



ACCOUNT# _____

NEW

UPDATE

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME		DATE OF BIRTH		
RACE	ETHNICITY		PREFERRED LANGUAGE			SOCIAL SECURITY #			
SEX M ___ F ___ Other: _____ (Please List)		GENDER IDENTITY: ___ Genderqueer identifies as neither Male or Female ___ Identifies as Male ___ Female-to-male ___ Additional gender category or other, please specify _____ ___ Identifies as Female ___ Male-to-female ___ Choose not to disclose				SEXUAL ORIENTATION ___ Choose not to disclose ___ Heterosexual (straight) ___ Bisexual ___ Homosexual (gay/lesbian) ___ Other _____			
MAILING ADDRESS				APT #	CITY		STATE	ZIP CODE 4 DIGIT	
STREET ADDRESS				APT #	CITY		STATE	ZIP CODE 4 DIGIT	
HOME PHONE ()		WORK PHONE ()			EXT	CELL PHONE ()		PREFERRED EMAIL ADDRESS	
REFERRING DOCTOR			HOW DID YOU HEAR OF US? Internet ___ Google Maps ___ Friend/Family ___ Drove by location ___ Insurance Company ___ Mailer/ Marketing ___		MARITAL STATUS MARRIED ___ DIVORCED ___ OTHER ___ SINGLE ___ WIDOWED ___ SEPARATED ___				
PRIMARY CARE DOCTOR									
PHARMACY NAME, PHONE NUMBER AND LOCATION									
PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU: RETIRED ___ OR DISABLED ___?)									
EMPLOYER NAME					OCCUPATION				
STREET ADDRESS				CITY		STATE	ZIP CODE 4 DIGIT		
PRIMARY INSURANCE									
INSURANCE COMPANY NAME				RELATION TO SUBSCRIBER			COPAY		
SUBSCRIBER'S NAME				SUBSCRIBERS EMPLOYER					
SUBSCRIBERS DATE OF BIRTH		SUBSCRIBER'S SEX MALE ___ FEMALE ___ OTHER ___		SUBSCRIBERS ID #		GROUP NUMBER			
SECONDARY INSURANCE									
INSURANCE COMPANY NAME				RELATION TO SUBSCRIBER			COPAY		
SUBSCRIBER'S NAME				SUBSCRIBERS EMPLOYER					
SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBERS SEX MALE ___ FEMALE ___ OTHER ___		SUBSCRIBERS ID #		GROUP NUMBER			
EMERGENCY CONTACT									
(NOT LIVING WITH YOU)		NAME			RELATIONSHIP	PHONE NUMBER- HOME/WORK/CELL ()			
RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?									
___ SELF (* If self do not fill in right field.) ___ SPOUSE ___ PARENT ___ GUARDIAN		SOCIAL SECURITY #		LAST NAME		FIRST NAME		MI	
		STREET ADDRESS			CITY	STATE	ZIP CODE 4 DIGIT		
		HOME PHONE ()		WORK OR CELL PHONE ()		EXT	DATE OF BIRTH		SEX M ___ F ___ Other ___
WORKERS COMP CLAIM #		DATE OF INJURY		EMPLOYER			STATE OR SELF INSURED?		
I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize Western Washington Medical Group to leave messages by voicemail, text, email or portal, which may contain details of my medical condition. By voluntarily providing your mobile phone number to WWMG, you agree to receive recurring non-marketing SMS messages regarding appointment reminders, cancellation or rescheduling, patient onboarding, care-related notifications, and billing updates. Message frequency varies. Message and data rates may apply. Providing a mobile number and consenting to SMS messages are not required to receive medical treatment or services from WWMG. Reply HELP for help or STOP to opt out. View the WWMG Privacy Policy and SMS Terms and Conditions.									
INITIALS				VOICEMAIL #					
PATIENT SIGNATURE Type name for signature				DATE					
For office use only									
Dr. _____		Ins. code		Acct #		Initials			



Western Washington
Medical Group

CONSENT TO RELEASE INFORMATION

(FAMILY AND FRIENDS)

I, GIVE THE PHYSICIANS AND OFFICE STAFF OF WESTERN WASHINGTON MEDICAL GROUP, PERMISSION TO DISCUSS MY MEDICAL CONDITION (PLEASE LIST FAMILY MEMBERS & FRIENDS ONLY). You may disclose health care information regarding testing, diagnosis, and treatment for the following:

Please check all that apply: ☐ HIV (Aids virus) ☐ Sexually transmitted diseases

☐ Psychiatric disorders/mental health ☐ Drug and/or alcohol use

All health care information _____

Health care in my medical record related to the following treatment or condition: _____

Health care information in my medical records for the date(s): _____

Other (e.g., x-rays, bills) specify date(s): _____

WITH: _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED

PATIENT SIGNATURE _____ DATE _____



Western Washington
Medical Group

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

Signature of client (or personal representative)

Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

Employee Name

Date

This form will be retained in your medical record



Western Washington
Medical Group

PLACE LABEL
HERE

Spine / Initial Eval*

Present History

How did the pain start?

