New Patient Information

How did you hear about us? _____

Patient Information

Name _____ Date of Birth _____

Street Address _____

City _____ Zip _____

Primary Phone (H or W) _____ Cell Phone _____

Email _____

Okay to leave message on the: ☐ Phone ☐ Email

Insurance Information

Insurance Company _____

Primary Insured's Name _____ Their Birthdate: _____

Relationship to Primary Insured Person _____ Co Pay $ _____

Emergency

Emergency Contact Person _____

Relationship _____ Phone _____

Medical Information

List of Medications _____

Allergies _____

Problem List _____

Past Medical History _____

Select Any and All That Apply:

- ☐ Prostate Cancer
- ☐ Deep Vein Thrombosis
- ☐ Currently Pregnant
- ☐ Polycythemia vera
- ☐ Breastfeeding

Do You Smoke? _____ How Many Every Day/Week? _____

For office Use Only		
	Neck _____ Arm _____ Chest _____	Ht _____ Wt _____ T _____ P _____
	Waist _____ Hips _____ Thigh _____	BP _____ Goal _____

Seattle Wellness Programs

Patient Consent Form

Effective September 2012

Patient's First Name	M.I.	Patient's Last Name	Date of Birth

Notice of Privacy Practices for Protected Health Information

I have been given a copy of the Seattle Wellness Programs Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify the office in writing of any restrictions to my patient file. Forms are available in the office.

Confidential Communications

I hereby consent and grant permission for practitioners employed by the Seattle Wellness Programs to discuss my medical treatment with my primary care physician, physical therapist, occupational therapist, hospital and/or rehabilitation staff, relating to my care and treatment (if necessary). I also understand that it is my responsibility to notify the office at Seattle Wellness Programs in writing of any restrictions to my patient file. Forms are available in the office.

Office Procedures & Consent to Treat

I hereby give consent to Seattle Wellness Programs to provide treatment and service(s) the assigned provider may deem necessary. I understand that I am responsible for payment of charges and that payment is due at the time of service, or I hereby assign insurance benefits to be paid directly to Seattle Wellness Programs for professional fees. I understand that I am responsible for charges not covered by my insurance policy. I understand that any amounts which are 90 days past due could be eligible for potential collections and turned over to a collection agency, unless prior arrangements have been made with Seattle Wellness Programs. Collection agency fees are recognized to be my (the patient/responsible party(s)) responsibility. I understand that I am responsible for a fee of $40 for any returned check.

Release of Information & Authorization

I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document. I understand that this original or facsimile will be placed in my patient file to be kept at the medical provider's office. I hereby authorize any practitioner examining and/or treating me, to release to any third party (such as an insurance company or governmental agency) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a lifetime release of information unless I have placed restrictions in my patient file and have completed the necessary forms. I hereby consent and authorize Seattle Wellness Programs to file medical claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me.

Patient's Signature	**Patient's Printed Name**	**Date Signed**
Representative's Signature	Representative's Printed Name	Date Signed

Representative: Please describe your authority to act on the patient's behalf: _____

Seattle Wellness Programs
4744 41st Ave SW, Ste 104
Seattle, WA 98116
(206) 388-2929

Effective February 12, 2013

To Our Patients:

Please call us if you need to cancel any appointment that you have with our office. If we do not receive a phone call or other notice to cancel twenty-four hours prior to your appointment, we may bill you for time lost at a rate of $50.00 per incident.

I'm sure you understand there are other patients who would like to schedule with us. It would be courteous and greatly appreciated if you let us know your change of plans so we can make your appointment time available to others on our waiting list.

Thank you for your understanding and cooperation.

Dr. Elissa J. Mullen

I understand the policy that Dr. Mullen has stated above and by signing this page I acknowledge that I am subject to this policy and may pay a fee if I do not cancel my appointment with at least 24 hours notice to Dr. Mullen's office.

Patient's Signature _____ Date _____

PATIENT MEDICAL INFORMATION

Name: _____ Date of Birth: __ / __ / __ Age: _____ Date: _____
Street: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____ Email: _____
Sex: M F Height: _____ Weight: _____ Weight *Last* Year: _____ Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Doctor's Name: _____

Your Sleep Complaints: What are your current and main sleep complaints? Check all that apply.

☐ Loud snoring ☐ Pauses in breathing while asleep ☐ Wake up gasping for breath
☐ Wake up tired ☐ Difficulty falling asleep ☐ Difficulty staying asleep
☐ Wake up too early ☐ Excessive movement in sleep ☐ Excessive daytime sleepiness
☐ Unusual or unwanted behaviors during sleep (explain): _____

_____

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations? Circle the number that best describes your likelihood of dozing off or falling asleep during the following situations. Even if you have not been in these situations recently, try to imagine how you would behave.

