

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: <input type="checkbox"/> Phone <input type="checkbox"/> 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: <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Polycythemia vera <input type="checkbox"/> Deep Vein Thrombosis <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Currently Pregnant	
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.

- | | | |
|--|---|---|
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Pauses in breathing while asleep | <input type="checkbox"/> Wake up gasping for breath |
| <input type="checkbox"/> Wake up tired | <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Wake up too early | <input type="checkbox"/> Excessive movement in sleep | <input type="checkbox"/> Excessive daytime sleepiness |
| <input type="checkbox"/> 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.

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 (Rx or OTC) is used:
9. Number of days per week you feel sleepy, tired or fatigued:
10. Please list any sleep aids (Rx or OTC) you are currently using or have used.

WORK DAYS	OFF-DAYS & HOLIDAYS

Name: _____ Dosage: _____
 Name: _____ Dosage: _____

11. Please check all sleep disturbances that apply to you.
- | | | | | |
|------------------------------------|-----------------------------------|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Spouse | <input type="checkbox"/> Snoring | <input type="checkbox"/> Pets |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Worrying | <input type="checkbox"/> Restless Legs | <input type="checkbox"/> 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 | <input type="checkbox"/> YES <input type="checkbox"/> NO | Lung Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heartburn | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO | Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hiatal Hernia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Arthritis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Fibromyalgia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sinusitis/Congestion | <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Head Injury | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes (Blood Sugar High / Low) | <input type="checkbox"/> YES <input type="checkbox"/> NO | Frequent or Severe Headaches | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you sleep on more than one pillow? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Deviated Nasal Septum / Polyps | <input type="checkbox"/> YES <input type="checkbox"/> NO | Chronic Nasal Discharge | <input type="checkbox"/> YES <input type="checkbox"/> NO | Seizure Disorder or Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Irregular Heartbeat | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stomach Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Parkinson's Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Attack | <input type="checkbox"/> YES <input type="checkbox"/> NO | Depression/Anxiety | <input type="checkbox"/> YES <input type="checkbox"/> NO | Chronic Muscular Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| COPD | <input type="checkbox"/> YES <input type="checkbox"/> NO | Peptic Ulcer | <input type="checkbox"/> YES <input type="checkbox"/> NO | Pain in Joints | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Other Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Glaucoma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Enlarged Tonsils/Adenoids | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Intestinal Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Dentures | <input type="checkbox"/> YES <input type="checkbox"/> NO | Personality Changes | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bipolar Disorder | <input type="checkbox"/> YES <input type="checkbox"/> NO | Shortness of Breath | <input type="checkbox"/> YES <input type="checkbox"/> NO | Memory Loss | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Anemia | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Enlargement | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Other medical problems which may impair sleep: _____

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