WELCOME

NATURAL CARE WELLNESS CENTER
6 SEELEY LANE, ELIOT, ME 03903

PATIENT INFORMATION

Date _____

SS# _____

Patient Name _____
Last Name

_____
First Name MI

Address _____

City _____

State _____ Zip Code _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birth Date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Occupation _____

Patient's Employer/School _____

Employer/School Address _____

Spouse's Name _____

Birth Date _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

Do you have insurance _____ Yes _____ No

If yes, Who: _____

==========

PHONE NUMBERS

Home (_____) _____

Cell (_____)_____

Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Phone (_____)_____

PCP Name/Address:_____

_____

_____

PATIENT CONDITION

Reason for Visit _____

_____

When did symptoms occur? _____

_____

Is this condition getting worse? _____ Yes _____ No

Have you had this problem before: _____ Yes _____ No

If Yes, when? _____

_____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

Sleep Habits:

Difficulty falling asleep ____Yes _No Staying asleep ___Yes __No

Urine:

How often: _____ Frequent _____ Scanty

Color: _____ Clear _____ Yellow _____ Dark Yellow

Bowel Movements:

How often: _____

Constipation _____Yes _____No Diarrhea _____Yes _____No

Odor _____Yes _____No Loose _____Yes _____No

Color _____ Black _____ Brown _____ Mucous

Flatulence _____Yes _____No Chills/Fever _____Yes _____No

Perspiration _____Yes _____No _____Spontaneous

Diet Cravings: ____Sweet ____ Salt ____Spicy ____Sour ____Pepper

Menses: (Women Only)

Clotting ____Yes ____No Pain ____Yes ____No

Length _____ Abnormal _____ Normal

Duration _____ Abnormal _____ Normal

Color _____ Abnormal _____ Normal

Quality _____ Abnormal _____ Normal

Flow _____ Scanty _____ Heavy _____ Normal

Onset/Age _____

Birth Controls _____ Yes _____ No _____ Age

Hormone Replacement Therapy: _____ Yes _____ No

If yes, when _____

Discharge ____Yes ____No

What treatment have you already received for your condition?

_____ Medications _____ Surgery _____ Physical Therapy

_____ Chiropractic Services _____ None _____Other

Name and address of other doctor(s) who have treated you for your condition:

_____

Date of last physical exam: _____

Height: _____ Weight:_____ BP: _____

Current smoker:_____ Former Smoker: _____ Never Smoker:_____

Race: Native or Alaskan Indian: ____ White:_____ Black:_____

Hispanic or Latino:_____ Non Hispanic or Latino:_____

Patient Information

Place a mark on "Yes" or No" to indicate if you have had any of the following:

AIDS/HIV	__ Yes __ No	Emphysema	__ Yes __ No	Measles	__ Yes __ No	Rheumatic Fever	__ Yes __ No
Alcoholism	__ Yes __ No	Epilepsy	__ Yes __ No	Migraine Headaches	__ Yes __ No	Scarlet Fever	__ Yes __ No
Allergy Shots	__ Yes __ No	Fractures	__ Yes __ No	Miscarriage	__ Yes __ No	Stroke	__ Yes __ No
Anemia	__ Yes __ No	Glaucoma	__ Yes __ No	Mononucleosis	__ Yes __ No	Suicide Attempt	__ Yes __ No
Anorexia	__ Yes __ No	Goiter	__ Yes __ No	Multiple Sclerosis	__ Yes __ No	Thyroid Problems	__ Yes __ No
Appendicitis	__ Yes __ No	Gonorrhea	__ Yes __ No	Mumps	__ Yes __ No	Tonsillitis	__ Yes __ No
Arthritis	__ Yes __ No	Gout	__ Yes __ No	Osteoporosis	__ Yes __ No	Tuberculosis	__ Yes __ No
Asthma	__ Yes __ No	Hearing Problems	__ Yes __ No	Pacemaker	__ Yes __ No	Tumors, Growths	__ Yes __ No
Bleeding Disorder	__ Yes __ No	Heart Disease	__ Yes __ No	Parkinson's Disease	__ Yes __ No	Typhoid Fever	__ Yes __ No
Breast Lump	__ Yes __ No	Hepatitis	__ Yes __ No	Pinched Nerve	__ Yes __ No	Ulcers	__ Yes __ No
Bronchitis	__ Yes __ No	Hernia	__ Yes __ No	Pneumonia	__ Yes __ No	Vaginal Infection	__ Yes __ No
Bulimia	__ Yes __ No	Herniated Disc	__ Yes __ No	Polio	__ Yes __ No	Venereal Disease	__ Yes __ No
Cancer	__ Yes __ No	Herpes	__ Yes __ No	Prostate Problem	__ Yes __ No	Whooping Cough	__ Yes __ No
Cataracts	__ Yes __ No	High Blood Pressure	__ Yes __ No	Prosthesis	__ Yes __ No	Other _____	
Chem. Dependency	__ Yes __ No	High Cholesterol	__ Yes __ No	Psychiatric Care	__ Yes __ No	_____	
Chicken Pox	__ Yes __ No	Kidney Disease	__ Yes __ No	Rheumatoid Arthritis	__ Yes __ No		
Diabetes	__ Yes __ No	Liver Disease	__ Yes __ No	Rheumatic Fever	__ Yes __ No		