- | | | | |
|--|----------------------------------|---|--|
| ☐ Suddenly | ☐ Fall | ☐ Injured at work | ☐ Injured during sports |
| ☐ Gradually | ☐ Bending | ☐ Injured in auto accident | ☐ No apparent cause |
| ☐ Lifting | ☐ Pulling | ☐ Hit from behind | ☐ Injured at home |
| ☐ Other (specify below) _____ | | | |

If other, please specify _____

Do you have any emotional reactions to your current problem? ☐ Yes ☐ No

If yes, what are the emotional reactions you have related to your current problem?

- | | | |
|---|--|---|
| ☐ I feel nothing matters | ☐ I feel angry | ☐ I feel sad (depressed) |
| ☐ I feel frustrated | ☐ I feel like taking my own life (suicidal) | ☐ Nothing can help me |

Pain

My pain is

- | | | | |
|--|--|--|---|
| ☐ Present Intermittently | ☐ Present but varies in intensity | ☐ Improving | |
| ☐ Worse -present more often | ☐ Worse - more intense | ☐ Worse - changing in character | ☐ Worse - changing in location |

Please mark the severity of pain that corresponds to the area of your body. Rate how much pain hurts on an average day.

- | | | | | | | | | | | | |
|------------------|---------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-----------------------------------|
| Back pain | ☐ 0
none | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10
worst |
| Leg pain | ☐ 0
none | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10
worst |
| Neck pain | ☐ 0
none | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10
worst |
| Arm pain | ☐ 0
none | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10
worst |

Past Treatments for this Problem

Have you had any troubles with this problem before? ☐ Yes ☐ No

If yes, when was the FIRST time it happened: ____/____/____

Have you seen any other doctors for your current problem?

☐ Yes ☐ No

If yes, list their name and date seen _____

Which of the following treatments have you had for this problem?

- | | | |
|---|--|---|
| ☐ Physical therapy | ☐ TENS Unit | ☐ Chiropractic Manipulation |
| ☐ Home exercise program | ☐ Epidural Steroid Injection | ☐ N/A - no prior treatments |
| ☐ Brace | | |

If you answered yes to any of the past treatments listed above, please provide additional details below. If you have not had any prior treatments for this problem please continue to the next section.

Physical Therapy ____/____/____ Where? _____ # of Sessions: _____

if physical therapy, what was done and was it helpful? _____

Exercise ____/____/____

Are you currently doing home exercises? ☐ Yes ☐ No

Brace ____/____/____

If yes, what type of brace?

TENS Unit ____/____/____

Are you currently using a TENS unit? ☐ Yes ☐ No

Epidural Steroid Injection ____/____/____

Was it helpful and how long did it last? _____

Epidural Steroid Injection #2 ____/____/____

Was it helpful and how long did it last? _____

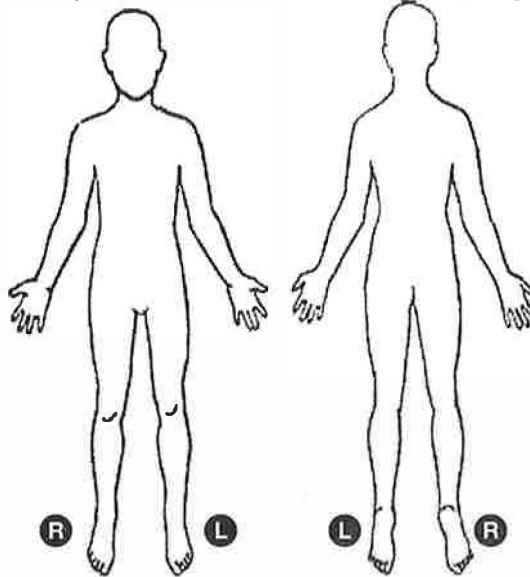
Epidural Steroid Injection #3 ____/____/____

Was it helpful and how long did it last? _____



Please continue to the next page...

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas to which your pain spreads.



- ✓ Stabbing
- Tingling
- Numbness
- + Pins and Needles
- ▲ Aching
- × Burning

Do you have loss of bowel or bladder control?

☐ Yes ☐ No

My weight is

☐ Increasing ☐ Decreasing ☐ Steady

Are there any problems with weak muscles?

