Better Energy Everyday Wellness Intake Form

Susan Alvarez Vineta, DC

Title: (Circle one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Prof. □ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Email _____

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female □ Unspecified

Social Security Number: _____-_____-_____ **Marital Status:** □ Single □ Married □ Widow

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer Data

Employer _____

Your Occupation _____

Work Phone (_____) _____-_____

Spouse Data

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Spouse Date of Birth _____/_____/_____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Who should we thank for a referral to our office? _____

Doctor's Initials _____

Medical Conditions: (Circle all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Other _____	□ Fibromyalgia	□ Asthma	□ Osteoporosis

Surgeries: (Circle all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□ Breast Augmentation	□ Other _____		

Allergies: (Circle all that apply to you)

□ Mold □ Seasonal □ Latex □ Milk or Lactose □ Animal _____
□ Chemical _____ □ Sulfites □ Eggs □ Wheat/Glutens □ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□ never	
Drink Alcohol:	□ occasional	□ often	□ never	
Exercise:	□ occasional	□ often	□ never	
Drink Water:	□ <64 oz/day	□>64 oz/day	□ never	**How many ounces?** _____
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never	□ former
Sleep:	□<8 hours/night	□ >=8 hours/night	□ Insomnia	
Diet (Servings):	□ Fruits _____	□ Vegetables _____	□ Lean Meats _____	
per day	□ Fast Food _____	□ Dairy _____	□ Wheat/Grains _____	

Family History: (Circle all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

Occupational Activities:

Most of the workday you are? □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Other_____

What job did you do during most of your life?_____

How would you describe the physical stress level at work? □ Low □ Medium □ High

Please list all current medications, over the counter and supplements (dose and frequency)

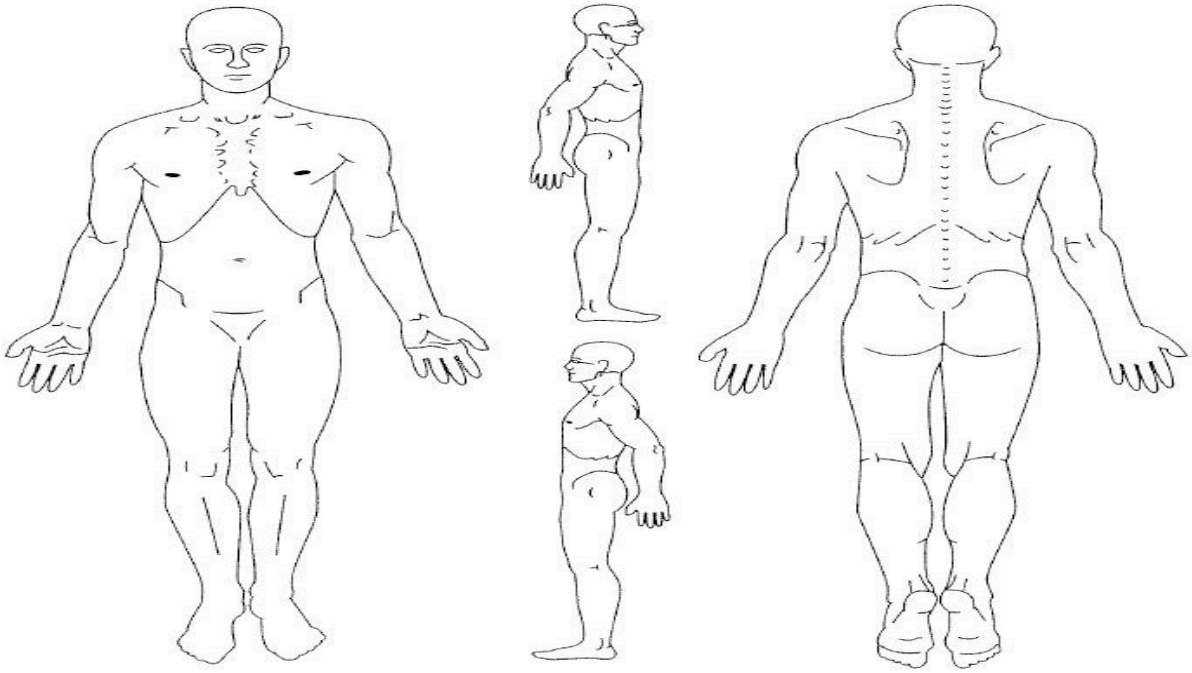
Patient Name_____Date_____

Doctor's Initials _____

Reason for Visit _____

While we will work closely with you to resolve your chief complaint, as health professionals we are also concerned about your overall wellness. We will discuss issues with you that may be impacting your overall health.

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache O=Other Type of Pain



Average Pain Intensity:

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:** _____

Does anything worsen your pain? Yes No **If Yes, please list:** _____

When did your symptoms begin? _____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

How did your symptoms begin? _____

Does the pain radiate? Yes No **If Yes, to where:** _____

Does your current complaint interfere with ☐Driving ☐Work ☐Sleep ☐Exercise ☐ Other_____

Patient Name_____Date_____

Doctor's Initials _____

How often do you experience your symptoms?

□ Constantly (76-100% of the day)	□ Frequently (51-75% of the day)	□ Occasionally (26-50% of the day)	□ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp	□ Ache	□ Numb	□ Shooting
□ Burning	□ Tingling	□ Throbbing	□ Other _____

What treatment have you already received for your condition?

□ Medications □ Surgery □ Physical Therapy □ Chiropractic Care □ Acupuncture
□ Other _____ □ None

Name of the other doctor(s) who have/or are treating you for this condition and how_____

_____

Review of Systems: Please fill out Standard Process Symptom Survey (separate document)

Are You Pregnant? (Check) ☐ **Yes** ☐ **No** ☐ **N/A** **Day of Last Menstruation** _____

PAYMENT POLICY

Thank you for choosing Better Energy Everyday Wellness Company as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. CASH, CREDIT CARD, or ELECTRONIC TRANSFER.
2. CLAIM SUBMISSION. Your insurance company may require a Super Bill, please request one at time of service. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
3. MISSED APPOINTMENT. Our policy is to charge $60.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.
All the answers provided are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at this time.

_____ _____
Signature of patient or responsible party **Date**

Patient Name_____

Doctor's Initials _____