Exercise: _____ None	_____ Moderate	_____ Daily	_____ Heavy
Work Activity: _____ Sitting	_____ Standing	_____ Light Labor	_____ Heavy Labor
Habits: _____ Smoking	_____ Alcohol	_____Coffee/Caffeine Drinks	_____ High Stress Level
_____ Packs/Day	_____ Drinks/Week	_____ Cups/Day	_____ Reasons

Are you Pregnant? _____Yes _____ No If yes, due date: _____

Injuries/Surgeries you have had:

Falls: _____ **Head Injuries**: _____ **Broken Bones**: _____ **Dislocations**: _____

Medications: **Allergies:** **Vitamins/Herbs:**

FOR DOCTOR USE ONLY:

Spirit: _____

Odor: _____ Sweet _____ Scorched _____ Rotten _____ Putrid

Angry: _____ Yes _____ No **Meek**: Angry: _____ Yes _____ No

Tongue: _____ Red _____ Pale _____ Purple _____ Spots _____ White _____ Yellow _____ Dry Yellow _____ Scalloped ____ Toothmarked

Size & Shape: _____ Large _____ Swollen _____ Stiff _____ Flaccid _____ Long _____ Short _____ Cracked _____ Quivering ____Deviated____ Toothmarked

Pulse: _____ Rapid _____ Slow _____ Full _____ Empty _____ Wiry _____ Slippery _____ Big _____ Minute _____ Superficial _____ Deep _____ Frail _____ Tight
_____ Short _____ Knotted _____ Soggy _____ Intermittent _____ Hidden _____ Hollow _____ Leather _____ Hurried _____ Flooding _____ Confined _____ Scattered

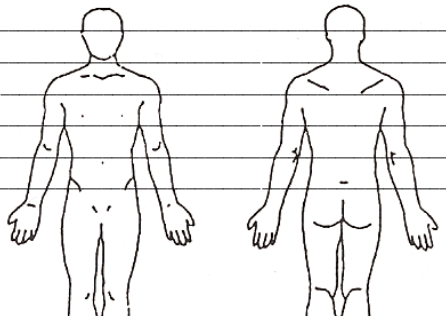
DO NOT WRITE BELOW

Complexion: _____ Pale _____ Yellow _____ Red _____ Blue _____ Green

Voice: _____ Fast _____ Slow _____ SingSong _____ Hollow _____ Deep

Fast: _____ Yes _____ No **Body Color**: _____White _____Yellow _____Other

Other information: _____



NOTICE

TO ALL NET, THERAPEUTIC EXERCISE, MASSAGE, AND COLON HYDROTHERAPY CLIENTS

Due to the high demand for the above services, we require a minimum of 24 hours notice to cancel an appointment, or you will be billed the **regular cash session fee.**

These appointments are reserved for you and cannot be rearranged for others awaiting an appointment with short notice of less than 24 hours.

We understand that there are times when exceptions will be necessary. These exceptions will be accepted at the discretion of the practitioners.

Thank you for your cooperation in this matter. The Natural Care Wellness Center Staff.

Signature: _____ Date: _____

Natural Care Wellness Center
6 Seeley Lane
Eliot, ME 03903
207-438-9242

NATURAL CARE WELLNESS CENTER

Dr. Scott Ferreira Dr. Jody Ferreira
6 Seeley Lane
Eliot, ME 03903
Tele# (207)439-9242

INDIVIDUAL PATIENT AUTHORIZATION

Patient's Name: _____ Date: _____

This authorization is to confirm the use or disclosure of protected health information. Please sign below to confirm that you have read and understand these statements.

I authorize the release of my medical records to my family practitioner or other physician. Please list name or names of physician_ _____

I authorize the release of my medical records to my health insurance company for payment of rendered services, if requested.

