Brown Chiropractic & Wellness Clinic

50 Forest Falls Drive
Yarmouth, ME 04096
www.brownchiropractic.net
Phone (207) 846-5111 Fax (207) 846-5988

Dr. Rebecca Brown
Dr. Steve Siu
Dr. Andrew Wawra
Dr. Andrew deBethune

Date: ___/___/___ Patient's Full Name: _____ MI: _____

Nickname: _____ Date of birth: ____/____/____ Age: _____

Mailing Address: _____ City: _____ State: ____Zip:_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Email: _____ Sex: ☐ Male ☐ Female

☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____ cell / home / work

Job Status: ☐ Not Employed ☐ Employed (fulltime) ☐ Employed (part time) ☐ Retired ☐ Student

Employer (or School)_____ Job Title: _____

How did you hear of us? _____

Who may we thank for referring you? _____

CHILDREN AND PREGNANCY

How many children do you have? _____

Children's ages?_____

Children's health concerns_____

Are you currently Pregnant? ☐No ☐Yes

Health concerns regarding pregnancy_____

_____

DRUGS & SUPPLEMENTS

Are you presently taking any **prescription drugs**, over-the-counter drugs, vitamins, or supplements? ☐ Yes ☐ No

Drugs/Supplements	Reason	Dosage	Frequency

Brown Chiropractic & Wellness Clinic

Patient name: _____

Today's date: _____

MEDICAL HISTORY

Are you currently experiencing or in the past experienced any of the following? Please check all that apply.

- ☐ Dizziness
- ☐ Severe headache
- ☐ Sudden onset headache
- ☐ Numbness and tingling in limbs
- ☐ Sudden muscle weakness
- ☐ Facial weakness or slurred speech
- ☐ Lost control of bowel or bladder
- ☐ Shortness of breath
- ☐ Chest pains
- ☐ Swelling in ankle
- ☐ Fainting
- ☐ Sudden inflamed painful calf/calves
- ☐ Pains at night
- ☐ Recent change in bowels
- ☐ Blood or urine in stool
- ☐ Night sweats
- ☐Recent unexplained weight loss
- ☐ Sudden changes in vision (blurred, double, flashes or floaters)

Please explain as needed: _____

_____

Do you have or have you had any of the following conditions or diseases? Please check all that apply.

Cardiovascular
- ☐ Anemia
- ☐ Bleeding disorders
- ☐ Stroke
- ☐ High blood pressure
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Circulation Issues

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Alcoholism
- ☐ PTSD
- ☐ Multiple Sclerosis
- ☐ Ringing in ears
- ☐ Childhood illness
- ☐ Ringing in ears

Organs
- ☐ Gallstones
- ☐ Liver disease
- ☐ Thyroid conditions
- ☐ Kidney disease
- ☐ Tumors/Growths
- ☐ Cancer
- ☐ Diabetes
- ☐ Constipation/Diarrhea/IBS
- ☐ Heartburn/GERD
- ☐ Urinary issues
- ☐ Allergies
- ☐ Autoimmune disease
- ☐ Lymphatic issues
- ☐ Reproductive issues
- ☐ Asthma
- ☐ Lung issues
- ☐ Gout

Musculoskeletal
- ☐ Sprains
- ☐ Fractures
- ☐ Herniated disc
- ☐ Nerve pain
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Hernia
- ☐ Scoliosis
- ☐ TMJ
- ☐ Congenital conditions
- ☐ Headaches/Migraines
- ☐ Osteoporosis
- ☐ Inflammatory Arthritis

Please explain as needed:_____

_____

_____

_____

Injury/Surgery	Date	Treatment

BrownChiropractic & WELLNESS CLINIC

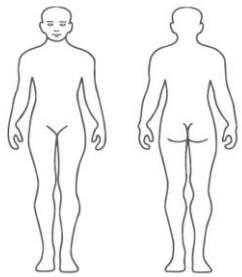
Patient: _____ **Date:** _____

NEW PATIENT EVALUATION SYMPTOM SURVEY

Please fill out **a condition box for each region** you are currently experiencing symptoms or, for which you have been receiving care for, even if it has resolved since your last exam. (Ex. neck, low back, shoulder, hip etc.) Leave blank if you are enjoying wellness care!

Primary Symptom _____ When did this symptom start: _____

Please enter additional symptoms on reverse side.



Please mark area of concern

What does it feel like (check all that apply)

__Numbness
__Tingling
__Stiffness
__Dull
__Aching
__Cramping
__Nagging
__Sharp
__Shooting
__Burning
__Throbbing
__Stabbing
__Swelling
__Other _____

How often do you feel pain?

__Resolved (0% of the time)
__Intermittent (less than 25% of the time)
__Occasional (25 – 50% of the time)
__Frequent (50 – 75% of the time)
__Constant (75 – 100% of the time)

Rate the intensity of your pain

Now	0	1	2	3	4	5	6	7	8	9	10
Typical	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

No symptoms — Intense Symptoms

Would you say this symptom is:

__New __Same
__Improving __Worse, but plateaued
__Better, but plateaued __Worsening

Impact of your Symptoms

How have your symptoms / condition interfered with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work				
Exercise				
Recreation				
Relationships				
Sleep				
Self Care				

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy				
Attitude				
Patience				
Productivity				
Creativity				
Other:_____				

Please complete the following statements regarding your goals of care:

I want to get rid of _____.

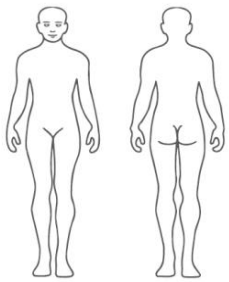
I want to get back to _____ that I ***have*** to do.

I want to get back to _____ that I ***love*** to do.

See Page 2

Patient: _____ **Date:** _____

Area of Symptom 2 _____ When did this symptom start? _____



Please mark area of concern

What does it feel like (check all that apply)

__Numbness __Sharp
__Tingling __Shooting
__Stiffness __Burning
__Dull __Throbbing
__Aching __Stabbing
__Cramping __Swelling
__Nagging __Other _____

How often do you feel pain?

__Resolved (0% of the time)
__Intermittent (less than 25% of the time)
__Occasional (25 – 50% of the time)
__Frequent (50 – 75% of the time)
__Constant (75 – 100% of the time)

Rate the intensity of your pain

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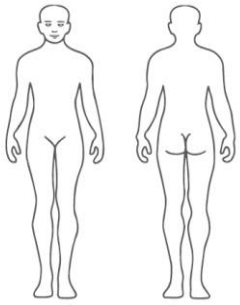
Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

No symptoms Intense Symptoms

Would you say this symptom is:

__New __Same
__Improving __Worse, but plateaued
__Better, but plateaued __Worsening

Area of Symptom 3 _____ When did this symptom start? _____



Please mark area of concern

What does it feel like (check all that apply)

__Numbness __Sharp
__Tingling __Shooting
__Stiffness __Burning
__Dull __Throbbing
__Aching __Stabbing
__Cramping __Swelling
__Nagging __Other _____

How often do you feel pain?

__Resolved (0% of the time)
__Intermittent (less than 25% of the time)
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__Constant (75 – 100% of the time)

Rate the intensity of your pain

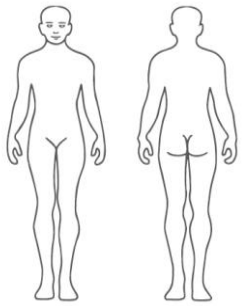
Now	0	1	2	3	4	5	6	7	8	9	10
Typical	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

No symptoms Intense Symptoms

Would you say this symptom is:

__New __Same
__Improving __Worse, but plateaued
__Better, but plateaued __Worsening

Area of Symptom 4 _____ When did this symptom start? _____



Please mark area of concern

What does it feel like (check all that apply)

__Numbness __Sharp
__Tingling __Shooting
__Stiffness __Burning
__Dull __Throbbing
__Aching __Stabbing
__Cramping __Swelling
__Nagging __Other _____

How often do you feel pain?

__Resolved (0% of the time)
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Rate the intensity of your pain

Now	0	1	2	3	4	5	6	7	8	9	10
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Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

No symptoms Intense Symptoms

Would you say this symptom is:

__New __Same
__Improving __Worse, but plateaued
__Better, but plateaued __Worsening

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2020
WAIVER FORM

Welcome to our practice. We want to make sure that your visit goes smoothly and meets your expectations in every way. As a courtesy to all our patients, we submit all bills and doctor's reports to your insurance company. Although we pre-verify your coverage and thoroughly ask for all the details and possible limitations, we find we are frequently given incorrect information. For this reason, **we recommend that you also call your insurance company to review your chiropractic benefits and any possible limitations.**

Payment of deductibles and co-payments are expected at the time of service or at the end of each week.

If your insurance company denies payment of any service, for whatever reason, you will be responsible for payment. The doctor will recommend treatment for you that she finds is medically necessary. If your insurance company limits the number of adjustments, exams or services (i.e. modalities, exercises, etc.), you will then become responsible, even if the insurance company denies the procedure as not medically necessary by their guidelines. If this occurs, we encourage you to file a complaint to the Maine Bureau of Insurance, as well as your insurance company.

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

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 evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the 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 subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

· You may request restrictions on your disclosures.
· You may inspect and receive copies of your records within 30 days with a request.
· You may request to view changes to your records.
· In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

· Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
· Obtain payment from third party payers.
· Conduct normal healthcare operations such as quality assessments and physician's certifications.

Under state law, if you have an HMO insurance plan, we are also required to disclose your health information without your consent or authorization to your primary care physician.

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. By signing below, you acknowledge receipt and the opportunity to review the Notice of Privacy Practice on the date below on behalf of **BROWN CHIROPRACTIC**. I understand that this notice describes in full the uses and disclosures of my protected health information by **BROWN CHIROPRACTIC** and informs me of my rights with respect to my protected health information.

AUTHORIZATION TO SHARE INFORMATION

Exam summaries are routinely faxed to PCP to assist in the coordination of care. Who is your current Primary Care Physician: _____ Location (clinic name & town): _____

__ Check here if you do NOT want your PCP to receive this information.

I authorize the staff of Brown Chiropractic to share any pertinent health & appointment information with my family members listed below:

Family members name: 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Patient (or responsible party) Signature: _____ Date: _____

Patient Name (please print legibly): _____

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50 Forest Falls Drive; Suite 4; Yarmouth, Maine 04096 207-846-5111 207-846-5988 fax
www.BrownChiropractic.net

Electronic Appointment Reminders

We make electronic appointment reminders. By default, these reminders will come via email **and** text messaging. If you prefer only one method, please check the appropriate box.

- TEXT messaging / CELL Phone:

  _____ (__ check here if you want **only cell** reminders)

- EMAIL:

  _____ (__ check here if you want **only text** reminders)

Health Insurance Changes?

(Please provide your new insurance cards for any changes.)

Will your insurance change soon? Yes No
What is your new Ins company name _____ ID#: _____

If no new company, will your level of benefits change, with the same carrier? Yes No

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Preferred Method of Contact:

On occasion we find it necessary to contact you directly. What is your preferred method of contact?

Home / Work / Cell: # _____

Best times: Early Morning / Mid Morning / Mid Afternoon / Late Afternoon / Evening

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Patient Name:_____ **Date:** _____