BETTER LIFE CHIROPRACTIC

Confidential Patient Information

Welcome to our practice! Please complete all questions. Thank you.

Name: ____ Date: _________________ SS#: _____________________

Date of Birth: _____/______/_______ Age: _______ Sex: M F Marital Status: M W D S

Home #: ____________________Cell#: ____________________ E-Mail Address: ________________________________

How were you referred to our office? ____

☐ **Full Time Resident** ☐ **Seasonal Resident** ☐ **Temporary Visitor, Leaving when? _________________**

Local Address: ____ City: ___________________ Zip: _____________

Permanent Address: ___________________________________ City, State: ________________________ Zip: ________

Employer: ____ Occupation: _____________________________

Who is financially responsible for this bill? ____

Method of Payment: (circle one) Cash Check Credit Card Insurance

List your chief complaints:

1) ____ For How Long? _________________________

2) ____ For How Long? _________________________

3) ____ For How Long? _________________________

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If Yes, when? _____________________

What do you hope to achieve with Chiropractic care?

☐Relief of symptoms only ☐ Total Corrective Care/Optimal Health

All first visit charges are payable when services are rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand A BETTER LIFE CHIROPRACTIC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to A BETTER LIFE CHIROPRACTIC will be certified upon receipt. HOWEVER, I clearly understand and agree that I am personally responsible for payment. Interest in the amount of 18% per annual or 1.5% per month will be charged on your account if it becomes past due.

x____ ____________________

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN DATE

In case of emergency, Please notify: ____ _________________

Name/Relation Tel #

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I_______________________________________HAVE READ A COPY OF **PATIENT NOTICE OF PRIVACY PRACTICES.**

(A Copy of A BETTER LIFE CHIROPRACTIC Notice of Privacy Practices included in this package of new patient intake forms)

x____ ______________________

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN DATE

HEALTH HISTORY

Check the following conditions that apply (past/present). Please add your comments to clarify the condition.

Musculo-Skeletal

___ *Neck Pain*
___ Shoulder/Arm/Hand Pain
___ Headaches/ Migraines
___ Jaw Pain/TMJ
___ *Mid Back Pain*
___ Chest/Rib/Abdominal Pain
___ *Low Back Pain*
___ Hip Pain
___ Sciatic Pain
___ Leg/foot pain
___ Problems Walking
___ Joint Stiffness/Swelling
___ Spasms/Cramps
___ Broken/Fractured bones
___ Strains/Sprains
___ Tendonitis
___ Bursitis
___ Arthritis
___ Osteoporosis
___ Scoliosis
___ Bone or Joint Disease
___ Other: ___________________

Circulatory and Respiratory

___ Dizziness
___ Shortness of Breath
___ Fainting
___ Cold Feet or Hands
___ Cold Sweats
___ Swollen Ankles
___ Pressure Sores
___ Varicose Veins
___ Blood Clots
___ Stroke
___ Heart Condition
___ Allergies
___ Sinus Problems
___ Asthma
___ High Blood Pressure
___ Low Blood Pressure
___ Lymphedema
___ Other: ___________________

Digestive

___ Nervous Stomach
___ Indigestion
___ Constipation
___ Intestinal Gas/Bleeding
___ Diahrrhea
___ Diverticulitis
___ Irritable Bowel Syndrome
___ Crohn's Disease
___ Colitis
___ Adaptive Aids
___ Other: ___________________

Nervous System

___ Numbness/Tingling
___ Twitching of Face
___ Fatigue
___ Chronic Pain
___ Sleep Disorders
___ Ulcers
___ Paralysis
___ Epilepsy
___ Chronic Fatigue Syndrome
___ Multiple Sclerosis
___ Parkinson's Disease
___ Spinal Cord Injury
___ Other: ___________________

Skin

___ Rashes
___ Allergies
___ Athlete's Foot
___ Warts
___ Moles
___ Acne
___ Cosmetic Surgery
___ Other: ___________________

Reproductive System

___ Pregnancy:
____ Current _____ Previous

Date of Last Menstrual Cycle:

_____/_____/_____

___ PMS
___ Menopause
___ Pelvic Inflammatory Disease
___ Endometriosis
___ Hysterectomy
___ Fertility Concerns
___ Prostate Concerns

Other

___ Loss of Appetite
___ Forgetfulness
___ Confusion
___ Depression
___ Difficulty Concentrating
___ Drug Use _________________
___ Alcohol Use _______________
___ Nicotine Use ______________
___ Caffeine Use ______________
___ Hearing Impaired
___ Visually Impaired
___ Burning upon Urination
___ Bladder Infection
___ Eating Disorder
___ Diabetes
___ Fibromyalgia
___ Post/Polio Syndrome
___ Cancer
Type: __________
Date Diagnosed ___________

Infectious Disease **(Confidential)**

___ HIV ___ TB ___ Hepatitis

Other congenitial or acquired disease: ___________________

Surgeries:____

____

Please list any additional comments regarding your health and well-being: ____________________________

____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Patient Signature: ____ Date: ____________________

***Doctor* Signature**: ____ Date: ____________________

A BETTER LIFE CHIROPRACTIC
661 Goodlette Road North; Suite 108; Naples, FL 34109
Tel (239)263-3369 Fax (239) 263-8842

Dr. Deanna Barbaro
Chiropractor

TERMS OF ACCEPTANCE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those for findings, we will recommend that you seek the services of all health care providers who specializes in that area.

Chiropractic has only one goal. It is important that each patient understand both the *objective* and the *method* that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ___________________________ have read and fully understand the above statements.

____ _____________
Signature Date

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Deanna Barbaro of A Better Life Chiropractic to use and disclose **PROTECTED HEALTH INFORMATION (PHI)** about me to carry out **TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).**
I have the right to review the Notice of Privacy Practices prior to signing this consent. A Better Life Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Deanna Barbaro, A Better Life Chiropractic, 661 Goodlette Road North, Suite 108; Naples, FL 34102 or send an email to cris@ablchiro.com.
With this consent, A Better Life Chiropractic **may call me, may email me, may mail** my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

By signing this form, I am consenting to A Better Life Chiropractic's use and disclosure of my Protected Health Information (PHO) to carry out Treatment, Payment and Health care operations (TPO).
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, A Better Life Chiropractic may decline to provide treatment to me.**

____ __________________________
Signature of Patient or Legal Guardian Date

A BETTER LIFE CHIROPRACTIC
661 Goodlette Road North; Suite 108; Naples, FL 34109
Tel (239)263-3369 Fax (239) 263-8842

Dr. Deanna Barbaro
Chiropractor

Dear Patients:

Massage therapy is a separate entity within our office. A minimum of 24 hours advanced cancellation is required. If notification is not received within this time period, you will be responsible for fees charged to our office.

Full massage session fees will apply if you are late for your appointment.

No future massage appointments will be scheduled if you have an outstanding bill for massage fees.

I understand the above stated massage cancellation policy:

Signature: _______________________________

Print Name: _______________________________

Date: _______________________________

MASSAGE THERAPY CLIENT WAIVER *Client Name* ________________________

I do hereby consent to having Massage Therapy performed by the therapists of A Better Life Chiropractic, Dr. Deanna Barbaro. I understand treatment may include *various massage techniques* involving movements of joints and soft tissues. I am aware that it is common to experience *muscle soreness* within the first few treatments. I do understand that underlying pathology, perhaps unknown to me or the therapist may render me more susceptible to injury. I further understand that **I will inform the therapist if any unusual physical discomfort occurs during or after treatment.**

I do understand that some of the therapy methods used in the office generate *heat*, such as hot stones, hot towels, hot shells and can rarely cause burn. **During treatment I will inform the therapist my level of temperature comfort to avoid burns.** I freely assume any risk on my chosen treatment.

Please initial each statement, then sign and date below:

______ I understand that massage therapy and bodywork are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow.

______ I understand that the bodywork practitioner does not diagnose illness, disease or any other physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made very clear that massage therapy and bodywork are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.

______ I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes only, and is not diagnostically prescriptive in nature.

______ I have stated all of my known medical conditions on the Client Information Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

______ I realize it is solely my responsibility to keep the bodywork practitioner updated on any changes in my physical health and I understand that **A Better Life Chiropractic and Dr. Deanna Barbaro** shall not be liable should I fail to do so.

______ I understand that all massage therapy and bodywork offered is strictly non-sexual.

______ By signing this release, I hereby waive and release **A Better Life Chiropractic** and its staff, massage therapists and bodywork practitioners from any and all liability, past, present and future relating to massage therapy and bodywork.

Treatment Results:
I do understand there are beneficial effects associated with massage therapy including, but not limited to, decrease pain, improved mobility, reduced muscle spasm as well as relaxing effects. However, I do understand that massage therapy is not an exact science and I acknowledge that *no guarantee has been made to me regarding the outcome of this care.* Over all I do agree with the treatment and am responsible for my decision to have massage therapy.

Client Signature ____ Date _____________