BELLEVUE BOWEN & OCCUPATIONAL THERAPY SERVICES, LLC
Tel: (425)818-5007 Fax: (425)749-7454
bellevuebowen@gmail.com www.bellevuebowen.com

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ___ Birthdate: _____ Sex: ☐ F ☐ M
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ E-mail: _____
Doctor: _____ Dr. Phone/Fax: _____
Emergency contact: _____ Relationship: _____ Phone: _____

MEDICAL HISTORY

1. List your current health concerns, most to least bothersome (include mental, emotional and physical):
   a. _____ c. _____
   b. _____ d. _____
2. Tests for your current symptoms? ☐ Yes ☐ No If yes: ☐ X-ray ☐ Bone Scan ☐ CAT Scan ☐ MRI ☐ Nerve Conduction
   Other: _____ Results: _____
3. Do you currently have, or have you had a history of, any of the following:

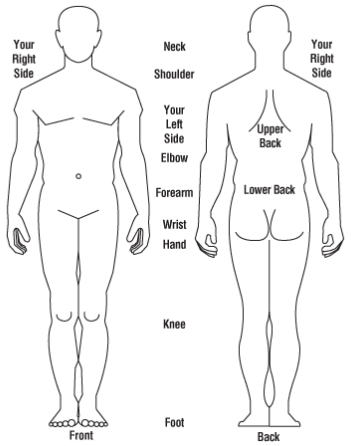
☐ AIDS	☐ Allergies	☐ Anemia	☐ Arthritis	☐ Artificial Heart Valves
☐ Artificial Joints	☐ Asthma	☐ Cancer Treatment	☐ Cardiac Pacemaker	☐ Diabetes
☐ Heart Murmur	☐ Heart Trouble	☐ High Blood Pressure	☐ Psychiatric Treatment	☐ Stroke

4. Currently taking medication for this or any other medical problem? ☐ Yes ☐ No If yes, list: _____
5. Previous surgeries / procedures and dates:
   a. _____ c. _____
   b. _____ d. _____

SUBJECTIVE EVALUATION

1. Primary complaint: _____
2. Describe how and when your symptoms began:
   _____
   _____
3. Current level of discomfort (0 = none, 10 = worst imaginable):
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
4. What aggravates your symptoms? _____
5. What eases your symptoms? _____
6. Symptoms in the morning: _____ Daytime: _____ Evening: _____
7. Symptoms are: ☐ Getting better ☐ Unchanged ☐ Getting worse
   Explain how: _____
8. Treatment for these symptoms? ☐ Y ☐ N If yes, describe treatment and results:
   _____
   _____

9. Mark your symptom areas on the body chart:



10. Work: _____ Hobby: _____
11. Currently working? ☐ Yes ☐ No If no, is it because of your symptoms? ☐ Yes ☐ No
12. Physical demands of your work: ☐ Heavy ☐ Moderate ☐ Light ☐ Sedentary Specifics: _____
13. Physical demands of your recreational activities / hobbies: _____
14. Able to participate in your recreational activities / hobbies? ☐ Yes ☐ No If no, explain: _____
15. Difficulty performing your daily activities? ☐ Yes ☐ No If yes, explain: _____
16. What do you think is the cause of your symptoms? _____
17. What are your goals for therapy? _____

The above information is true and complete, to the best of my knowledge. (print to sign)

Signature of Patient / Guardian: _____ Date: _____

For the treatment of minors: I hereby grant permission for Therapy to be performed on this minor.

Parent Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

(Required by law)

The Health Insurance Portability and Accountability Act of 1996 is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us be kept properly confidential. As required by "HIPAA", following is an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

• **Treatment** – providing, coordinating, or managing health care and related services by one or more health care providers.
• **Payment** – such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
• **Health care operations** – include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to a staff member of Bellevue Bowen & Occupational Therapy Services, LLC.

• The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to request a copy of our current *Notice of Privacy Practices* at any time.

If you feel that your rights to privacy have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above. (print to sign)

Signature of Patient / Guardian: _____ Date: _____

For the treatment of minors: I hereby grant permission for Therapy to be performed on this minor.

Parent Signature: _____ Date: _____

Signature: _____ Date: _____