Olympic Spine & Sound Pain Solutions
6603 220th St. SW Ste. 102
Mountlake Terrace,
WA 98043
425-774-2411

OLYMPIC
SPINE & SOUND PAIN SOLUTIONS

Welcome to Olympic Spine & Sound Pain Solutions! At your first appointment you will be meeting with the doctor for your complimentary consultation. The doctor will review your history, current symptoms, and perform a screening examination to determine if it's likely youare a candidate for our treatment procedures. If you are a candidate for treatment, the doctor will make recommendations for a comprehensive examination, testing, x-rays, and/or treatment; these are not covered in your complimentary consultation. If you choose to receive additional examination, testing, and/or treatment, you will incur normal charges.

Comprehensive examination, testing, x-rays, and/or treatment are not included in your complimentary consultation.

It is our desire that no one is denied health care due to finances. If a patient makes their healthcare a priority, we will work with them to make arrangements that also work financially.

Respectfully yours,

Kaiya Hunsaker

Office Manager

Please sign this letter to indicate that you have completely read and understood its contents.

*Print Name*_____*Date* _____

Signature _____

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Name Printed:_____ ID #: _____

Patient Signature:_____ **Date:** _____

Authorization to Release Information to Physician

At Olympic Spine & Sound Pain Solutions, we believe it is important that all your physicians worktogether for your benefit. By signing this release, you are authorizing us to release reports and information to your doctor(s) regarding your treatment at Olympic Spine & Sound Pain Solutions.

Patient Signature:_____ Date: _____

Authorization to Release Information to Designated Individuals

I authorize that Olympic Spine & Sound Pain Solutions can share my healthcare information with the following individuals:

Name:_____ Relationship to Patient: _____

Name:_____ **Relationship to Patient:** _____

Patient Signature:_____ **Date:** _____

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____Attempt_____

Staff Name_____

Olympic Spine & Sound Pain Solutions

(Staff only) MRN OPS:_____ OSST:_____ Reviewed w/Patient: _____/_____

Last Name:_____ First Name:_____ Date: ___/____/___

DOB: _____ Sex: M | F | Marital Status: _____ Spouse/Significant Other: _____

Primary Care Provider: _____ Occupation: _____

(Minors only) Name of parent/guardian:_____ Phone # (if different): _____

Address: _____City: _____State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Email: _____

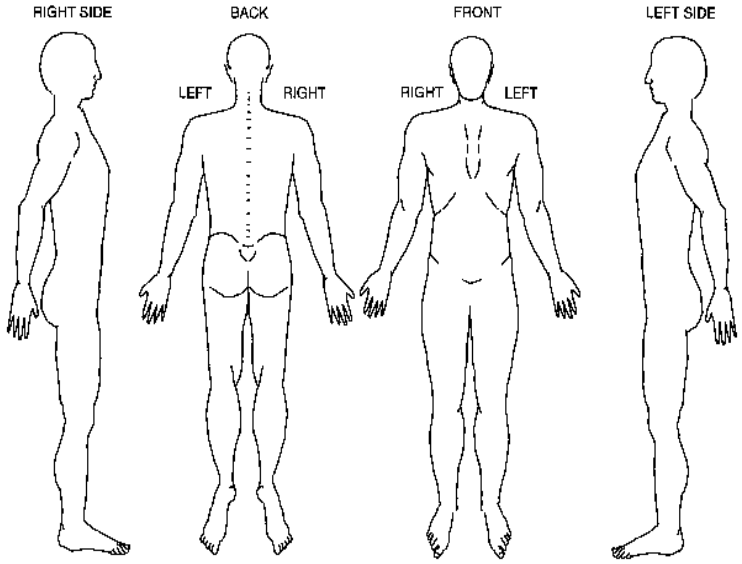
EMERGENCY CONTACT: Contact Name:_____ Phone:_____

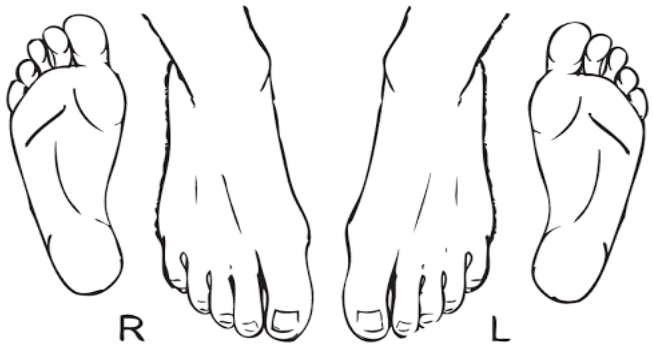
Are we authorized to release your medical information to the listed emergency contact? **Yes** or **No**

How did you hear about our clinic? _____

CHIEF COMPLAINTS: On the diagrams, please mark where you are experiencing any symptoms

Use the following as a guide: P = Pain T = Tingling N = Numbness B = Burning W = Weakness





Describe the symptoms & location you are experiencing them. Rate on a scale of 0-10 (0= no discomfort, 10= worst imaginable).

