- Other (describe):

Skin & Hair

- Rashes
- Hives
- Ulcerations
- Eczema
- Psoriasis
- Acne
- Dandruff
- Itching
- Hair loss
- Change in hair/skin texture
- Fungal infections
- Other (describe):

Neuropsychological

- Seizures
- Numbness
- Tics
- Poor memory
- Depression
- Anxiety
- Irritability
- Easily stressed
- Abuse survivor
- Considered/attempted suicide

Neuropsychological (cont.)

- Seeing a therapist
- Other (describe):

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Venereal disease
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stone
- Impotence
- Premature ejaculation
- Nocturnal emission

Gynecology

- Age menses began: _____
- Length of cycle
(day 1 to day 1): _____
- Duration of flow: _____
- Irregular periods
- Painful periods
- PMS
- Vaginal discharge; color
- Vaginal sores
- Vaginal odor
- Clots
- Breast lumps
- # of pregnancies: _____
- # of live births: _____
- # of premature births: _____
- Age at Menopause: _____
- Date of last PAP: _____
- Date of last period
begun: _____

Name any other symptoms and/or additional remarks/comments:

PLEASE FILL OUT ALL THE FOLLOWING SECTIONS THAT ARE APPLICABLE TO YOUR VISIT WITH US. THANK YOU.



2946 Eastlake Avenue East • Seattle, WA 98102
206.632.5500 • 206.632.5601 fax
www.alliancehealingarts.com

CHIROPRACTIC CARE

1) Tell me about your experience with chiropractic:

Have you seen a chiropractor before (check)? () Yes () No

If yes, who?

When?

Reason for visit:

How did you respond?

Posture plays an important role in your overall health.

Are you aware of any poor postural habits in yourself or your family? _____

2) Tell me about your spinal health:

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shun). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened distorted posture. Posture distortions have many serious and adverse affects on your overall health.

The most common and detrimental postural distortion is called Forward Head Syndrome (a hunched forward posture starting in the neck and progressively moving down your spine weakening the entire body. Have you have been told or feel like you carry your head forward? () Yes () No

Cervical Spine (Neck): Postural distortions from subluxations (causing Forward Head Syndrome), in your neck will weaken the nerves in your arms, hands, and head. Do you experience any of the following:

- () Neck pain
- () Pain in your shoulders/arms/hands
- () Numbness/tingling in arms/hands
- () Coldness in hands/feet
- () Sinusitis
- () Headaches
- () Dizziness
- () Visual disturbances
- () Weakness in grip
- () Allergies/Hay Fever
- () Recurrent colds/flu
- () Hearing disturbances
- () Thyroid conditions (explain): _____

Thoracic Spine (Upper Back): Postural distortions, from subluxations in your upper back (resulting from Forward Head Syndrome), will weaken the nerves to the heart and lungs. Do you experience any of the following:

- () Heart palpitations
- () Heart murmurs
- () Tachycardia
- () Heart attacks/Angina
- () Recurrent lung infections/bronchitis
- () Asthma/wheezing
- () Shortness of breath
- () Pain on deep inhalation/exhalation

Thoracic Spine (Mid Back): Postural distortions, from subluxations in your mid back, will weaken the nerves into your ribs/chest and upper digestive track. Do you experience any of the following:

- () Mid back pain
- () Pain into your ribs/chest
- () Indigestion
- () Heartburn
- () Nausea
- () Ulcers/Gastritis
- () Hypoglycemia
- () Tired/irritable after eating or when you haven't eaten for a while



2946 Eastlake Avenue East • Seattle, WA 98102
206.632.5500 • 206.632.5601 fax
www.alliancehealingarts.com

CHIROPRACTIC CARE

2) Tell me about your spinal health: (cont.)

Lumbar Spine (Low Back): Postural distortions, from subluxations in your low back, will weaken the nerves into your legs/feet and pelvic organs. Do you experience any of the following:

- Pain into your hips/legs/feet
- Numbness/tingling in your legs/feet
- Frequent/difficulty urinating
- Coldness in your legs/feet
- Sexual dysfunction
- Constipation/Diarrhea
- Recurrent bladder infections
- Weakness/injuries in hips/knees/ankles
- Muscle cramps in your legs/feet
- Menstrual irregularities/cramping (women)

Name any other symptoms and/or additional remarks/comments:

3) Authorization of Care:

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for services provided, and agree to ensure full payment of all charges.

