be truly well
CHIROPRACTIC & DAY SPA

Patient Name _____ **Date**_____

Address_____

City_____ **State**_____ **Zip code**_____

Date of Birth_____**Gender**_____**Occupation**_____

Referred By_____

Email_____

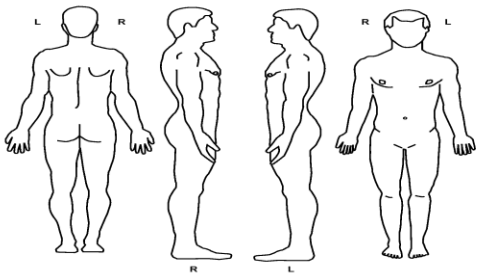
Home phone#_____ **Mobile Phone#**_____

Appointment Notification Reminder Preference: _____ **Email** _____**Home Phone Message** _____**Text Message**

Primary Care Physician PCP) _____ **PCP Phone**_____

Permission to discuss your chiropractic care with your PCP? Y or N This option can be changed at any time in writing.

1. Please indicate on the drawings below your PRIMARY COMPLAINT (One Area Only)



2. How often do you experience your symptoms?
□ Constantly (76-100% of the time)
□ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time)
□ Intermittently (1-25% of the time)

3. How would you describe the type of pain?
□ Sharp □ Numb □ Achy □ Stiff □ Stabbing w/ motion
□ Burning □ Shooting □ Shooting w/ motion
□Other:_____

4. How are your symptoms changing with time?
□ Getting Worse □ Not changing □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately
□ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?□ Not at all □ A little bit
□ Moderately □Quite a bit □ Extremely

8. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Orthopedist
□ ER physician □ Primary Care Physician
□ Physical Therapist □Other:_____

9. How long have you had this problem?□ ___days
□ _____weeks □ _____months □_____years

10. How do you think it began? □unknown □from a fall
□ poor posture □ auto accident □ work injury □sports injury
□ leisure activities □ Other_____

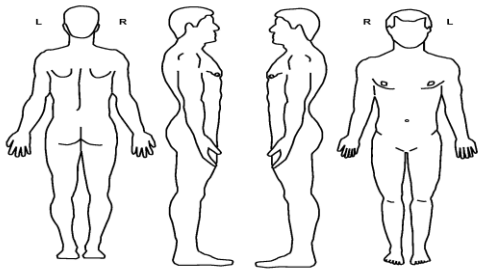
11. What aggravates your primary problem?

_____

12. What alleviates your primary problem?

_____

1. Please indicate on the drawings below your SECONDARY COMPLAINT (One Area Only)



2. How often do you experience your symptoms?
□ Constantly (76-100% of the time)
□ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time)
□ Intermittently (1-25% of the time)

3. How would you describe the type of pain?
□ Sharp □ Numb □ Achy □ Stiff □ Stabbing w/ motion
□ Burning □ Shooting □ Shooting w/ motion
□Other:_____

4. How are your symptoms changing with time?
□ Getting Worse □ Not changing □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately
□ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?□ Not at all □ A little bit
□ Moderately □Quite a bit □ Extremely

8. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Orthopedist
□ ER physician □ Primary Care Physician
□ Physical Therapist □Other:_____

9. How long have you had this problem?□ ___days
□ _____weeks □ _____months □_____years

10. How do you think it began? □unknown □from a fall
□ poor posture □ auto accident □ work injury □sports injury
□ leisure activities □ Other_____

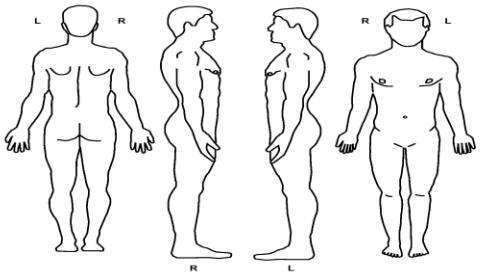
11. What aggravates your secondary problem?