☐ None ☐ Weak in arms ☐ Weak in legs ☐ Generally weak

Sleep pattern

☐ No difficulty with sleep ☐ Unable to fall asleep ☐ Can't maintain sleep ☐ Wake frequently due to pain

Functional Activities

I can comfortably sit for ☐ 1 min ☐ 5 min ☐ 10 min ☐ 15 min ☐ 20 min ☐ 30 min ☐ 45 min ☐ 1 hour ☐ 2 hours +

I can comfortably stand for ☐ 1 min ☐ 5 min ☐ 10 min ☐ 15 min ☐ 20 min ☐ 30 min ☐ 45 min ☐ 1 hour ☐ 2 hours +

I can comfortably walk for ☐ 1 min ☐ 5 min ☐ 10 min ☐ 15 min ☐ 20 min ☐ 30 min ☐ 45 min ☐ 1 hour ☐ 2 hours +

Daily Activities

I can do ____ of my housework ☐ All ☐ Some ☐ None

I can do ____ of my leisure activities ☐ All ☐ Some ☐ None

I can do ____ of my work ☐ All ☐ Some ☐ None

My sex life is

☐ normal with no pain
☐ normal with some pain

☐ nearly normal, but painful
☐ severely restricted by pain

☐ nearly absent because of pain
☐ absent, pain prevents any sex

Do you have any difficulty with sexual function?

☐ Yes ☐ No ☐ N/A

Prior Tests

What tests have you had done for your problem?

☐ X-ray ☐ Myelogram ☐ CT ☐ Bone scan ☐ MRI ☐ EMG ☐ Discogram ☐ N/A

If you have had any of the tests listed above, please provide additional details if you know them.

X-ray / /

Where?

Results

Myelogram / /

Where?

Results

CT / /

Where?

Results

Bone Scan / /

Where?

Results

MRI / /

Where?

Results

EMG / /

Where?

Results

Where?

Results



Current Medications, inhalers, eye drops, patches...	Dose and Frequency	What do you take it for?

Supplements, Herbal remedies, currently taking	Dose and Frequency	What do you take it for?

Allergies	Reaction that you had	Serious injuries or fractures
☐ Latex		
☐ Iodine		
☐ Penicillin		
☐ Sulfa		
Other _____		
Other _____		
Other _____		
☐ Food Allergies:		

Review of Systems (check all that apply)

Constitutional	☐ Fever	☐ Sweats	☐ Recent weight loss	☐ No complaints
	☐ Chills	☐ Fatigue		
If recent weight loss, how many pounds lost? _____				
Skin	☐ Rashes	☐ Sores	☐ Scars	☐ No complaints
Cardiovascular	☐ Chest Pain	☐ Palpitations	☐ Swelling hands/feet/ankles	☐ No complaints
Respiratory	☐ Short of breath	☐ Cough	☐ Coughing blood	☐ No complaints
Hematologic	☐ Bruise easily	☐ Bleeding disorder	☐ Blood clots	☐ No complaints
Stomach/Intestinal	☐ Heartburn	☐ Constipation	☐ Abdominal pain	☐ No complaints
Urology	☐ Pain with urination	☐ Incontinence	☐ Frequent urination	☐ No complaints
Musculoskeletal	☐ Stiffness	☐ Sprains	☐ Swelling	☐ No complaints
Neurological	☐ Headaches	☐ Numbness	☐ Dizziness	☐ No complaints
Mental Health	☐ Anxiety	☐ Depression	☐ Sleep problems	☐ No complaints

This form was completed by _____ ☐ Patient ☐ Parent/Guardian

Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record at Western Washington Medical Group.

X

DATE _____

Patient Name _____

Today's Date _____

REVIEW OF SYSTEMS

Have you had any of the following during the past year?
Please circle Yes if any apply to you

Cardiac

Chest pain Yes
Swelling in legs/ Edema Yes
Leg cramps or calf pain Yes
Palpitations or arrhythmias Yes

Constitutional/ General

Fevers Yes
Headaches Yes
Sleeping difficulty Yes
Fainting Yes

Eyes

Double or blurry vision Yes
Wear Glasses or contacts Yes
Eye disease or injury Yes

Gastrointestinal

Blood in stool Yes
Diarrhea Yes
Constipation Yes
Nausea or vomiting Yes
Acid indigestion/ heartburn Yes

Genitourinary

Blood in urine Yes
Frequency in urination Yes
Burning or painful urination Yes
Incontinence or dribbling Yes

Hematology

Bruises or bleeds easily..... Yes
Bleeding disorder..... Yes
Blood clot, DVT, or a Yes
Pulmonary embolism... Yes

Pulmonary

Shortness of breath Yes
Wheezing Yes
Asthma..... Yes
Frequent cough Yes
COPD or Emphysema..... Yes

Skin

Rashes or itching..... Yes
Changes in moles or skin lesions Yes
Psoriasis..... Yes

