INITIAL HEALTH HISTORY

Name: ____**Date:** _______________**Referred By:** _______________
Date of Birth: ________________________ **Occupation/Employer:** ____
Address: ____**City/State/Zip:** _________________________________
Cell Phone: __________________________**Home/Work Phone:** _________________ **Email:** __________________________
Primary Healthcare Provider: ____**Phone:** _____________________________
Permission to consult primary care provider. Please Initial if yes: ____
Emergency Contact: ____________________________________ **Contact Phone:** ______________________________________

HEALTH HISTORY

MUSCULO-SKELETAL
_____ Large Metal Implants (Joints-teeth)
_____ Bone or joint disease
_____ Tendonitis
_____ Bursitis
_____ Broken/fractured bones
_____ Arthritis
_____ Sprains/strains
_____ Low back, hip, leg pain
_____ Neck, shoulder, arm pain
_____ Headaches/Head injuries
_____ Spasms/cramps
_____ Jaw pain/TMJ
_____ Lupus
_____ Other ___________________

SKIN
_____ Melanoma or any skin cancer
_____ Rosacea
_____ History of Keloids
_____ Unhealed Wounds
_____ Allergies
_____ Rashes
_____ Athletes Foot
_____ Wart
_____ Other ____________________

ALLERGIES
_____ Allergies to Zinc or Nickle
_____ Nuts
_____ Other ___________________

INFECTIOUS/AUTOIMMUNE DISEASE
_____ HIV/AIDS
_____ Any communicable diseases
_____ Herpes/ Shingles
_____ Disease name(s): ______________

DIGESTIVE
_____ Abdominal operations
_____ Constipation Gas/bloating
_____ Diverticulitis
_____ Irritable bowel syndrome
_____ Other ____________________

REPODUCTIVE
_____ Pregnant
_____ Nursing
_____ PMS
_____ PCOS-Endometriosis-Fibroids
_____ Other ____________________

ENDOCRINE
_____ Thyroid (Hypo/Hyper)
_____ Diabetes
_____ Adrenal Fatigue
_____ Pituitary
_____ Other: ____________________

ADDICTIONS
_____ Drug/alcohol addiction
_____ Nicotine/Caffeine Addiction
_____ Sugar
_____ Other ____________________

NERVOUS SYSTEM
_____ Epilepsy
_____ Neurobiological disorders
_____ Lack of sensitivity
_____ Numbness/tingling
_____ Chronic pain
_____ Fatigue
_____ Sleep disorders
_____ Other ____________________

CIRULATORY- CARDIOVASCULAR
_____ Heart condition
_____ Pacemaker or other devices
_____ Thrombosis
_____ Taking any Anti-Coagulants
_____ Hemophilia
_____ History of internal bleeding
_____ Varicose veins
_____ High/Low blood pressure
_____ Lymphedema
_____ Breathing difficulty
_____ Sinus problems
_____ Allergies
_____ Other ____________________

OTHER
_____ Cancer/tumors
_____ Chemotherapy (within last 6 months)
_____ Radiation (within last 6 months)
_____ Eating disorders
_____ Organ transplant
_____ Kidney or Liver Issues
_____ Depression
_____ Anxiety
_____ Other __________________

If answered YES to any of the above, please explain: ____
____
____
____
Current medications that you're taking: (Include aspirin, ibuprofen, natural supplements) _________________________
____
____
____
Are you taking any recreational drugs? ____

PREVIOUS HISTORY (Include year and treatment received)

Surgeries: ____
____
Accidents: ____

I, ____ have read through and answered honestly all the above questions. All previous questions of mine have been answered and I understand the treatment in its entirety. It is my choice to receive treatment; I realize that these sessions are being given for the well-being of my body and mind. I agree to communicate with my practitioner any time I feel like my wellbeing is being compromised.

I understand that the practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that none of the services offered at ***Uma Clinic*** are a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status.

