10 Minute Walk-In Clinic

Lab Paid _____

540 West Avenue, Arlington, WA 98223
Phone: (360) 435-8262 Fax (360) 474-1394

Patient Information

Last Name:	First Name:			Birth Date: / /
Address:	City:	State:	Zip:	Gender: (circle one) M F
Cell Phone: Evening Phone:		Regular Doctors Name:		What City?

Medical Information - Patient or parent to complete this information

Reason for Today's Visit:

Allergies to Medications:

Your Current Medications:

Please list any medical problems such as Diabetes, Hypertension, Asthma, Migraine, Depression, Cholesterol, Thyroid, etc.

I hereby consent to treatment by the attending provider for medical and surgical procedures, tests, and local anesthetics as deemed necessary by myself and the provider. I acknowledge that I understand that the **10 Minute Walk-In Clinic** is a separate business than the Arlington Pharmacy. The **10 Minute Walk-In Clinic** is independently owned and operated. Arlington Pharmacy has no control over the practice of the **10 Minute Walk-In Clinic.** I fully understand that I am financially responsible for any and all of the costs of my health care. I further understand and agree to pay for services and tests. I understand that none of these charges are covered by Medicare, Welfare, L & I and most other health insurance programs. Our prices are low because we do not participate with any insurance plans. It is unlikely that your insurance company will reimburse you for the expense of this office visit.

The **10 Minute Walk-In Clinic** limits its practice to just one problem that can readily be diagnosed and treated within a 10 minute time frame. The clinic provides episodic health care. For reoccuring problems or medical conditions that do not resolve, it is the patient is responsibility to seek the advise of a primary care physician or a medical specialist. It is not our intention to replace the comprehensive care of your primary care provider.

I hereby authorize the release of today's visit and any tests to my Primary Care Provider whom I have indicated on this registration form. I authorize my records to be transmitted by phone, fax, mail or other means to my Primary Care Provider. If someone other than the patient is signing this authorization, please state the relationship with the patient and the reason the patient is unable to sign. I authorize the **10 Minute Walk-In Clinic** to leave voice mail messages concerning my health information (such as lab results, follow up care, etc.) at my home or cell phone. By my signature below I acknowledge that I have seen a copy of the Notice of Privacy Practices for the **10 Minute Walk-In Clinic**. I may have a free copy of this policy simply by asking for it.

Signature of Patient * _____ Date: _____

*** If the patient is a child under the age of 18, complete the following:**

Parent or Guardian's Signature: _____ Date: _____

Print Name of parent or Guardian: _____

PLEASE COMPLETE THIS SIDE ONLY

THEN TAKE TO THE PHARMACY CASHIER

10 Minute Walk-In Clinic 540 West Ave, Arlington, WA 98223 Phone 360 435-8262

Date: _____ Name: _____ Time: _____ Birth date: _____ M F
(Last) (First)

SUBJECTIVE: Chief Complaint: _____ How Long? _____

Circled = Pos Crossed out = Neg

Chills Fever
Chest Congestion
Cough: with Phlegm: Cl Gr Yel
Wheezing Chest Pain
Fatigue Body Aches
Sore Throat
Eyes: Red Matted FB Itch Burn Goop

Headache
Location: Front Back Side Lt Rt
Pulsate Stab Squeeze Ache
Photophobia Phonophobia
Hx: Sinusitis Bronchitis Cystitis ↑BP
Diabetes Pneumonia Asthma OM

Sinus Pressure
Rhinorrhea: Cl Gr Yel
Nasal Congestion
Ears: Pain Pressure Lt Rt
Decreased Appetite OK
Nausea Vomiting Diarrhea
Abdominal Pain

Current Meds:

UTI
Frequency Dysuria, Hesitancy
Urgency, Flank Pain, Blood
Pregnant: Yes No
LMP:
Smokes: ____ pks/day **Allergies:**

OBJECTIVE:

Weight	lbs
Resp	/min
Pulse	/min
Temp	F
BP	/
Pulse Oxi	%

Strep ID: Neg Pos

UA: Neg WBC

General: ___ Appears in no acute distress
Skin: ___ Good color, no rashes
Ears: ___ TMs grey, light reflex present
Eyes: ___ Sclera θ injected, lids θ edema, θ matting
Nose: ___ No discharge, no injection, no congestion
Sinuses: ___ Non tender on palpation of frontal and maxillary
Pharynx: ___ No injection, θ cobble stoning, θ drainage
Tonsils: ___ No swelling, no drainage
Neck: ___ Supple and without nodes
Lungs: ___ Clear, no rales, no wheezing, no rhonchi
Heart: ___ Reg rhythm
___ No murmur
CVA: ___ Non tender on palpation.
Abd: ___ Soft and non tender, no rebound
Neuro: ___ Alert & Orientated x 3, Speech clear, Gait ok, Strength ok
___ Cerebella intact, PERLA, sharp/dull sensation intact
___ Cranial Nerves II-XII intact, DTRs equal, Neg Rhomberg

ASSESSMENT:

PLAN: **Rx:**

___ STOP SMOKING
___ Use vaporizer, humidifier or steam
___ Repeat $10 Strep ID within 3 days prn
___ Ibuprofen and Tylenol alternate q3h prn
___ Warm gargles ___ Simple Saline Nasal Spray
___ OTC Decongestants - Mucinex - Antihistamines
___ Follow-up with PCP prn or _____ days
___ Recheck (in ____ days) or if symptoms persist or increase

Practitioner's Signature