Health Moves
17000 140th Ave NE Unit 206
Woodinville, Washington, US - 98072

New Patient Packet_2023

Personal Details

First Name * ______________________

Last Name * ______________________

Date of Birth * ______________________

Gender: ☐ Male ☐ Female ☐ Unknown

Blood Group ______________________

Language ______________________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Others

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name ______________________

Caregiver Last Name ______________________

Email * ______________________

Home Phone ______________________

Mobile Phone ______________________

Work Phone ______________________

Fax ______________________

Primary Phone *: ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * ____________________

Address Line2 ____________________

City * ____________________

Country * ____________________

State * ____________________

Zip code * ____________________

Postbox No ____________________

Emergency Contact Name ____________________

Emergency Contact Number ____________________

Extn ____________________

Primary Insurance Details

Insurance Type *

- ☐ MEDICARE
- ☐ MEDICAID
- ☐ TRICARE CHAMPUS
- ☐ CHAMPVA
- ☐ GROUP HEALTH PLAN
- ☐ FECA BLK LUNG
- ☐ OTHER

Insurance Plan Name or Program Name * ____________________

ID * ____________________

Insurance Company Name (Payer Name) * ____________________

Payer Id * ____________________

Payer Address ____________________

Payer City ____________________

Payer Country ____________________

Payer State ____________________

Payer ZipCode ____________________

Valid From

Valid Until

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Policy Group/FECA # ______________________

Copay ______________________

Deductible ______________________

Employer/School Name ______________________

Comments

Insured Person Details

Patient Relationship *
☐ Self ☐ Spouse ☐ Child
☐ Other

First Name * ______________________

Last Name * ______________________

Date of Birth * ______________________

Sex *
☐ Male ☐ Female ☐ Unknown

Address Line 1 ______________________

Address Line 2 ______________________

City ______________________

Country ______________________

State ______________________

Zip Code ______________________

Home Phone ______________________

Mobile Phone ______________________

What is the main reason for your visit today?

Other conditions / concerns for future discussion?

Other Healthcare Providers:

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Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Past Medical History

Cardiovascular

☐ Abnormal Heart Rhythm ☐ Arterial Clot
☐ Carotid Artery Disease ☐ Congestive Heart Disease
☐ Coronary Artery Disease ☐ Deep Vein Thrombosis
☐ High Cholesterol ☐ Hypertension ☐ Heart Attack
☐ Peripheral Vascular Disease ☐ Superficial Vein Clot
☐ Phlebitis ☐ Heart Valve Disease
☐ Other ____________________

Comments ____________________

Pulmonary

☐ Asthma ☐ Bronchiectasis ☐ Chronic Bronchitis
☐ COPD ☐ Croup ☐ Cystic Fibrosis ☐ Pneumonia
☐ Pulmonary Embolism ☐ Pulmonary Hypertension
☐ Respiratory Syncytial Virus ☐ Sarcoidosis ☐ Sleep Apnea
☐ TB

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Gastrointestinal

☐ Cirrhosis ☐ Colon Polyps ☐ Crohn's Disease
☐ Gall Stones ☐ GERD (heartburn) ☐ Hepatitis A
☐ Hepatitis B ☐ Hepatitis C ☐ Incontinence of Feces
☐ Irritable Bowel Syndrome ☐ Pancreatitis
☐ Peptic Ulcer Disease ☐ Ulcerative Colitis
☐ Other ____________________

Comments ____________________

Renal

☐ Bed Wetting ☐ Benign Prostatic Hypertrophy
☐ Chronic Renal Failure ☐ Endometriosis
☐ Erectile Dysfunction (Impotence) ☐ Frequent Bladder Infections
☐ Glomerulonephritis ☐ Infertility ☐ Kidney Stones
☐ Urinary Incontinence
☐ Other ____________________

Comments ____________________

Musculoskeletal/Connective Tissue - Chondromalacia Patellae

☐ Chronic Pain ☐ Fibromyalgia ☐ Fractures ☐ Gout
☐ Juvenile Rheumatoid Arthritis ☐ Osgood-Schlatter Disease
☐ Osteoarthritis ☐ Osteoporosis
☐ Systemic Lupus Erythematosus
☐ Other ____________________

Comments ____________________

Endocrine

☐ Addison's Disease ☐ Carcinoid Syndrome
☐ Cushing's Disease ☐ Diabetes, Type 1 ☐ Diabetes, Type 2
☐ Hyperthyroidism ☐ Hypothyroidism ☐ Osteoporosis
☐ Panhypopituitarism
☐ Other ____________________