I authorize release of my medical records to any third party payer including insurance, workman's compensation, attorney, auto insurance, etc, if requested.

I authorize Natural Care Wellness Center to send information to my house concerning birthdays or newsletters, and to leave messages on my home, cell phone or work answering machine, such as appointment times.

Patient's signature: _____

NATURAL CARE WELLNESS CENTER

Dr. Scott Ferreira Dr. Jody Ferreira
6 Seeley Lane
Eliot, ME 03903
Tel# (207)439-9242

PRIVATE PRACTICES ACKNOWLEDGEMENT

I have received the notice of the HIPAA Privacy Practice and I have been provided an opportunity to review it.

Name: _____

Date of Birth: _____

Signature: _____ Date: _____

NATURAL CARE WELLNESS CENTER

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AUTHORIZATION, ASSIGNMENT AND CONSENT TO TREAT

Our office policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account.

_____ I hereby authorize NATURAL CARE WELLNESS CENTER to bill the insurance company for services rendered on my behalf. The billing of such services are a privilege and not a guarantee of coverage. I further authorize the physician and/or supplier to release any information required to process my insurance claims.

_____ I authorize direct payment to you any sum I now or hereafter owe, by my attorney out of the proceeds of any settlement of my case, and/or by insurance company obligated to make payment to me or you based in whole or part upon the charges made for the services.

_____ I understand that whatever amounts you do not collect from the insurance company and/or attorney, whether it be all or part of what is due, I personally owe and agree to pay you.

I hereby authorize the doctors of NATURAL CARE WELLNESS CENTER and whomever they designate as their assistant or authorized representative to administer chiropractor care, acupuncture or colon hydrotherapy as they deem necessary. We invite you to discuss openly treatment, services, and charges rendered at this office, so that there is mutual agreement and clarity.

i understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any change in my medical status.

Signature: _____ Date: _____

Signature of parent or guardian if Patient is under 18 years of age::

_____ Date: _____

BACK INDEX

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 fill in the one statement that most closely describes your problem.*

Pain Intensity
⓪ I can tolerate the pain I have without having to use pain killers.
① The pain is bad but I manage without taking pain killers.
② Pain killers give complete relief from pain.
③ Pain killers give very little relief from pain.
④ Pain killers have no effect on the pain and I do not use them.

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 manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, wash with difficulty, and stay in bed.

Walking
⓪ Pain does not prevent me from walking any distance..
① Pain prevents me from walking more than 1 mile.
② Pain prevents me from walking more than 1/2 mile.
③ Pain prevents me from walking more than 1/4 mile.
④ I can only walk using a stick or crutches.

⑤ I am in bed most of the time and have to crawl to the toilet.

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, 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.

Sitting ("favorite chair" includes a recliner)
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 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 Pain prevents me from sitting at all.

Standing (REMEMBER, standing is NOT walking)
⓪ I can stand as long as I want without extra pain.
① I can stand as long as I want but it gives me extra pain.
② Pain prevents me from standing for more than 1 hour.
③ Pain prevents me from standing for more than 30 minutes.
④ Pain prevents me from standing for more than 10 minutes.
⑤ Pain prevents me from standing at all.

Sleeping
⓪ Pain does not prevent me from sleeping well.
① I can sleep well only by using tablets.
② Even when I take tables I have less than 6 hours sleep.
③ Even when I take tablets I have less than 4 hours sleep.
④ Even when I take tablets I have less than 2 hours sleep.
⑤ Pain prevents me from sleeping at all.

Sex Life
⓪ My sex life is normal and causes no extra pain.
① My sex is normal but causes some extra pain.
② My sex life is nearly normal but is very painful.
③ My sex life is severely restricted by pain.
④ My sex life is nearly absent because of pain.
⑤ Pain prevents any sex life at all.

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 effect on my social life apart from energetic interests.
③ Pain has restricted my social life and I do not go out as often.
④ Pain has restricted my social life to my home.
⑤ I have no social life because of pain.

Travelling
⓪ I can travel anywhere without extra pain.
① I can travel anywhere but it gives me extra pain.
② Pain is bad but I manage journeys over 2 hours.
③ Pain restricts me to journeys of less than 1 hour.
④ Pain restricts me to short necessary journeys under 30 minutes.
⑤ Pain prevents me from travelling except to the doctor or hospital.

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

Back Index Score

NECK INDEX

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 fill in 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 worse imaginable at the moment.

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 dresses, I wash with difficulty and stay in bed.

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)

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 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.

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.

Driving
⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want without 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.

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.

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 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.

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.

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