_____

12. What alleviates your secondary problem?

_____

1. Please indicate on the drawings below your
ADDITIONAL COMPLAINT (One Area Only)



2. How often do you experience your symptoms?
□ Constantly (76-100% of the time)
□ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time)
□ Intermittently (1-25% of the time)

3. How would you describe the type of pain?
□ Sharp □ Numb □ Achy □ Stiff □ Stabbing w/ motion
□ Burning □ Shooting □ Shooting w/ motion
□Other:_____

4. How are your symptoms changing with time?
□ Getting Worse □ Not changing □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately
□ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?□ Not at all □ A little bit
□ Moderately □Quite a bit □ Extremely

8. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Orthopedist
□ ER physician □ Primary Care Physician
□ Physical Therapist □Other:_____

9. How long have you had this problem?□ ___days
□ _____weeks □ _____months □_____years

10. How do you think it began? □unknown □from a fall
□ poor posture □ auto accident □ work injury □sports injury
□ leisure activities □ Other_____

9. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately
□ Quite a bit □ Extremely

10. How much has the problem interfered with your social activities?□ Not at all □ A little bit
□ Moderately □Quite a bit □ Extremely

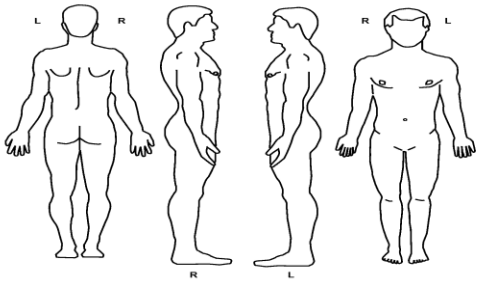
11. What aggravates your problem?

_____

12. What alleviates your problem?

_____

1. Please indicate on the drawings below your
ADDITIONAL COMPLAINT (One Area Only)



2. How often do you experience your symptoms?
□ Constantly (76-100% of the time)
□ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time)
□ Intermittently (1-25% of the time)

3. How would you describe the type of pain?
□ Sharp □ Numb □ Achy □ Stiff □ Stabbing w/ motion
□ Burning □ Shooting □ Shooting w/ motion
□Other:_____

4. How are your symptoms changing with time?
□ Getting Worse □ Not changing □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately
□ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?□ Not at all □ A little bit
□ Moderately □Quite a bit □ Extremely

8. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Orthopedist
□ ER physician □ Primary Care Physician
□ Physical Therapist □Other:_____

9. How long have you had this problem?□ ___days
□ _____weeks □ _____months □_____years

10. How do you think it began? □unknown □from a fall
□ poor posture □ auto accident □ work injury □sports injury
□ leisure activities □ Other_____

9. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately
□ Quite a bit □ Extremely

10. How much has the problem interfered with your social activities?□ Not at all □ A little bit
□ Moderately □Quite a bit □ Extremely

11. What aggravates your problem?

_____

12. What alleviates your problem?

_____

*** If you have additional areas of complaints (more than four), please inform front desk and they will provide you with additional pages.**

1. How would you rate your Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

2. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

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

□ Rheumatoid Arthritis □ Diabetes □ Lupus □None
□ Heart Problems □ Cancer □ ALS □Other_____

4. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ Dizziness	□	□ **SMOKING _____ packs per week**
□	□ Neck Pain	□	□ High Blood Pressure	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Heart Attack	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Chest Pains	□	□ Diabetes
□	□ Low Back Pain	□	□ Stroke	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Angina	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Stones	□	□ Depression
□	□ Wrist Pain	□	□ Kidney Disorders	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Bladder Infection	□	□ Epilepsy
□	□ Hip Pain	□	□ Painful Urination	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Loss of Bladder Control	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Prostate Problems	□	□ Asthma
□	□ Ankle/Foot Pain	□	□ Abnormal Wt Gain/Loss	**FEMALES ONLY**	
□	□ Jaw Pain	□	□ Loss of Appetite	□	□ Birth Control
□	□ Joint Pain/Stiffness	□	□ Abdominal Pain	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Ulcer	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Hepatitis	□	□ Dysmenorrheal (cramps)
□	□ General Fatigue	□	□ Liver/Gallbladder Disorder	□	□ Endometriosis
□	□ Muscular Incoordination	□	□ Cancer	□	□ Menopause Symptoms
□	□ Visual Disturbances	□	□ Tumor		
□	□ Chronic Sinusitis	□	□ Other _____		

5. List all prescription or over-the-counter medications and doses/refills you are currently taking:

_____

6. List all of the supplements you are currently taking:

_____

7. List all surgical procedures you have had:

_____

8. Have you ever been hospitalized? □ No □ Yes

If yes, explain _____

9. Have you had significant past trauma? □ No □ Yes

If yes, explain _____

10. List any medicine allergies you may have:

_____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for **Be Truly Well Chiropractic & Day Spa** regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **the Billing Dept. 19A Haines St, Newark, DE 19711. 302-525-4343.**

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for **Be Truly Well Chiropractic & Day Spa**

