Belleview
SPINE AND WELLNESS

Date: _____

Patient Information

Name: _____
Last First MI

Date of Birth: _____ Sex: ❑ Male ❑ Female

Who may we thank for referring you to our office? _____

Email address: _____

Mailing Address: _____
Street/Apt City State Zip

Telephone: Cell_____ Work_____ Alt._____

May we leave you voicemails regarding your appointments? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address:_____ Phone: _____

Emergency contact: Name:_____ Relation:_____ Tel. _____

Phone #: (H)_____ (W) _____

Accident Information

Is this visit due to an accident? ❑ No ❑ Yes (**STOP** and see the front desk, we have a different intake for you!)
If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Insurance Information

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Policy Holder Name:_____ D.O.B. :_____

Relationship to patient (if other than self):_____ Phone # _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X)_____ **DATE** _____

Patient Intake

Name: _____DOB:_____/_____/_____Age:_____Date of Exam:_____

❑Low Back Pain
❑Pain between Shoulder Blades
❑Neck Pain
❑Tension/Headaches
❑Fibromyalgia

❑Tension Across Top of Shoulders
❑Numbness/Tingling in Arms/Hands
❑Numbness/Tingling in Legs/Feet
❑Pain in the legs
❑Pain in the feet

❑Tired/Fatigued
❑Difficulty Sleeping
❑Allergies
❑Digestive Problems
❑Carpal Tunnel

Other *(Explain)*_____

Which of the above is the worst? _____

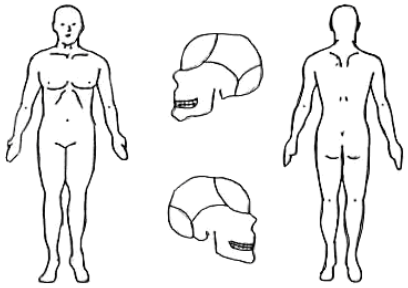
How long have you had it? _____

What does it feel like? *(Describe)* _____

What have you done that has helped this problem?_____

What does this problem prevent you from doing?_____

Indicate PRIMARY area of pain/symptoms below:



What have you tried to help relieve/get rid of this problem and how much did it help? (Circle)

❑Medications | Helped? ***Little*** ***Some*** ***Much***
❑Exercise | Helped? ***Little*** ***Some*** ***Much***
❑Nutrition | Helped? ***Little*** ***Some*** ***Much***
❑Phys. Therapy | Helped? ***Little*** ***Some*** ***Much***
❑Chiropractic | Helped? ***Little*** ***Some*** ***Much***

Does this cause:
❑Moodiness
❑Irritability
❑Sleep interruptions
❑Restriction of Daily Activities

How does this affect your work?
❑Decreased productivity
❑Unable to work long hours
❑Exhausted at the end of the day
❑Poor attitude
❑Decision making

How does this impact your life?
❑Lose patience with spouse/children
❑Difficulty with household duties
❑Hinders ability to exercise/play sports
❑Interferes with ability to do hobbies

Are you currently under drug and/or medical care? ❑ Yes ❑ No

If so, who is your primary care physician?_____

Please list **all** current medications, including name, dosage, and frequency:

_____
_____
_____

Indicate if you have any immediate family members with any of the following:

❑ Diabetes ❑Rheumatoid Arthritis
❑ Cancers ❑ Heart Problems
❑ Lupus ❑ ALS

Have you ever been hospitalized? Y/N
If yes, please explain:

_____
_____

Please list **all** current supplements, including name, dosage, and frequency:

_____
_____
_____

If you've ever had surgery, list procedure(s) and date(s):

_____
_____
_____

Have you had significant past trauma? Y/N
If yes, please explain:

_____
_____

Social History:

Intake of following: **Caffeine**_____cups/day **Alcohol**_____drinks/week **Cigarettes**_____packs/day

Exercise frequency: ❑Never ❑Daily ❑Weekly ❑Walking ❑Running ❑Swimming ❑Lifting

How would you rate your overall health? ❑Excellent ❑Good ❑Fair ❑Poor

Please list any known **allergies**:_____

Is there anything else you feel we should know?_____

Patient Name:_____Date:_____

Past Medical History and Review of Systems

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches: how often?_____
___	___	Slurring of speech
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Endocrine
___	___	Diabetes
___	___	Thyroid problems
		Cardiovascular
___	___	High blood pressure
___	___	High cholesterol
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating/Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	**Skin**
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Medicines previously tried, dosage, duration and outcome.

☐Advil ☐Aleve ☐Tylenol ☐Steroids ☐Prescriptions for a period of ☐0-3mos, ☐3-6mos, ☐6-12 mos ☐12+mos

Please check ALL options you have previously tried to assist in above symptoms:

____Over the counter medications
____Prescriptions
____Dietary Changes
____Exercise
_____ Consult with specialist
_____ Supplements
_____ Alternative medication/treatment therapies

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Belleview Spine and Wellness, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as BSW) the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to BSW for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing BSW as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to BSW all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either BSW, myself, and/or my family members as a result of services rendered by BSW, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that BSW is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that BSW can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this_____day of_____20____.

_____ _____

Patient Signature Patient Name Printed

_____

Signature of Legal Guardian/Representative (if applicable)

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stoke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injection, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about this consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I understand that I will receive appointment reminders via text message.

Patient Name:_____ Signature:_____ Date: _____

Parent or Guardian:_____ Signature:_____ Date: _____

Witness name: _____ Signature: _____ Date: _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of_____.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ _____

Patient Name Printed Date

x_____
Patient Signature

_____ _____

Witness Name (Office Staff) Date

x_____
Witness Signature