SYMMETRY&FLOW
HEALTHCARE

Patient Information

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ DOB: _____ Age: _____

Phone #: (H) _____ (W) _____ (C) _____

Gender: Male □ Female □ Number of Children: _____ S.S#: _____

Marital Status: Married □ Single □ Divorced □ Separated □ Widowed □

Occupation: _____ Employer: _____

Employer's Address: _____ Phone #: _____

Emergency Contact: (Name) _____ (Relation) _____ (Phone) _____

Do you have a Health Spending Account (HSA) or Flexible Spending Account (FSA)? Yes □ No □

How did you hear about us? _____

Accident Information

Is this visit due to an accident? □ Yes □ No

If yes, what type: □ Auto □ Work □ Other

Has it been reported? □ Yes □ No

If yes, to whom? _____

Primary Insurance Information

□ Cash □ Group □ Work / Comp □ Auto □ Other

Name of Insurance Co. _____ ID #: _____ Group #: _____

Name of Insured: _____ DOB: _____

Relationship to Patient: □ Self □ Spouse □ Parent

I certify that I (or my dependent) _____ have insurance coverage with and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Bellevue Wellness., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature: _____ Date: _____

(We will need a copy of your insurance card and driver's license)

Need a reminder for your next appointment !!

Symmetry & Flow takes yet another time-consuming task off your hands. And the setup is as easy as 1-2-3! Simply give us your cell phone number and the provider and let us take care of the rest. No more hours on the phone. No more forgotten appointments! Every day, every patient, and every appointment can be reminded in a way that works best for each individual patient.

Cell Phone #: _____

Provider:

Verizon □ ATT&T □ T-Mobile □ Sprint □ MetroPCS □

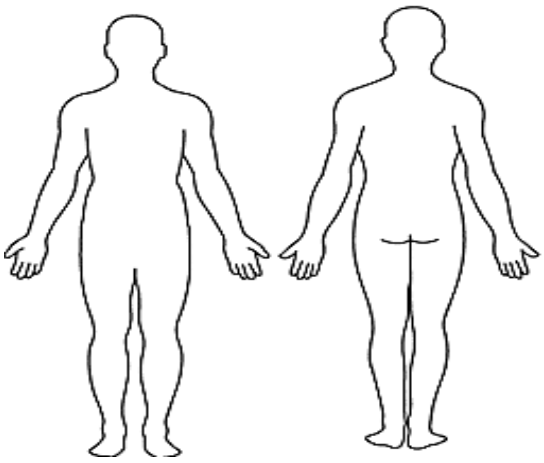
US Cellular □ Virgin Mobile □ Nextel □ Cricket □ Boost Mobile □

Patient Initial Intake Form

Is today's chief complaint caused by:

□ Auto Accident □ Work Injury □ Other

Indicate on the drawing the <u>MAIN</u> Symptom we are seeing you for:



1. **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)

2. **How would you describe the type of pain?**

   □ Sharp
   □ Dull
   □ Diffuse
   □ Achy
   □ Burning
   □ Shooting
   □ Stiff
   □ Numb
   □ Tingly
   □ Sharp with motion
   □ Shooting with motion
   □ Stabbing with motion
   □ Electric like with motion
   □ Other:_____

3. **How are your symptoms changing with time?**

   □ Getting worse □ Staying the same □ Getting better

4. **Using a scale from 0-10 (10 being worst), how would you rate your problem**

   0 1 2 3 4 5 6 7 8 9 10 (Circle one please)

5. **How much has the problem interfered with your work?**

   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

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

7. **Who else have you seen for your problem?**
   □ Chiropractor □ Neurologist □ Primary care physician
   □ ER physician □ Orthopedist □Other:_____
   □ Massage Therapist □ Physical Therapist □ No one

8. **How long have you had this problem?** _____

9. **How do you think your problem began?**_____

10. **Do you consider this problem to be severe?** □Yes □Yes, at times □No

11. **What aggravates your problem?**_____

12. **What concerns you the most about your problem; what does it prevent you from doing?**
_____

13. **What is your:** **Height:**_____ **Weight:**_____

14. **How would you rate your overall health?**
   □ Excellent □ Very Good □ Good □ Fair □ Poor

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

18. **What activities do you do outside of work/school?**_____

19. **Indicate if you have any immediate family member with any of the following:**
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Disease □ Stroke
□ Osteoporosis □ High Blood Pressure □ Cancer If so, what type? _____

20. **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 condition listed below, place a check in the "present" column.**

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
☐	☐	Headaches	☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart attack	☐	☐	Excessive thirst
☐	☐	Upper back pain	☐	☐	Chest pain	☐	☐	Frequent urination
☐	☐	Mid back pain	☐	☐	Stroke	☐	☐	Smoking tobacco
☐	☐	Low back pain	☐	☐	Angina	☐	☐	Chewing tobacco
☐	☐	Shoulder pain	☐	☐	Kidney stones	☐	☐	Drug dependence
☐	☐	Elbow/Arm pain	☐	☐	Kidney disorder	☐	☐	Alcohol dependence
☐	☐	Wrist pain	☐	☐	Bladder infection	☐	☐	Allergies
☐	☐	Hand pain	☐	☐	Painful urination	☐	☐	Depression
☐	☐	Hip pain	☐	☐	Loss of bladder control	☐	☐	Systemic lupus
☐	☐	Thigh pain	☐	☐	Prostate problems	☐	☐	Dermatitis / Eczema
☐	☐	Knee pain	☐	☐	Unexpected weight loss	☐	☐	Rashes
☐	☐	Ankle/foot pain	☐	☐	Loss of appetite	☐	☐	HIV / AIDS
☐	☐	Jaw pain	☐	☐	Abdominal pain	☐	☐	Psoriasis
☐	☐	Arthritis	☐	☐	Ulcer	☐	☐	General fatigue
☐	☐	Rheumatoid Arthritis	☐	☐	Hepatitis	☐	☐	Chronic Sinus Infection
☐	☐	Cancer	☐	☐	Liver/Gall bladder disorder	☐	☐	Visual disturbances
☐	☐	Tumor	☐	☐	Dizziness	☐	☐	Asthma

21. **List all prescription medications you are currently taking:**_____

_____

22. **List all surgical procedures you've had in the past:**_____

_____

23. **What activities do you do at work/school:**
- ☐ **Sit**
- ☐ **Stand**
- ☐ **Computer work**
- ☐ **On the phone**

24. **Have you ever been hospitalized?** ☐ No ☐ Yes
If yes then why_____

Patient Signature_____ Date:_____

Symmetry & Flow Healthcare Centers, Inc

www.BeHealthyWeston.com

Informed Consent for Chiropractic and Massage Care

Every type of health care is associated with some risk of potential problem. This includes Chiropractic and Massage treatment. We want you to be informed about potential problems associated with Chiropractic health care before consenting to treatment.

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a coming side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient /Guardian Name (Printed): _____ Date: _____

Patient / Guardian Signature_____

X-Ray Questionnaire : FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Patient Name: _____

- □ There is a possibility that I a may be pregnant at this time.
- □ Yes, I am pregnant
- □ No, I am not pregnant at this time

Date of last menstrual period: _____

Patient's Signature: _____ Date: _____

Massage Therapy: Late / Cancellation Policy

As a courtesy, please let us know as early as possible if you need to cancel an appointment. If you will be arriving exceptionally late (>15minutes) please call ahead as your appointment may have to be rescheduled. Any appointment not canceled 24 hours prior to scheduled time will be billed at the current rate ($40). Late cancellations and missed appointments cannot be billed to your Insurance and will be billed directly to **you**.

Signature: _____ Date:_____

symmetry&flow
Pain, Injury Rehab & Performance Studio

Our Clinic Protects your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company and with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners. We will obtain your authorization before disclosing any information.

Safeguards in place at our office include:
• Limited access to facilities where information is stored.
• Policies and procedures for handling information.
• Requirements for third parties to contractually comply with privacy laws.
• All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information:
• About your financial transactions with us (billing transactions).
• From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

• From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).
In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you -e.g. your name, address, Social Security number, etc.).
We value our relationship with you, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 754-206-0838.

Yours sincerely,
Vaneza Chaple, DOM, LAc
Joaquin W. Rosado, DC

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Pain, Injury Rehab & Performance Studio

Please check any services you would like more information about:

www.BeHealthyWeston.com

- **Ultrasonic Vibration / Performance Program** - is one of the most amazing and most beneficial programs developed and released in recent years. Ultrasonic Vibration Therapy appears to be a revolutionary therapy that enhances the quality of life and brings wellness to almost anyone of any age and any physical condition. Listed below are some of the benefits: improved coordination & balance, increase in bone mineral density after 6 months of only 10 minutes a week, increased lymphatic drainage, increase in serotonin levels, and improved metabolism.

- **Non-surgical Facial Rejuvenation** - Facial rejuvenation acupuncture is a wonderful timeless beauty technique used by the Chinese for 2500 years. Cosmetic acupuncture was performed on the Empress, today, it is an effective non-surgical yet painless way to lessen the appearance of fine lines as well as deeper wrinkles. Treatments improve muscle tone and dermal contraction, increase collagen production, tightens pores, and increases local circulation of blood and lymph around the face. Additionally, specialized frequency-specific electrically stimulated needles improve skin elasticity as well as the tone of the facial muscles, equating to your skin having a more youthful glow.

- **Trigger Point Therapy** - is a natural procedure using advanced technology to eliminate painful areas of muscle that contain trigger points (knots) of muscle that form when muscles do not relax. Trigger points may irritate the nerves around them and cause referred pain, or pain that is felt in another part of the body.

- **Injury Rehabilitation** - involves stretching and strengthening the muscles of the body. Physical Rehabilitation is critical to correct postural issues. Our advanced program involves increasing balance, improves coordination, and decreases risk of injury. We specialize and customize individual rehabilitation for sport, work, and auto injuries to ensure a timely return to your activities of daily living.

- **Peripheral Neuropathy and Carpal Tunnel Program** - advanced rapid release technology and rehabilitation treatment for people that suffer from numbness, tingling or burning pain in their arms, hands, legs or feet. This is great for tendonitis and plantar fasciitis.

- **Headache Relief Program** - advanced program designed to effectively treat migraines and many other types of headaches.

- **Healthcare Workshop** - Bring a friend to this hands-on workshop and learn the latest on nutrition, sleep and how to maintain your joint and spinal health for years.