The doctor will not be held responsible for any health conditions or diagnosis which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs. Also, if I terminate my care prematurely, I understand all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits directly to the Alliance for all services rendered.

Signature

Today's Date

Parent/Guardian



2946 Eastlake Avenue East • Seattle, WA 98102
206.632.5500 • 206.632.5601 fax
www.alliancehealingarts.com

MASSAGE TREATMENT

1) Tell me about your experience with massage:

Have you had a massage before (check)? () Yes () No When? _____

Reason for visit:

How did you respond?

2) Please check all that apply today:

- () Contact Lens Please describe: Hard or Soft
- () Infection Please describe:
- () Inflammation/Swelling Please describe:
- () Fever Please describe:
- () Communicable Illness Please describe:

3) What areas would you like to concentrate on:

Symptom/Area	Pain Level (0 - 10)	Duration of Pain/ How long has this pain bothered you?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name any other symptoms and/or additional remarks/comments:

4) Release:

Because a massage therapist must be aware of any existing physical conditions, I have listed all my known medical conditions and physical limitations and will inform the massage therapist in writing of any change in my health.

I understand massage therapists do not diagnoses illness, disease, or any other medical, physical, or emotional disorder; nor do they perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment that I have.

Unless arrangements are made beforehand, payment is due at the time of appointment. The hourly rate is \$100. A discount of \$20 will be given if payment is received at the time of service.

I agree to give 24 hours notice if I must cancel my appointment. I agree to pay a \$80 cancellation fee to the massage therapist for missed appointments not canceled within 24 hours.

Signature

Today's Date

Parent/Guardian

PLEASE CONTINUE ON AND FILL OUT ALL THE FOLLOWING SECTIONS THAT ARE APPLICABLE TO YOUR VISIT WITH US. THANK YOU.



2946 Eastlake Avenue East • Seattle, WA 98102
206.632.5500 • 206.632.5601 fax
www.alliancehealingarts.com

ACCUPUNCTURE TREATMENT

1) Tell me about your experience with acupuncture: Are you new to acupuncture (check)? () Yes () No
Have you ever tried Chinese herbal medicine? () Yes () No

Reason for visit: (Please describe your condition at its worst.)

2) Please list any concurrent therapies: _____

3) Consent:

I, the undersigned, hereby authorize Julie Booker of Acupuncture at Alliance to perform the following specific procedures:

- () ACUPUNCTURE—Insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.
- () HERBAL PRESCRIPTIONS—May be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given internally or as a wash. Herbal formulas may include shell, mineral, or animal materials. If you do not want animal-based materials in your formula, let Julie know.
- () CUPPING—Cups made of glass, bamboo, or other materials are placed on the skin creating a vacuum effect involving heat or other devices. Mild bruising may occur.
- () PLUM BLOSSOM OR STEVEN STAR HAMMER—Light tapping on an area of the skin with a small sterile hammer, which has seven points.
- () GUA SHA—Rubbing or scraping an area of the body with a round instrument. Mild bruising may occur.
- () MOXA—Indirect burning on an acupoint using a stick, string, or ball moxa to create a warming effect.

I recognize the potential benefits and risks of these procedures include:

Potential Benefits:

- Drugless relief of systems
- Improved balance of bodily energies which may lead to prevention or elimination of presenting problem
- Strengthened body constitution

Potential Risks:

- Discomfort, pain, infection, blistering at site of moxa use
- Temporary discoloration of skin
- Nausea, loose bowel movements, abdominal cramping
- Aggravating of symptoms existing prior to acupuncture treatment
- Other potential unforeseen consequences

With this knowledge, I voluntarily consent to the above procedures, realizing that there are no guarantees given by Acupuncture at Alliance or Julie Booker regarding the cure or improvement of my condition.

I hereby release Acupuncture at Alliance, Alliance Chiropractic, and Julie Booker from any and all liability, which may occur in connection with the abovementioned procedures, except for the failure to perform the procedures with the appropriate medical care. I understand I am free to withdraw my consent and to discontinue my participation in these procedures at any time.

