

# Quantum Light Healthcare

Dr Kathleen "Kat" Halloran, ND Phone: 425-774-1814 Phone/Fax: 1-888-955-4443  
Edmonds: 7631 – 212<sup>th</sup> St SW | Suite 106B | Edmonds, WA 98026  
North Bend: 231 Bendigo Blvd N | North Bend, WA 98045

## Primary Insurance Information:

Date: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_

Sex: M / F Birthdate: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Relationship Status:

Single  Married  Partnered  Divorced  Widowed  Other

Insurance ID#: \_\_\_\_\_

Patient SSN: \_\_\_\_\_

Group ID# \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Copay: \_\_\_\_\_ Deductible: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Have a Health Savings Account? Yes / No

Work Phone: \_\_\_\_\_

ASSIGNMENT:  I do not have medical insurance and am responsible for all charges.

Which Phone # would you prefer us to use? \_\_\_\_\_

May we leave messages? \_\_\_\_\_

Employment:

Employed  F/T Student  P/T Student  Retired  Other

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Parent / Guardian / Spouse / Partner Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## EMERGENCY CONTACT:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
(Responsible Party Signature)

## Please Initial and Sign Below:

\_\_\_\_\_, I, the undersigned, understand that I am financially responsible for all charges and agree to pay for services. I certify that I have insurance with \_\_\_\_\_ and I authorize direct payment to Dr Kathleen Halloran, ND for any insurance benefits for services rendered. I understand that if I fail to provide complete and accurate billing at the time of service, I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee.

\_\_\_\_\_, I understand that my records are confidential and protected by the Federal HIPPA Health Information Protection Act and can only be released to other practitioners by signed authorization from the patient upon request.

X \_\_\_\_\_

(Responsible Party Signature)

## Secondary Insurance Information:

Insurance Name: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Group# \_\_\_\_\_

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YOUR NAME \_\_\_\_\_ DATE \_\_\_\_\_

The following information will be helpful for us to get to know you, and to manage our time together. It is completely confidential.

Please describe the primary purpose of your visit:

\_\_\_\_\_

Would you like Dr Halloran to be your Primary Care Doctor? Yes ( ) No ( )

Would you like Dr Halloran to coordinate and collaborate with your other doctors and providers? Yes ( ) No ( )

List all medications and dosages

\_\_\_\_\_

Do you take any supplements? Please list below

\_\_\_\_\_

Briefly list any past illnesses and/or hospitalizations

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Are you Allergic to any medications or foods?

\_\_\_\_\_

Are there any illnesses that run in your family (heart disease, cancer, diabetes, etc...)?

\_\_\_\_\_

Have you been vaccinated for the following:

Childhood Shots Yes / No

Hepatitis B Yes / No

HPV Yes / No

Seasonal Flu Yes / No

Anthrax Yes / No

H1N1 "Swine" Flu Yes / No

Others? Yes / No : Please Explain

\_\_\_\_\_

Who do you live with and how are those relationships for you?

\_\_\_\_\_

Do you smoke cigarettes Y( ) N( )

Do you use recreational drugs Y( ) N( )

Prescription narcotics Y( ) N( )

Drink Alcohol Y( ) N( ) If so, how much/often \_\_\_\_\_

Any other information Dr Halloran should know?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Quantum Light Healthcare – Dr Kat Halloran, ND | Symptom Intake Form

Please review the following and circle if any of the following symptoms **are new to you, seem unusual, or appear to be related to today's visit.**

Feel free to skip any categories that don't apply.

**General** - recent weight change, fever

Other – please explain: \_\_\_\_\_

**Skin** - Any rashes, lumps, skin color change, new moles or changes in existing moles

Other – please explain: \_\_\_\_\_

**Eyes** - Changes in vision.

Other – please explain: \_\_\_\_\_

**Nose and Sinuses** - Nasal Allergies, nosebleeds, or sinus trouble

Other – please explain: \_\_\_\_\_

**Neck**- swollen glands, lump in throat

Other – please explain: \_\_\_\_\_

**Breasts (females only)** lumps, discomfort, nipple discharge

Other – please explain: \_\_\_\_\_

**Respiratory** - Cough, wheezing, history of lung problems or frequent infections, shortness of breath.

Other – please explain: \_\_\_\_\_

**Heart** - History of heart trouble, high blood pressure, palpitations; shortness of breath lying down, chest pain or tightness

Other – please explain: \_\_\_\_\_

**Gastrointestinal** - Trouble swallowing, heartburn, appetite changes, nausea, vomiting, hemorrhoids, constipation, or diarrhea. Abdominal pain, food intolerance. Jaundice, or hepatitis, history of parasitic or yeast infections,

Other – please explain: \_\_\_\_\_

**Musculoskeletal** - numbness or tingling in arms or legs, joint pain, stiffness, soreness, neck pain, back pain, other pain

Other – please explain: \_\_\_\_\_

**Genito Urinary** - Increased frequency of urination, burning or pain on urination, blood in urine, frequent UTI's (bladder infections), menstrual pain / irregularities, menopausal symptoms

Other – please explain: \_\_\_\_\_

**Sleep** - Trouble falling to sleep, waking up and cant get back to Lack of restful sleep. Excessive daytime sleepiness, wake up tired. Pain or breathing problems that interfere with sleep. Leg movements that interfere with sleep, excessive fatigue.

Other – please explain: \_\_\_\_\_

**Sexual** - Changes in sexual interest, satisfaction, sexually transmitted disease exposure.  
History of sexual trauma.

Other – please explain: \_\_\_\_\_

**Mood** - Mood swings, loss of interest or enjoyment in life, crying spells, agitation or anxiety.

Other – please explain: \_\_\_\_\_

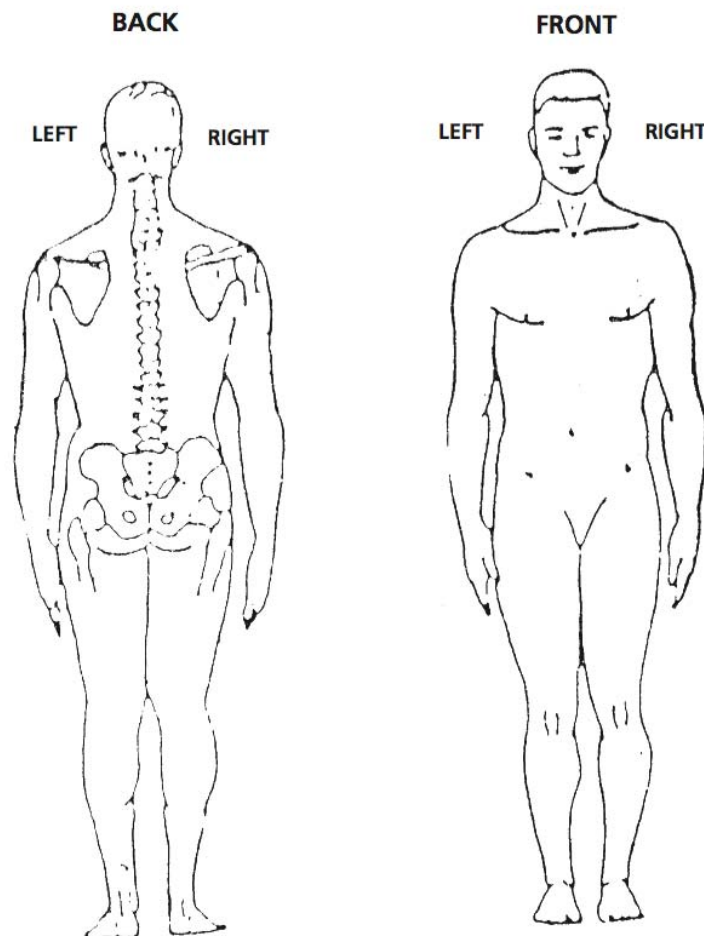
**Social** – Stress or loss such as death, divorce, job change, feel like you work too much or have a stressful job, moving, or anticipation of upcoming event such as presentation or public speaking.

Other – please explain: \_\_\_\_\_

**Please circle areas of discomfort using the diagram below:**

Please complete the "Pain Diagram" by using the letters in the key below to indicate on the diagram your areas of pain.

<b>PAIN</b>	<b>(P)</b>
<b>TINGLING</b>	<b>(T)</b>
<b>NUMBNESS</b>	<b>(N)</b>
<b>BURNING</b>	<b>(B)</b>
<b>STIFFNESS</b>	<b>(S)</b>



**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_