Comments ____________________

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Neurological

☐ ADD ☐ ADHD ☐ Alzheimer's Disease ☐ Autism
☐ Cerebral Palsy ☐ Degenerative Disc Disease ☐ Dementia
☐ Headaches, Tension ☐ Huntington's Disease ☐ Meningitis
☐ Mental Retardation ☐ Migraines ☐ Multiple Sclerosis
☐ Muscular Dystrophy ☐ Myasthenia Gravis
☐ Parkinson's Disease ☐ Sensory Neuropathy ☐ Seizures
☐ Stroke ☐ TIAs
☐ Other ____________________

Comments ____________________

Hematologic

☐ Hemolytic Anemia ☐ Iron Deficiency Anemia
☐ Pernicious Anemia ☐ Sickle Cell Disease ☐ Thalassemia
☐ Other ____________________

Comments ____________________

Allergy/Immune/Skin

☐ Allergies ☐ Angioedema ☐ Chicken Pox
☐ Ear Infections (frequent) ☐ Eczema ☐ Giardiasis
☐ Immune Deficiency ☐ Psoriasis ☐ Sinusitis (frequent)
☐ Other ____________________

Comments ____________________

Other

☐ Cancer ☐ Cataract ☐ Glaucoma ☐ Over Weight
☐ Other ____________________

Comments ____________________

Psychiatric

☐ Anxiety ☐ Anorexia Nervosa ☐ Bipolar Disorder
☐ Bulimia ☐ Depression ☐ Obsessive Compulsive
☐ Schizophrenia
☐ Other ____________________

Comments ____________________

Surgical History:

Family History

Father

Medical Problems

Age at Death (if NA, please indicate) ________

Cause of Death (if NA, please indicate)

Mother

Medical Problems

Age at Death (if NA, please indicate) ________

Cause of Death (if NA, please indicate)

Brother(s)

How many? ________

Medical Problems

Age at Death (if NA, please indicate) ________

Cause of Death (if NA, please indicate)

Sister(s)

How many? ________

Medical Problems

Age at Death (if NA, please indicate) ________

Cause of Death (if NA, please indicate)

Son(s)

How many? ______

Medical Problems

Age at Death (if NA, please indicate) ______

Cause of Death (if NA, please indicate)

Daughter(s)

How many? ______

Medical Problems

Age at Death (if NA, please indicate) ______

Cause of Death (if NA, please indicate)

Paternal Grandfather

Medical Problems

Age at Death (if NA, please indicate) ______

Cause of Death (if NA, please indicate)

Paternal Grandmother

Medical Problems

Age at Death (if NA, please indicate) ______

Cause of Death (if NA, please indicate)

Maternal Grandfather

Medical Problems

Age at Death (if NA, please indicate) ______

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Cause of Death (if NA, please indicate)

Maternal Grandmother

Medical Problems

Age at Death (if NA, please indicate) ________

Cause of Death (if NA, please indicate)

Pregnancy/Gynecological History

Pregnancies (#): ____________________

Children (#): ____________________

Terminations (#): ____________________

Miscarriages (#): ____________________

Please check off all that apply:

☐ Menstrual Problems
☐ Pregnancy Problems

If you have had a hysterectomy, was it:

☐ Total (ovaries removed)
☐ Partial (ovaries retained)

Current Birth Control: ____________________

Age Periods started: ____________________

Age at Menopause: ____________________

Last Pap Smear: ____________________

Last Mammogram: ____________________

Social History

Occupation

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Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ______________

Number of Children ______

Names and Ages

Hobbies

Exercise (type)

Frequency of exercise: ☐ Daily ☐ Weekly ☐ Rarely ☐ Never

Caffeine: ☐ Coffee ☐ Tea ☐ Chocolate ☐ Soda ☐ Other ______________

Comments ______________

Amount of caffeine consumed (please indicate type): ______

Smoking: ☐ Never ☐ Now (indicate packs/day below) ☐ In past (indicate quit date below) ☐ Other ______________

Comments ______________

If you have smoked in the past before, please indicate how many packs/day or when the quit date was: ______

Type: ☐ Cigarettes ☐ Cigar ☐ Smokeless ☐ Other ______________

Comments ______________

Foods Restricted: ☐ Wheat ☐ Dairy ☐ Peanuts ☐ Soy ☐ Red Meat ☐ Other ______________

Comments ______________

How often do you use alcohol?

☐ Social ☐ None ☐ Rare ☐ Experimented with
☐ Regular ☐ Occasional Binge ☐ In past
☐ Current alcoholic ☐ Past alcoholic
☐ Other ____________________

Comments ____________________

Who is your emergency contact? *

____

What is your emergency contact's phone number? *

[ ]