Example: Tingling in right foot _____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Symptom #1:_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Symptom #2:_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Symptom #3:_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Symptom #4:_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Symptom #5:_____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____

When did your symptoms begin?_____ How often do you have this symptom?_____
Is it constant or does it come and go? _____Are the symptoms getting progressively worse? **Yes | No | Unknown**

Does the pain radiate ("shooting down" or "shooting up")? **Yes | No** If so, where does the pain radiate?_____
_____

How would you characterize your symptom? (Circle all that apply): **Dull | Sharp | Achy | Shooting | Burning | Stabbing Throbbing | Stiffness | Numb**
Other_____

What makes your condition worse? (Circle all that apply): **Coughing | Sneezing | Bearing Down | Lifting | Bending Driving | Cold/Hot Weather | Sitting | Standing | Lying Down | Walking | Moving Your Head | Bowel Movement**
Other_____

What makes your condition better? (Circle all that apply): **Rest | Movement | Sitting | Standing | Lying Down | Physical Therapy | Heat | Ice | Massage | Stretching | Over-the-counter Medication | Prescribed Medication | Injections**
Other_____

What time of the day are your symptoms worse? (Circle all that apply): **Morning | Afternoon | Evening | Sleeping | At Work | Other**_____

What time of the day are your symptoms better? (Circle all that apply): **Morning | Afternoon | Evening | Sleeping | At Work | Other**_____

Is there any known cause of your symptoms? (Circle all that apply): **Auto Accident | Work Injury | Lifting | Slip/Fall**

Overexertion | Strenuous Position | Unknown | Other _____

If known cause, how soon did symptoms start?(Circle) **Immediately | Hours Later | Next Day | Days Later | Week Later**

Is there any color change or temperature change to the skin?: **Yes | No** _____

When your symptoms are at their worst, describe what happens: _____
_____

Have you experienced symptoms like these before?: **Yes | No (when?)** _____
Have you missed any work due to this condition?: **Yes | No (dates?)** _____
Have you had to modify or restrict your activities at work? **Yes | No (restrictions?)** _____

Previous Testing:

Have you had any of the following testing?

X-ray: Y/N Area: _____ Date: _____ MRI: Y/N Area: _____ Date: _____

CT Scan: Y/N Area: _____ Date_____ EMG/NCV: Y/N Area: _____ Date: _____

Was there a previous diagnosis for your condition? i.e. Have you been told what is causing your problem? _____
_____

Treatment Options:

Is there any type of treatment that you would not consider at this time? _____
_____

What is your most important treatment objective? (Reduce pain, increase function, correct cause, prevent progression) _____

Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____

LIFESTYLE & HABITS:

Average amount of sleep per night (hours): (Circle) **0 1 2 3 4 5 6 7 8 9 10 11 12+**
How often do you typically wake up at night? (Circle) **0 1 2 3 4 5+ times**

Are you awakened due to pain? If yes, how often: _____

Smoking (packs/day): (Circle) **Never 1 2 3 4+ Quit_____ years ago.** Caffeinated drinks (cups/day): **0 1 2 3 4 5 6+**

Alcohol consumption (drinks per day): (Circle) **0 1 2 3 4 5 6+** Drug/Substance use: **Yes | No** _____

Exercise (times per week): (Circle) **0 1 2 3 4 5 6 7** Type of exercise: _____

What do you feel your stress level is currently? (0 being no stress and 10 being maximal stress)
1 2 3 4 5 6 7 8 9 10

What three things has this condition caused you to miss out on the most?

1) _____ 2) _____ 3) _____

PREVIOUS TREATMENT / ACCIDENTS / HOSPITALIZATIONS:

☐ Physical Therapy | Location?: _____ Date of last PT: _____ Duration: _____

☐ Acupuncture: _____ ☐ Psychotherapy:_____ ☐ Chiropractor : _____

☐ Tens _____ ☐ Injections _____ Failed Treatments/Other: _____

☐ Prescription Medications _____

Have you been told you need an injection? YES NO _____

Have you been told you need spinal surgery? YES NO _____

(Please inform us of any/all recent injuries that could have contributed to your current condition.)

