Welcome To

THE ALLERGY AND SPINE CENTER

PROVIDING THE BEST CARE NATURALLY

Dr. Brittany Bowers | www.AllergyandSpine.com | 615.991.3100

PATIENT INFORMATION

Today's Date _____/_____/_____

First Name: _____ Middle Initial: _____ Last Name:_____

Prefers To Be Called: "_____" Birth Date: _____/_____/_____ Age: _____ Sex: ❑ M ❑ F

If under 18, Parent/Legal Guardian's First Name: _____ Last Name: _____

Relationship: _____ Phone: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Phone(s): Cell (_____) _____-_____ Home (_____) _____-_____

Email: _____ **(We will never share your email!)**

Are you: ❑ Single ❑ Married ❑ Divorced ❑ Partnered ