Birthwell

Patient Demographics Form

Date: _____/_____/_____

Patient Name: _____ _____ _____
First MI Last

Date of Birth: ____/____/_____ Sex: M / F

Parent/Guardian Name: _____ _____ _____
First MI Last

Street Address: _____ Home Phone: _____

City: _____State_____ Zip _____ Mobile Phone: _____

Email Address: _____

Family Physician's Full Name: _____

PATIENT RESPONSIBILITY

I understand that Dr. Tammy Watkins and Dr. Nicole Shabino are non-participating physicians, and as such, will not bill my insurance company, should I have insurance that covers chiropractic care. All payments for my care are due at the time of service.

Birthwell has my permission to contact me the following ways:

___ May leave message on my home answering machine ___ May call my cell phone ___ May call me at work
___ May make a reminder call for appointments ___ May email me: _____

X _____ _____
Signature of Patient or Legal Representative Date

If patient is under the age of 18:

Full Name of Parent or Legal Representative: _____

Address if different than your own: _____

City _____State _____ Zip _____ Day Phone _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

My signature below indicates that I have been given an opportunity to read Birthwell's "NOTICE OF PRIVACY PRACTICES" and to have any questions answered before signing.

Signed: _____Date _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of an incompetent patient

For OFFICE USE ONLY: Employee Signature:_____Date_____

[ ] Efforts to Obtain: _____

[ ] Reason patient refused to sign: _____

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Adult Intake Form

Today's Date: ____/____/_____

Name: _____

What do you prefer to be called? _____

How did you hear about us? Friend Our Website Ad

Facebook Other: _____

Whom may we thank for referring you to Birthwell?

_____

Accident Information

Is condition due to an accident: Yes No

Type of accident: Auto Work Other _____

Date of accident: ____/____/_____

Has the accident been reported? Yes No

To whom: _____

Attorney's Name: _____#: _____

Claim#: _____

Contact: _____

Company: _____

Condition Information

Have you seen a chiropractor before? Yes No

If yes, what for? _____

Reason for this visit: _____

_____

When did your symptoms begin? _____

Is the condition getting worse? Yes No

Is the pain: Constant Comes and goes

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Ache ☐ Tingle

☐ Numbness ☐ Shooting ☐ Burning ☐ Stiffness ☐ Cramp

☐ Swelling ☐ Other:_____

Rate the severity of pain (0-no pain, 10-severe): _____

Does it affect: ☐ Work ☐ Sleep ☐ Daily Activity

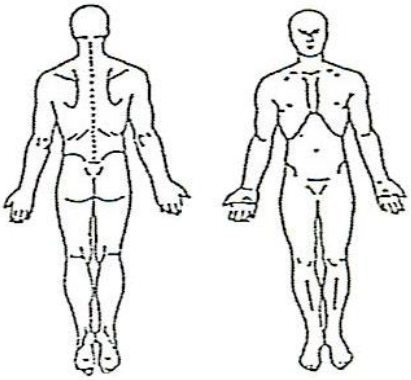
Activities that are painful: ☐ Sitting ☐ Lying down

☐ Standing ☐ Walking ☐ Bending ☐ All activity

Which is the worst? _____

Which is the best? _____

Please mark an X on the picture of the involved areas:



Have you received other treatments for your condition?

☐ Surgery ☐ Medications ☐ Physical Therapy

☐ Chiropractic ☐ Other: _____

Names of Doctors who have treated you for your condition:

_____

Other Symptoms: ☐ Headache ☐ Pins/Needles in arm/legs

☐ Arm or leg pain ☐ Loss of smell or taste ☐ Fatigue

☐ Numbness in fingers/toes ☐ Cold hands/feet ☐ Depression

☐ Shortness of breath ☐ Constipation/Diarrhea

☐ Upset stomach ☐ Loss of balance ☐ Shoulder pain

☐ Ears ringing ☐ Loss of memory ☐ Chest pain ☐ Irritability

☐ Dizziness/fainting ☐ Nervousness ☐ Tension

Daily Habits

Sleep position: ☐ Stomach ☐ Side ☐ Back

Work Position: ☐ Sitting ☐ Standing ☐ Heavy labor ☐ Light labor

☐ Computer work Is your work station ergonomically correct? Yes No

Occupation _____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Do you smoke? Yes No Packs/Day _____

Do you drink alcohol? Yes No Drinks/week _____

Do you drink caffeine? Yes No Cups/day _____

Do you use recreational drugs? Yes No

Do you have a high stress level? Yes No

What vitamins/supplements are you taking? _____

_____

What medications are you taking? _____

_____

Health History

Injuries/Surgeries you have had:	Description	Date
Falls		
Head injuries		
Broken bones		
Dislocations		
Surgeries		
Auto Accidents		
Other		

Please select all that apply or have occurred in your life:

☐ Anemia	☐ Osteoporosis	☐ Pinched Nerve	☐ Gout
☐ Arthritis	☐ Heart Disease	☐ Miscarriage	☐ Migraines
☐ Asthma	☐ Herniated Disc	☐ Multiple Sclerosis	☐ Thyroid
☐ Cancer	☐ Pacemaker	☐ High Blood Pressure	
☐ Diabetes	☐ Rheumatoid Arthritis	☐ High Cholesterol	

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes
Mother's side	☐	☐	☐	☐
Father's side	☐	☐	☐	☐

When you were a child, did you have a difficult birth? Yes No

If yes, which of the following: ☐ C-section ☐ Breach ☐ Forceps

Are you pregnant? Yes No Due Date: _____

I certify that I have read and understand the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature: _____

Date: ____/____/_____

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment I use as a doctor of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment
As a part of the analysis, examination, and treatment, you are consenting to the possible following procedures: Spinal manipulative therapy, palpation, range of motion testing, muscle strength testing, postural analysis, Kinesio taping, electrical muscle stimulation, and/or ultrasound therapy.

The material risks inherent in chiropractic adjustment.
As with any healthcare producer, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myclopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious compilations including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described are rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set 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 postpones.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Tammy Watkins and/or Dr. Nicole Shabino and 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 that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Patient Signature Date

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