SIGNATURE: ____ **DATE:** _________________________

Appointment Policies

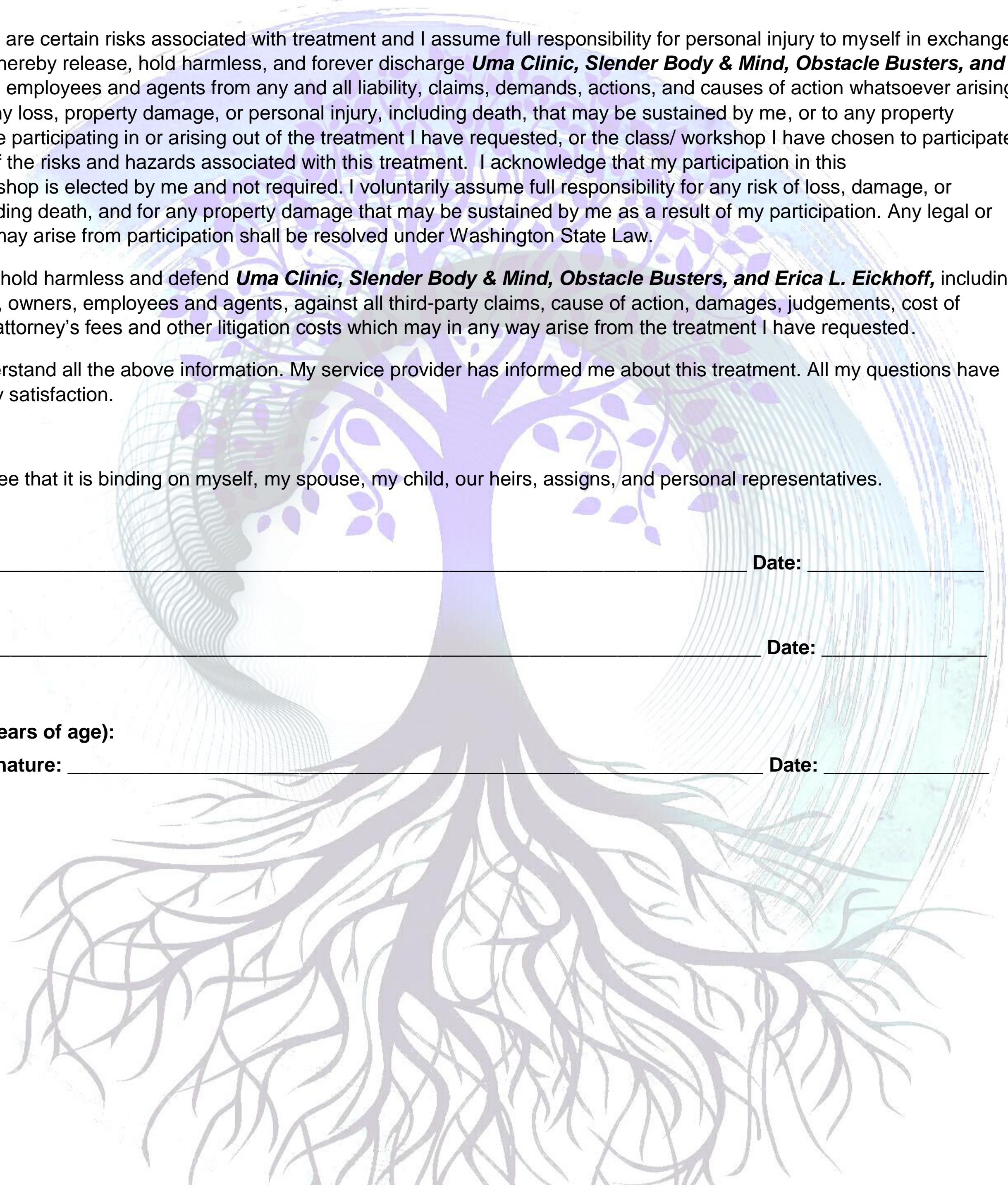
Please realize that when you set your appointment up that it is for a specific amount of time. Late arrivals are not granted extensions but will receive the remainder of their scheduled session.

Should the circumstance arise where you need to cancel or reschedule an appointment a *24-hr notice is required*. **Failure of giving the required notice will result in a cancellation fee of the full rate of the missed appointment** You are personally responsible for this fee, and its payment is required before your next scheduled appointment.

I hereby agree to the above stated charge and agree to pay the above stated fee.

Client Signature: ___________________________________ **Date:** ______________________

RELEASE OF LIABILITY & HOLD HARMLESS AGREEMENT:



I recognize that there are certain risks associated with treatment and I assume full responsibility for personal injury to myself in exchange for such treatment. I hereby release, hold harmless, and forever discharge ***Uma Clinic, Slender Body & Mind, Obstacle Busters, and Erica L. Eickhoff,*** its employees and agents from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, property damage, or personal injury, including death, that may be sustained by me, or to any property belonging to me while participating in or arising out of the treatment I have requested, or the class/ workshop I have chosen to participate in. I am fully aware of the risks and hazards associated with this treatment. I acknowledge that my participation in this treatment/class/workshop is elected by me and not required. I voluntarily assume full responsibility for any risk of loss, damage, or personal injury, including death, and for any property damage that may be sustained by me as a result of my participation. Any legal or equitable claim that may arise from participation shall be resolved under Washington State Law.

I agree to Indemnify, hold harmless and defend ***Uma Clinic, Slender Body & Mind, Obstacle Busters, and Erica L. Eickhoff,*** including its officers, members, owners, employees and agents, against all third-party claims, cause of action, damages, judgements, cost of expenses, including attorney's fees and other litigation costs which may in any way arise from the treatment I have requested.

I have read and understand all the above information. My service provider has informed me about this treatment. All my questions have been answered to my satisfaction.

I understand and agree that it is binding on myself, my spouse, my child, our heirs, assigns, and personal representatives.

Printed name: ____ **Date:** _____________

Signature ____ **Date:** _____________

(If under eighteen years of age):
Legal Guardian Signature: ____ **Date:** _____________

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to obtain a paper copy of this notice from us upon request.

CLIENT NAME:_____________________________________

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices from.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Signature:____**Date:** ___________________________

Patient Name: ____

Relationship to Patient: ____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED

BELOW: