Quantum Light Healthcare

Dr Kathleen "Kat" Halloran, ND   Phone 425-774-1814   Phone/Fax 1-888-955-4443
Edmonds: 7631 212th St SW | Suite 106 B | Edmonds, WA 98026
North Bend: Park Street Healing Arts | 318 E Park Street | North Bend, WA 98045

Date____________________

Patient Name: ___________________________________

Address:____

City___________________ State_____ Zip__________

Email Address___________________________________

Gender: M / F / Other   Birthdate:_______________

Relationship Status:
__Single __ Married __Partnered __Divorced __Widowed __Other

Patient SSN: ________________________

How did you hear about us?__________________________

Home Phone:_____________________________________

Cell Phone:______________________________________

Work Phone:_____________________________________

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 (If Different than above)

Name:____

Phone:________________________ Relationship:_________

Insurance Name:__________________________________

Insurance Phone:_________________________________

Claims Address:__________________________________

Subscriber's Name:________________________________

Subscriber's Birthdate:____________________________

Relationship to you:_______________________________

Insurance ID#____________________________________

Group#____

Employer of Insured_______________________________

Copay_______   Deductible:_______________

Do you have a Health Savings Account? Yes / No

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

____
(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 will be assessed a $75 cancellation 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 for the patient upon request.

X____
Responsible Party Signature

Quantum Light Healthcare

Dr. Kathleen "Kat" Halloran Phone: 1-888-955-4443
7631 – 212th St SW | Suite 106B | Edmonds, WA 98026

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: __________________

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: ____

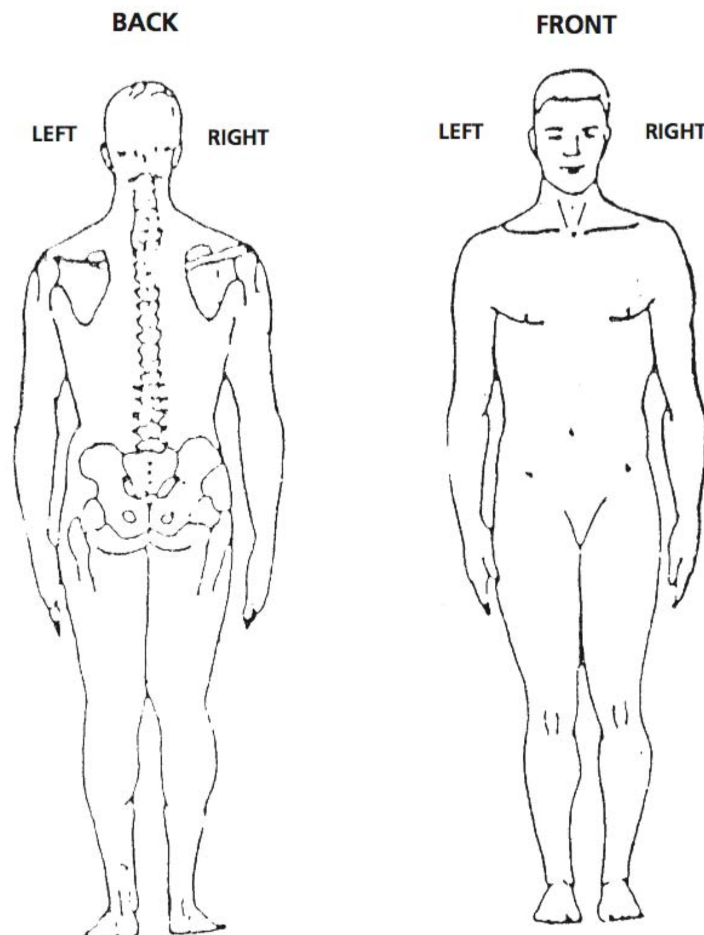
Mood - Mood swings, loss of interest or enjoyment in life, crying spells, agitation or anxiety.
Other – please explain: ____

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.

PAIN	**(P)**
TINGLING	**(T)**
NUMBNESS	**(N)**
BURNING	**(B)**
STIFFNESS	**(S)**



Patient Signature:____ **Date:**__________________