Musculoskeletal

Limping..... Yes
Joint pain..... Yes
Joint stiffness..... Yes
Joint swelling..... Yes
Numbness to arm or leg..... Yes

Patient's Signature:

(or parent/legal guardian)

Practitioner's Initials _____

PAST MEDICAL HISTORY

Have you ever had any of the following?
Please circle Yes if any apply to you

Yes Diabetes
Yes Thyroid disorder
Yes Kidney or Renal disorder
Yes Stroke/TIA
Yes Seizures or Epilepsy
Yes Anemia
Yes Varicose Veins
Yes High Blood Pressure
Yes High Cholesterol
Yes Heart Problems _____
Yes Heart Attack/ Myocardial Infarction
Yes Heart Stents or Balloon Angioplasty
Yes Atrial Fibrillation
Yes Irregular Heartbeat
Yes Pacemaker
Yes Heartburn, Acid reflux
Yes Ulcers or Gastritis
Yes Esophagitis, Barrett's or Hiatal Hernia
Yes Seasonal Allergies
Yes Sleep Apnea, if Yes CPAP use? _____
Yes Tuberculosis
Yes Gout
Yes Cancer _____
Yes Migraines
Yes Depression
Yes Anxiety
Yes Fibromyalgia
Yes Chronic Pain _____
Yes Hepatitis A , B , C (circle which)
Yes HIV or exposure to it
Yes History of MRSA, VRE, Staph infections
Yes Anesthesia problems? _____
Yes Post Operative Nausea/Vomiting

Other Diagnoses or Symptoms that we should be aware of?



Surgery

Have you had surgeries for this problem? ☐ Yes ☐ No

If yes, please list surgeon, if it was helpful and what was done.

Have you had breast implants? (necessary for surgeries that require you to lie on your stomach) ☐ Yes ☐ No ☐ N/A

Would you accept blood products or blood transfusion if necessary? ☐ Yes ☐ No

Have you ever had complications with surgery? ☐ Yes ☐ No

If so, please list the name of the surgery and any complications below. You may wish to include problems before, during, or after your procedure, as well as any problems you may have had with anesthesia.

Complication _____ Year _____

Complication _____ Year _____

Employment Status

Are you currently employed? ☐ Yes ☐ No

Present employer _____

What is your occupation? _____ How long have you worked there? _____

My present job consists of: ☐ Ladders ☐ Lifting ☐ Sitting ☐ Standing ☐ Stairs ☐ Walking

Other Job Duties

Per work day, how many hours do you sit? ☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ >8

Per work day, how many hours do you stand? ☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ >8

How many pounds do you lift for your job? ☐ <15 lbs ☐ 15-25 lbs ☐ 25-40 lbs ☐ 40-60 lbs ☐ >60 lbs

If unemployed or currently not working, please provide a date for at least one of the following.

Retired on _____

Total disability _____

Medical leave began _____

Social Security disability _____

Laid off _____

When did you last work? _____

Would your employer allow you to return to work with restrictions? ☐ Yes ☐ No

Social History

What sports, exercise activity, or hobbies do you participate in? _____

Do you live alone or as only adult in the house? ☐ Yes ☐ No

Alcohol use: Never Rarely Moderate Daily # of drinks _____ Recovery Treatment

Tobacco use: Never Yes, current packs/day _____ How many years _____ Quit-year _____

This form was completed by ☐ Patient ☐ Parent ☐ Guardian ☐ POA ☐ Family member ☐ Other

Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record.

X

DATE

Pain Catastrophizing Scale

Everyone experiences painful situations at some point in their lives. We are interested in the types of thoughts and feeling that you have when you are in pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4

Neuropathic Pain Questionnaire

1 Numbness: rate your usual pain:

0 ← No Numbness/Sensation → 100 Worst Numbness Imaginable

2 Tingling Pain: rate your usual pain:

0 ← No Tingling/Pain → 100 Worst Tingling Pain Imaginable

3 Increased Pain Due To Touch: rate your usual pain:

0 ← No Increase At All → 100 Greatest Increase Imaginable

Patient Name: _____ Date: _____

Opioid Assessment for Patients

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1 How often do you have mood swings?	☐	☐	☐	☐	☐
2 How often have you felt the need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3 How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4 How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5 How often is there tension in the home?	☐	☐	☐	☐	☐
6 How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7 How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8 How often do you feel bored?	☐	☐	☐	☐	☐
9 How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10 How often have you worried about being left alone?	☐	☐	☐	☐	☐
11 How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12 How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐
13 How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14 How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15 How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16 How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17 How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18 How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19 How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20 How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21 How often have you been sexually abused?	☐	☐	☐	☐	☐
22 How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23 How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24 How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

Please include any additional information you wish about the above answers. Thank you

Patient Name: _____ Date: _____