Do you have a history of any of the following? (Circle) **Work Injury | Auto Accident | Slip & Fall Accident**
If so, please list approximate dates and incident:

1. Date____/____/____Incident _____
2. Date____/____/____Incident _____

Have you ever been hospitalized? **Yes | No** If so, when and for what condition?

1. Date____/____/____Condition _____
2. Date____/____/____Condition _____

Have you had any surgeries? **Yes | No** If so, when and for what condition?

1. Date____/____/____Surgery _____
2. Date____/____/____Surgery _____

Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____

REVIEW OF SYSTEMS:

Do you currently have any of the following?

(Circle all that apply)

General: Weight loss | Weight gain | Fever | Fatigue | Loss of appetite | Nausea | Vomiting

Cardiovascular: Chest pain | Chest pressure |Shortness of breath | Irregular heartbeat | Murmur

Respiratory: Coughing | Difficulty breathing Asthma/wheezing | Coughing up blood

Gastrointestinal: Constipation | Diarrhea | Heartburn Bloody stool | Pain in stomach | Ulcers | Hepatitis

Eyes: Vision problem | Glaucoma | Blurred vision | Double vision | Glasses | Eye pain

ENT: Ear pain | Hearing loss | Ear noises |Nosebleed Sore throat | Hoarseness | Dental issues | Difficulty swallowing

Psychiatric: Depression | Anxiety | Panic attack | Suicide attempts | Suicidal thoughts| Homicidal thoughts|

Hematology: Anemia | Blood disorders

Musculoskeletal: Arthritis | Joint pain | Swelling in legs or arms | Back pain | Neck pain | Muscle pain | Muscle spasms/cramps | Muscle weakness | History of broken bones | Recent falls

Skin: Skin problems | Rash | Slow healing | Easy bruising | Itching |Yellow or thick toenails

Neuro: Lightheaded/dizzy | Fainting | Weakness | Stroke | Tremors | Seizures | Memory loss | Sensation changes to skin (burning/tingling/numb)

Genitourinary: Painful urination | Frequent urination Bloody urine | Incontinence | Sexual difficulty | Frequent urinary tract infections

Endocrine: Excessive thirst |Excessive hair growth | Unexplained hair loss | Unexplained weight changes

WOMEN ONLY:

Any chance of pregnancy? Y/N

Is there any chance that you may be PREGNANT? Y/N
Date of last menstrual period _____/_____/_____

Have you had any of the following in the last 3 months? (Check all that apply)

☐ Neck Pain ☐ Wrist Pain ☐ Upper Back Stiffness ☐ Low Back Pain ☐ Hip Pain

☐ Neck Stiffness ☐ Elbow Pain ☐ Mid Back Pain ☐ Low Back Stiffness ☐ Knee Pain

☐ Shoulder Pain ☐ Upper Back Pain ☐ Mid Back Stiffness ☐ Leg Pain ☐ Ankle Pain ☐ Foot Pain

Vascular Screening:

Have you recently experienced any of the following? (mark all that apply):

☐ Double Vision / Sudden Onset of Vision Problems

☐ Dizziness, Vertigo or Light-headedness

☐ Sudden Numbness/ Weakness of Face, Arms or Legs

☐ Difficult Speaking

☐ Difficulty Swallowing

☐ Difficulty Walking

☐ Nausea, Vomiting, or Queasiness

☐ Numbness or Loss of Sensation on one side

☐ Involuntary Rapid Eye Movements (nystagmus)

☐ None of the above

☐ If you are experiencing Headaches or Neck Pain, have you experienced pain like this before?

☐ Yes, I have had headaches / neck pain like this before.

☐ No, this pain is different than I have experienced in the past. ☐ Did your headache or neck pain start suddenly?

Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____

PAST MEDICAL HISTORY:

Have you ever had any of the following? (Circle all that apply)

Heart: Coronary artery disease | Hypertension Murmurs | Valvular disease | Aneurysm | High cholesterol || Heart failure Angina | Stents Other:_____

Gastrointestinal: Ulcer | Reflux | Gastritis | Hepatitis | Liver disease | Cancer | Bleeding | Diverticulosis | Other: _____

Neuro: Stroke | Aneurysm | Brain cancer | Nerve injury Spinal cord injury | Alzheimer's | Dementia | Seizures Parkinson's | Other:_____

Kidney: Failure | Stones | Dialysis | Kidney stents Other:_____

Lungs: Asthma | COPD | Emphysema | Bronchitis | TB Pneumonia | Lung cancer | Other:_____