Signature

Today's Date

Parent/Guardian

PLEASE CONTINUE ON. REVIEW AND SIGN THE PROFESSIONAL FEE SCHEDULE FOR ALLIANCE SERVICES. THANK YOU.



2946 Eastlake Avenue East • Seattle, WA 98102
 206.632.5500 • 206.632.5601 fax
 www.alliancehealingarts.com

Alliance New Patient Form

PROFESSIONAL FEE SCHEDULE

CHIROPRACTIC

Consultation	No Charge
Chiropractic Examination	\$50 to \$200
Chiropractic Office Visits (averages)	\$45 to \$85
Chiropractic Radiographic Studies (averages)	\$40 to \$250

MASSAGE & ACUPUNCTURE

Consultation	No Charge
1 Hr. Massage Treatment	\$80 to \$100
1 Hr. Acupuncture Treatment	\$80 to \$150

(All fees are standard and primarily based on our professional association's guidelines)

MASSAGE & ACUPUNCTURE CANCELLATION POLICYWe require a 24-hour cancellation notice for all scheduled massage and acupuncture appointments. Failure to give us 24-hour notice will result in a full service cancellation fee of \$80.00 (per session). If you are 15 minutes past your appointment time and have not called to let us know, your appointment time will be forfeited and can be given to someone else.

This form has been prepared for your convenience and information. We offer several methods of payment for your needs. Please read carefully and choose the plan which is appropriate. This information will enable us to better serve you and avoid misunderstandings in the future. If special arrangements are necessary, please consult with the Accounts Manager. Our main concern is your health and well-being, and we will do our best to help you.

PLAN # 1 – CASH: Fees are to be paid at the time services are rendered.

CHIROPRACTIC: For those wishing to participate in corrective care, we have several plans which cover a set amount of visits for a monthly fee. Payment for the month will be due on the 1st and the 15th of each month. Details of each plan are disclosed on a separate sheet. We can determine together which plan is appropriate for your treatment recommendations after an exam has been performed. If special arrangements are needed, please consult with the Accounts Manager.

PLAN # 2 – HEALTH INSURANCE: If you have health insurance which covers Chiropractic Care and/or Massage Therapy and/or Acupuncture and you would like us to, we will bill your insurance directly. As a courtesy to you, we will also verify your coverage and benefits, if provided with your identification card. Until we have the complete, necessary information to verify your coverage, you will be required to make payment for your account. Any co-payments or non-covered amounts are due at the time of service. Once billing has begun, we will keep you informed about any deductible, copayments and services not covered for which you will be responsible for. If you need a referral from your primary care provider to be eligible for Chiropractic Care and/or Massage Therapy and/or Acupuncture, we can assist you by completing a referral request based on the findings of your examination. If you do not already have a referral, you may be responsible for today's visit charges.

PLAN # 3 – INDUSTRIAL INJURY: You need to report your accident to your employer, bring in the necessary insurance information (is your company self-insured?), and sign industrial accident forms for billing by your second visit. We will bill your insurance directly. Industrial Injury claims will cover up to 6 1-hour massage therapy treatments. Additional treatments are subject to request from the provider giving service. Acupuncture is NOT a covered service for industrial injury claims.

PLAN # 4 – AUTOMOBILE INJURY: Please provide the accident report, your car insurance information, the liable party's auto insurance, and the name of your attorney, if applicable. Until your coverage and benefits are verified, you will be required to make payment for your account. Once verified, the insurance will be billed directly. In some cases, the final payment check may come to you; if this happens, you are required to bring the check to us.

PLAN # 5 – MEDICARE (CHIROPRACTIC ONLY): Medicare requires an examination and x-rays to demonstrate the need for chiropractic care, but they do not cover this expense. They do cover 80% of the charges for adjustments after an annual deductible is met. If you have secondary insurance, they usually cover the 20% that Medicare does not. Some insurance companies cover your Medicare deductible, and some do not cover anything if Medicare pays the entire 80%. We will need your Medicare and secondary identification cards to verify your exact coverage with both plans. Please make sure that Medicare has your secondary insurance information otherwise they will not forward claims to your secondary insurance.

I fully understand the fee schedule as explained above and qualify for plan_____. I understand that regardless of any insurance plan, I am ultimately responsible for my account

Signature

Today's Date

Printed Name