_____ _____

Patient Signature Date

_____ _____

Patient's Legal Representative if required Date

If signed by patient's legal representative, please state representative's relationship to patient:

_____

Patient Billing Agreement/Assignment of Benefits

Medical Services Billing
Keep in mind that your insurance policy is a contract between you and your insurance carrier. As a service to you, BTW (Be Truly Well) will file your insurance claims on your behalf if we have been given the correct information and you have assigned benefits to the doctor. If we are in-network with your insurance we will submit the charges directly to your primary insurance. We will submit to your secondary insurance if you provide us with the secondary information. After your insurance completes payment to us, you are responsible for payment of any allowable remaining patient balance that was not paid at the time of service. Should we be quoted incorrect benefits by your insurance, we must collect whatever balance is correct at the time of filing the claims. All insurance benefit information provided to you is an estimate at the time we received the information.

Maintenance Care
The goal of your Acute Treatment is to reach maximum medical improvement. Once you have followed your treatment plan(s) to reach that point, your care will be transitioned to Maintenance Care, which are less frequent visits, often weekly, bi-weekly, or monthly. These visits are not covered under Health Insurance and will be an out of pocket expense. At the time you have reached maintenance care, we will go over the cost with you to determine how often you are able to come in to avoid an exacerbation of your condition.

Uninsured/Under-insured Patient Visits
We understand that office visits can add up. Because of this, we are a Participating Provider with the Medical Discount Plan, Chiro Health USA. CHUSA allows us to discount some of our services by up to 60%. If you are interested in joining this discount plan, please speak with the front desk.

Co-Pays / Co-insurance / Deductibles
These are collected at the check-in desk after you see the doctor. Co-pays are a flat rate per visit and co-insurance is a percentage of your plan's contracted rates. If your Insurance plan has an office visit deductible, you are required to pay the amount stated by your Insurance.

Medicare
Medicare only covers spinal manipulation as treatment of an Acute Condition. If we know at the time of your visit that there will likely be charges for procedures not normally paid by your insurance, you will be asked to sign a release form (ABN) acknowledging your responsibility for payment of theses services should your insurance not pay for them.

Billing Process
If you know you are unable to make payment in full before 60 days you may call our office and make payment arrangements to avoid having your account go to the collection agency.

Cancellations
As a courtesy we do not charge a cancellation fee for chiropractic care, but would greatly appreciate a phone call ahead of time. For massage therapy appointments, there will be a 50% cancellation fee because our therapists arrive specifically for their appointments and are only paid per visit. If you need to cancel a massage therapy appointment, please give 24 hours notice or a charge will be placed on your case. This charge is not billable to your insurance company, but a personal liability.

Payment Methods Accepted
For your convenience we accept Debit cards, Visa, MasterCard, Discover, American Express, Cash and Checks.

I hereby assign BTW the right to bill and receive payment from my health insurances and authorize BTW to release information to them for payment and audit purposes and provide access to my records to the necessary parties to accomplish this task. I acknowledge understanding the above policies and procedures as a patient of BTW.

……

Insurance Carrier | ID/Policy Number | Group/Plan | Date of Birth

……

Printed Patient Name | Patient or Guardian Signature | Today's Date

Patient Informed Consent Form

Congratulations on choosing Chiropractic Health Care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (Chiropractic Manipulative Therapy; CMT) and other care procedures are safe and cost effective.

All health care professionals are regulated by laws and boards. These health care professional are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed Consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury i.e., breaks, fractures, dislocations; drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is undesirable result, but it does not necessarily indicated an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon the facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, Chiropractic care does not use drugs or surgery, and does not diagnose internal or medical conditions. This clinic is staffed with graduate Chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of Vertebral Subluxation Complex (VSC) with its physical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. are needed. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy-CMT). Adjustments are made by Chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The Goal of Chiropractic health Care is to reduce and/or stabilize the nerve interference caused by VSC and its Component Parts. There are over 200 different adjustment techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A CMT is the application of a quick, specific, precise movement over a very short distance to a specific segmental contact point, usually on a vertebra to reduce or stabilize the VSC and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care. All health care procedures have some risks. With CMT's these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horners' Syndrome, Vertebral Artery Syndrome (VAS), Strokes, etc. The chances of this occurring have been generally estimated by experts to be approximately 1 per 250,000 treatments.

I hereby consent to be treated by the Doctors of Be Truly Well Chiropractic & Day Spa for conditions known at the time of treatment, pertaining to Chiropractic Care.

……

Patient Name Patient or Guardian Signature Date