Endocrine: Diabetes | Hypothyroidism Hyperthyroidism | Other:_____

Psychiatric: Depression | Bipolar | Anxiety | Panic disorder | OCD| Schizophrenia | ADD/ADHD Other:_____

Bone/Muscular: Arthritis | Rheumatoid arthritis | Gout | Osteoporosis | Osteopenia | Scoliosis | Fibromyalgia Other:_____

Cancer: _____

Do you have a Pacemaker/Defibrillator or Spinal Cord Stimulator? _____

Other: _____

ALLERGIES / MEDICATIONS / SUPPLEMENTS:

Prescription Medications	Supplements	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **List of Medications Attached**

Do you take any form of blood thinners, including daily aspirin? _____

FAMILY HISTORY

Has any member of your family been diagnosed with any of the following? **(Circle all that apply)**

Cancer | Diabetes | High Blood Pressure | Stroke | Heart Disease | Hypertension | Depression | Spinal Pain
Other: _____ If yes, what is their relation to you? _____ **Father side | Mother side | Siblings**

Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____

Additional Information & Resources

If you are interested in receiving additional information about any of the following, please check the boxes below:

Conditions

- ☐ Peripheral Neuropathy
- ☐ Sciatica
- ☐ Chronic Headaches
- ☐ Dizziness/ Balance Disorders
- ☐ Whiplash Injuries
- ☐ Mild Traumatic Brain Injury
- ☐ Chronic Back/Neck Pain
- ☐ Joint Pain (Hip, Knee, Foot, Shoulder, Elbow, Hand)
- ☐ Carpal Tunnel Syndrome

Treatment

- ☐ Non-Surgical Decompression
- ☐ Non-Invasive Laser
- ☐ Clinical Nutrition
- ☐ Functional Neurology
- ☐ Vitamins / Supplements
- ☐ Bioelectrical Therapy
- ☐ Trigger Point Injections
- ☐ PRP (Platelet Rich Plasma Injections) Injections
- ☐ Physical Rehabilitation

THIS FORM IS COMPLETED BY:

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Representative: _____ Date: _____

Signature of Authorized Representative: _____

Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____

Neuropathy Specific Questionnaire

What do you think is the cause of your neuropathy?

_____

Please rate the severity:

- ☐ MINIMAL (Annoying but causing NO limitations)
- ☐ SLIGHT (Tolerable but causing a little limitation)
- ☐ MODERATE (Sometimes tolerable but definite
- ☐ SEVERE (Causing Significant limitations)
- ☐ EXTREME (Causing near constant limitations)
- ☐ THE PROBLEM IS GETTING WORSE

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins + Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping

Do you have a Pacemaker/Defibrillator? Yes No

Have you ever had a thrombosis (blood clot)? Yes No If yes, when & where? _____

Have you ever had a surgical repair of an abdominal aortic aneurysm? Yes No

When did you last have blood tests?_____Are you aware of any abnormal findings? Yes No

If yes, what was abnormal?_____

Has your **balance** or ability to walk been affected yet? Yes No If yes, describe below in what way(s):

_____

Please complete this section thoroughly. **Mark** a "√" if you've experienced any of the following:

Diabetes: Type I, II	Heavy Metal Toxicity	Numbness in Feet
(Last A1c:_____)	Alcohol Abuse	Swollen Ankles/Feet
Chemotherapy	Drug or Substance Abuse	Feet, Ankle or Hands Discolored
Cancer (_____)	Shingles	Feet, Ankle or Hands Cold
High Cholesterol	HIV/AIDS	Fatigue
Taking Statins	Stroke (date:_____)	Poor Circulation
Lower Back Pain	Seizures	Plantar Fasciitis
Chronic Neck or Back Pain	Dizziness / Balance	Spinal Stenosis
Spine Surgery – describe:	Walking Difficulty	Kidney Dialysis
(_____)	Numbness in Hands	Chemical Exposure

Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____

WALKING LIMITATIONS QUESTIONNAIRE

These questions ask about limitations to your ability to walking due to altered sensation in your feet, fatigue,instability, disequilibrium or dizziness during the **past 4 weeks**. For each statement please circle the one number that best describes your degree of limitation. Please check that you have circled one number for each question

