1900 116th Avenue NE Ste. 200
Bellevue, WA 98004
(425) 243-7966

PATIENT INTAKE FORM

PATIENT INFORMATION

1. Today's Date ______________________________
2. Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _______
3. **Name** ______________________________ ____________
   (FIRST NAME) (MIDDLE INITIAL)
   ____
   (LAST NAME)
4. SSN# ____________-____________-______________
5. Gender: ☐ M ☐ F
6. **Date of Birth** _________/_________/_________
7. Occupation ______________________________
8. Employer ______________________________
9. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
10. Spouse's Name ______________________________
11. How did you hear about us?
    - ☐ Patient Referral, Who? ______________________
    - ☐ Walk-In ☐ Event ☐ Google/Bing Maps
    - ☐ Internet (Google, Yelp, Facebook)
    - ☐ Other ______________________________

CONTACT INFORMATION

1. Email ______________________________________
2. Address ______________________________________
   ____________________ ______ __________
   (CITY) (STATE) (ZIP)
3. Which number would you prefer we contact?
   - ☐ Home Phone (_______) __________-______________
   - ☐ Work Phone (_______) __________-______________
   - ☐ Cell Phone (_______) __________-______________
   - Cell Carrier ________________________
4. Appointment reminder option:
   ☐ Email ☐ Text Message ☐ Both
5. **In case of emergency, contact**
   Name ______________________________________
   Phone (_____) __________-______________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company provided and assign directly to Dr. Stephanie Woo all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the provided insurance company(ies) and their agents for all purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
PRINT name of Patient, Parent, Guardian or Personal Representative

____ ← SIGN HERE
SIGNATURE of Patient, Parent, Guardian or Personal Representative

__________/__________/__________
DATE

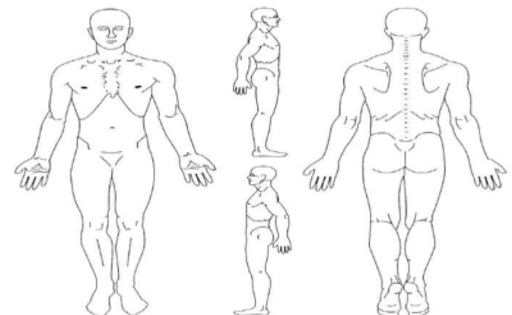
ACCIDENT INFORMATION

1. Is your condition related to an accident? ☐ No, skip this section ☐ Yes, Date _________/_________/_________
2. Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other ______________________
3. To whom have you made a report of your accident?
   ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other ______________________
4. Attorney Name (if applicable) ____

PATIENT CONDITION

1. Reason for visit ____
2. When did your symptoms appear? ______________________________
3. Rate your pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
4. Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
5. How often do you have this pain? ______________________________
6. Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
7. Activities type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
8. Activities or movements that are painful to perform:
   ☐ Sit ☐ Stand ☐ Walk ☐ Bend ☐ Lying Down

Below, please mark any pain or symptom area(s) below:



(Continue on back)

HEALTH HISTORY

1. If any, what treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other ________________________

2. Name/address of the doctor(s) who have treated you for your condition ____

3. Date of Last: Physical Exam _______/_______/_______ Spinal X-Ray _______/_______/_______ Blood Test _______/_______/_______
Spinal Exam _______/_______/_______ Chest X-Ray _______/_______/_______ Urine Test _______/_______/_______
Dental X-Ray _______/_______/_______ MRI, CT-Scan, Bone Scan _______/_______/_______

4. Please mark if you have had any of the following:

AIDS/HIV	______	Diabetes	______	Liver Disease	______	Rheumatoid	______
Alcoholism	______	Emphysema	______	Measles	______	Arthritis	______
Allergy Shots	______	Epilepsy	______	Migraines	______	Rheumatic Fever	______
Anemia	______	Fractures	______	Miscarriage	______	Scarlet Fever	______
Anorexia	______	Glaucoma	______	Mononucleosis	______	Stroke	______
Appendicitis	______	Goiter	______	Multiple Sclerosis	______	Suicide Attempt	______
Arthritis	______	Gonorrhea	______	Mumps	______	Thyroid Problems	______
Asthma	______	Gout	______	Osteoporosis	______	Tonsillitis	______
Bleeding Disorders	______	Heart Disease	______	Pacemaker	______	Tuberculosis	______
Breast Lump	______	Hepatitis	______	Parkinson's	______	Tumors	______
Bronchitis	______	Hernia	______	Disease	______	Typhoid Fever	______
Bulimia	______	Herniated Disk	______	Pinched Nerve	______	Ulcers	______
Cancer	______	Herpes	______	Pneumonia	______	Vaginal Infections	______
Cataracts	______	High	______	Polio	______	Venereal Disease	______
Chemical	______	Cholesterol	______	Prostate Problem	______	Whooping Cough	______
Dependency	______	Kidney Disease	______	Prosthesis	______		______
Chicken Pox	______			Psychiatric Care	______	Other ____________	______

EXERCISE LEVEL ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

HABITS ☐ Alcohol (_______ drinks/day) ☐ Coffee/Caffeine Drinks (_______ cups/day)
☐ Smoking (_______packs/day) ☐ High Stress Level (Reason: ______________________)

If Female, are you pregnant? ☐ No ☐ Yes, due date _________/_________/_________

PREVIOUS INJURIES/SURGERIES (*if applicable*)

	Description	Date
☐ Falls	______________________________	_________/_________/_________
☐ Dislocations	______________________________	_________/_________/_________
☐ Broken Bones	______________________________	_________/_________/_________
☐ Head Trauma	______________________________	_________/_________/_________
☐ Surgeries	______________________________	_________/_________/_________
☐ Other	______________________________	_________/_________/_________

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Pharmacy Name ______________	______________________	______________________
Pharmacy Phone (____)_____-_______	______________________	______________________

FOR OFFICE USE ONLY

Doctor's Notes