Be Well

Chiropractic & Health

255 Hope Street Providence RI 02906

Patient Intake

Name_____ Date _____

Address _____

City_____ State _____ Zip _____

Phone_____ Email Address _____

Age_____Date of Birth _____ Social Security # _____

Gender _____Preferred Pronoun _____Marital Status (S) (M) (D) (W)

Number of Children _____Occupation _____Referred by _____

Emergency Contact _____ Phone Number _____

General Practitioner's name & number _____

Please state the main reason for your visit._____

_____

Please list any difficulties you are experiencing with activities you have engaged in since your condition arose:

_____

Please check the statement that best applies to your expectations of care:

_____ I wish to improve my overall health and wellbeing. Other: _____

_____ I am interested in structural/postural correction.

_____ I am interested in pain relief only. _____

Please list all known allergies. _____

Please list any medication, over the counter products, vitamins or herbs you are taking.

_____

Please list any previous dislocations or fractures (broken bones) and the year in which they occurred.

_____

Please list any previous surgeries or operations and the year in which they occurred.

_____

Please list any health conditions for which you have been seen by a physician in the past year.

_____

Have you ever had cancer? **Y** or **N** If Yes, What kind? _____

Please list any medical conditions not listed above. _____

Family History

Do you have a family history of any of the following? Please indicate **who** has had this condition.

( ) High Blood Pressure ( ) Heart Attack ( ) Stroke
( ) Kidney Disease ( ) Emphysema ( ) Seizure-Convulsions
( ) Rheumatoid Arthritis ( ) Mental Illness ( ) Asthma
( ) Thyroid Disease ( ) Diabetes ( ) Cardiovascular
( ) Ulcer or Stomach Problems ( ) Cancer. what type? _____

( ) Other _____

Habits: (please check)

Cigarettes?_____Quantity _____For How Long?_____
Alcohol?_____Quantity _____For How Long?_____
Coffee?_____ Quantity _____

Have you lost or gained weight in the past year? _____

Do you exercise regularly? Y or **N** What kind of exercise? _____

Do you have a pacemaker or any metal implants? _____

Females: Date of last menstrual period _____Do you have any reason to believe that you may be pregnant? **Y** or **N**

Is there anything else you would like to discuss with the doctor? _____

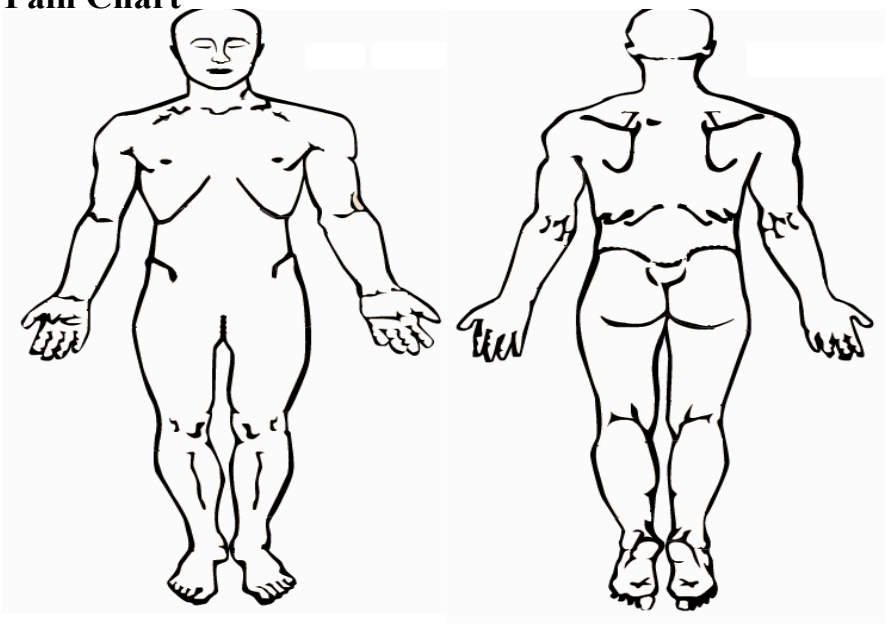
_____

Show Area(s) of Pain or Unusual Feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiating pain. Include all affected areas.

Numbness	Pins & Needles	Burning	Achy	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /

Pain Chart



Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please check under the letter **N** if you have these conditions now (within the past 12 months) or under **P** if you ever had these conditions in the past.

	Now	Past		Now	Past		Now	Past
	N	**P**		**N**	**P**		**N**	**P**
Appetite Decrease	___	___	**Fever**	___	___	**Memory Loss**	___	___
Arm Pain	___	___	Frequent Colds	___	___	Menstrual Problems	___	___
Arthritis	___	___	Headache	___	___	Muscle Spasms	___	___
Back Pain	___	___	Heartburn	___	___	Neck Pain	___	___
Balance Problems	___	___	Vomiting Blood	___	___	Nervousness	___	___
Belching	___	___	Blood in Stools	___	___	Night Sweats	___	___
Bowel Habit Change	___	___	Blood in Urine	___	___	Shoulder Pain	___	___
Chest Pains	___	___	Spitting Up Blood	___	___	Sinus Problems	___	___
Cold Feet	___	___	Hemorrhoids	___	___	Sleep Problems	___	___
Cold Hands	___	___	Hoarseness	___	___	Stiffness	___	___
Constipation	___	___	Irritability	___	___	Stomach Problems	___	___
Depression	___	___	Joint Swelling	___	___	Fainting	___	___
Diabetes	___	___	Knee Pain	___	___	Tension	___	___
Diarrhea	___	___	Leg Cramps	___	___	Ears Ringing	___	___
Double Vision	___	___	Light Sensitivity	___	___	Urinary Difficulty	___	___
Dizziness	___	___	Loss of Smell	___	___	Urinary Incontinence	___	___
Shortness of Breath	___	___	Loss of Taste	___	___	Urinary Retention	___	___
Hypertension	___	___	Dark Tarry Stools	___	___	Vertigo	___	___
Fatigue	___	___						

Other Symptoms:_____

Acceptance as a Patient

I understand and agree that the doctors of Be Well have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. When I am accepted as a patient, I assign full benefits to Be Well. I understand that Be Well reserves the right to charge me in the amount of $45.00 for any missed appointments without 24 hours notice.

_____ _____

Signature Date

Release of Records

I hereby authorize you, your employees and agents to furnish to all pertinent healthcare provider/person(s) and health insurance companies, all records and reports, including X-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I or my dependent may have had in the past, now have, or may have in the future.

_____ _____

Signature Date

For office use only

H: _____ W:_____lbs BP: _____/_____ P:_____bpm R: _____bpm

CC:_____

_____

_____

_____

Patient Name: _____

• **The nature of the chiropractic adjustment.** The doctor may use her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," which signifies gases moving through those joints allowing for the movement to occur. You may feel or sense movement.
• **The material risks inherent in chiropractic adjustment.** As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.
• **The probability of those risks occurring.** Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with prominent authority stating that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."1 Haldeman, Scott, D.C. M.D.
• **Ancillary treatment.** The doctor may offer treatment options, aside from chiropractic manipulation, that may include physiotherapy, rehabilitation, and nutritional and lifestyle counseling. Such further treatment options will be discussed with you after a thorough examination and report of findings has been completed.
• Other treatment options exist for your condition. The material risks inherent in such options and the probability of such risks occurring include:
• **Overuse of over-the-counter medications** produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
• **Prescription muscle relaxants and pain-killers** can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance, self-discipline in not abusing the medicine and proper professional supervision.
• **Hospitalization** in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability if iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon variables.
• **The risks inherent in surgery** include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies with many factors.
• **The risks and dangers attendant to remaining untreated**. Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.
Regarding INSURANCE: This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

*****Do Not Sign Until You Have Read And Understand The Above.*****

I have read the above explanation of the chiropractic adjustment and related treatment. Treatment options, risks, and benefits have been discussed, and I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and benefits involved in undergoing treatment and have decided to undergo the treatment recommended. Having been informed of all risks and benefits, I hereby give my consent to that treatment.

Printed Name	Signature
Signature of Parent or Guardian (if a minor)	Date