In the past 4 weeks how much have your symptoms effected the following:	Not at all	A little 25%	Moderately 50%	Quite a bit 75%	Extremely 100%
Limited your ability to walk?	**1**	**2**	**3**	**4**	**5**
Limited your ability to run?	**1**	**2**	**3**	**4**	**5**
Limited your ability to climb up or down stairs?	**1**	**2**	**3**	**4**	**5**
Made standing when doing things more difficult?	**1**	**2**	**3**	**4**	**5**
Impaired your balance when standing or walking?	**1**	**2**	**3**	**4**	**5**
Limited how far you can walk without stopping?	**1**	**2**	**3**	**4**	**5**
Increased the effort needed for you to walk?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use supports when walking **indoors** e.g. holding on to furniture, using a cane, etc?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use support when walking **outdoors**, e.g. using a cane or walker, etc?	**1**	**2**	**3**	**4**	**5**
Slowed down your pace walking?	**1**	**2**	**3**	**4**	**5**
Affected how smoothly you walk?	**1**	**2**	**3**	**4**	**5**
Made you concentrate on your walking?	**1**	**2**	**3**	**4**	**5**

WALKING SCALE QUESTIONAIRE SCORE TOTAL_____

DISABILITY SCORE: 12 NORMAL, 13-27 MILD, 28-45 MODERATE, >46 SEVERE DISABILITY

FINANCIAL DISCLAIMER

The following is an explanation of what to expect and be aware of when it comes to the financial aspect ofyour treatment at Olympic Spine & Sound Pain Solutions.

You are legally responsible for your bill at the time you receive services from the clinic. You are ultimatelyresponsible for ensuring that the clinic is reimbursed for the services that we provided to you.

Co-pays are due at time of service. Payment options for a treatment plan will be presented to you after yourclinical Report of Findings.

If you have insurance we are not contracted with, we reserve the right to not bill it.

If you have insurance we are contracted with, we will bill it for covered services. Because policies are often customized per plan, we cannot always be sure what your insurance requires of you, which is why we will alsoverify coverage and benefits as a courtesy to you. Please note that insurance companies consistently issue thedisclaimer that quoted benefits are not a guarantee of payment. Please be sure to provide all current insurance info that you would like to be billed. Olympic Spine & Sound Pain Solutions is responsible for submitting an accurate bill to your insurance company. We recommend that you make yourself aware of whatyour insurance covers. If you would like a template for questions to ask your insurance, we will provide one upon request. Please note: Non-covered services, services that do not meet your insurance's criteria of medical necessity, or services that exceed the benefit maximum, will be your financial responsibility.

We do our best to make our patients aware when an insurance company doesn't process claims the way wewere told; however, it is the patient's responsibility to make sure his/ her insurance is processing claims correctly. Your insurance company is responsible for sending you an explanation of benefits (EOB) when it processes claims. If you have any questions regarding information on the EOB, please call your insurance company for details. Your insurance company is responsible for acting in your best interests by paying or declining to pay within a certain number of days from when claims were billed.

It is your responsibility to provide any required information (referrals, authorization numbers, claim forms, accident information). It is also your responsibility to follow the policy guidelines of your insurance company.Policies vary widely on which provider types, procedures, services, or items an insurance company will cover.

If your insurance changes, or if you are involved in an automobile or work accident, please inform us immediately. This allows the clinic to bill correctly, and to follow the required directions of your insurance. Ifyou do not tell us about a change to your insurance within two weeks of the change, a $20 charge will be added to your account for additional administrative work.

Due to the large number of patients and treatments performed, we do not provide monthly statements. If you would like a monthly statement, please make the request with the Front Desk staff.

If your insurance companypays your account in full, you will not receive a bill from us unless you specifically request a copy. If our recordsindicate that you have a balance after your insurance pays, you will receive a statement indicating your account balance. It is Olympic Spine & Sound Pain Solutions policy to send statements for up to 12 months after your last date of service. This can be due to the time it takes for all claims to be processed accurately.

The consultation and initial exam fees range from $88.00 to $443.00; X-Ray fees range from $66.00 to $279.00,and individual treatment fees range from $32.00-$375.00.

Cancellation/ Missed Appointment Policy: We require 24 hours' business day notice for any massage andphysical rehabilitation appointments, or you will incur a missed appointment fee of $45.

The patient is responsible for paying an administrative fee for any extra reports and/ or medical records not requested by the insurance company (For example: disability forms, work restriction reports, etc.). Since thesereports are not required to process your insurance claim, they are not billable to insurance and the financial responsibility is yours.

AUTHORIZATIONS:

I hereby authorize release of any medical information necessary to prepare and submit claims. I authorize payment of any medical benefits from third parties for claim submitted to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out ofproceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier andmyself. I understand that if I have insurance, the fees for services I receive will be billed to my insurance company. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be due and payable.

I have read and understood all statements on this document.

I, _____, have read and understand the terms and conditions stated above.

Signature

Patient Name:_____Date:_____ID: _____

Printed Office