0 = *No* chance of dozing 2 = *Moderate* chance of dozing
1 = *Slight* chance of dozing 3 = *High* chance of dozing

1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting, inactive in a public place	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch (without alcohol)	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3
Total Epworth Score				

Sleep Patterns & Environment: Please use the table on the right to answer questions 1-9, then proceed to question 10.

WORK DAYS	OFF-DAYS & HOLIDAYS

1. What is your typical bedtime?
2. How long does it take you to fall asleep?
3. Average number of hours slept (exclude time spent awake in bed):
4. Average number of awakenings per night:
5. After going to bed, number of trips to the bathroom:
6. Number of naps during the day:
7. Number of nights per week that alcohol was used before bed:
8. Number of nights per week a sleeping aid (R_x or OTC) is used:
9. Number of days per week you feel sleepy, tired or fatigued:
10. Please list any sleep aids (R_x or OTC) you are currently using or have used.
    Name: _____ Dosage: _____
    Name: _____ Dosage: _____
11. Please check all sleep disturbances that apply to you.
    ☐ Pain ☐ Anxiety ☐ Spouse ☐ Snoring ☐ Pets
    ☐ Breathing ☐ Coughing ☐ Worrying ☐ Restless Legs ☐ Temperature
12. Is your room conducive to sleep? (cool, quiet, comfortable mattress, dark) _____

_____

Berlin Questionnaire: Please mark your answers clearly.

1. Do you snore?
   ☐ Yes ☐ No ☐ Don't know
2. How loud is your snoring?
   ☐ As loud as breathing ☐ As loud as talking ☐ Louder than talking ☐ Can be heard in next room
3. How frequently do you snore?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or never
4. Does your snoring bother other people?
   ☐ Yes ☐ No ☐ Don't know
5. Has anyone ever noticed you stop breathing in your sleep?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or never
6. How often do you feel tired after sleeping?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or never
7. Do you feel tired during your waking time?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or never
8. How often do you nod off or fall asleep while driving?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or never
9. Do you have high blood pressure?
   ☐ Yes ☐ No ☐ Don't know
10. Is your BMI over 30?
    ☐ Yes ☐ No ☐ Don't know

FOR OFFICE USE ONLY:
Category I _____ Category III _____
Category II _____ High Risk / Low Risk

Current Medication List: Please list all medications you are currently taking. Attach a separate sheet if necessary.

MEDICATION	REASON FOR TAKING	DOSAGE	FREQUENCY

Do you use supplemental oxygen? ☐ YES ☐ NO If yes, when & what amount? ☐ PRN ☐ 24/7 at ___ l/min

Medical History: Do you currently or have you ever had any of the following conditions? Answer each question.

Tuberculosis	☐ YES ☐ NO	Lung Disease	☐ YES ☐ NO	Heartburn	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Asthma	☐ YES ☐ NO	Hiatal Hernia	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO	Arthritis	☐ YES ☐ NO
Heart Murmur	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO	Fibromyalgia	☐ YES ☐ NO
Sinusitis/Congestion	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Head Injury	☐ YES ☐ NO
Diabetes (Blood Sugar High / Low)	☐ YES ☐ NO	Frequent or Severe Headaches	☐ YES ☐ NO	Do you sleep on more than one pillow?	☐ YES ☐ NO
Deviated Nasal Septum / Polyps	☐ YES ☐ NO	Chronic Nasal Discharge	☐ YES ☐ NO	Seizure Disorder or Epilepsy	☐ YES ☐ NO
Irregular Heartbeat	☐ YES ☐ NO	Stomach Disease	☐ YES ☐ NO	Parkinson's Disease	☐ YES ☐ NO
Heart Attack	☐ YES ☐ NO	Depression/Anxiety	☐ YES ☐ NO	Chronic Muscular Pain	☐ YES ☐ NO
COPD	☐ YES ☐ NO	Peptic Ulcer	☐ YES ☐ NO	Pain in Joints	☐ YES ☐ NO
Other Heart Disease	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Enlarged Tonsils/Adenoids	☐ YES ☐ NO
Intestinal Disease	☐ YES ☐ NO	Dentures	☐ YES ☐ NO	Personality Changes	☐ YES ☐ NO
Bipolar Disorder	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO	Memory Loss	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Heart Enlargement	☐ YES ☐ NO	Stroke	☐ YES ☐ NO

Other medical problems which may impair sleep: _____

Operations & Hospitalizations: Please list all operations you have had or will have.

_____

_____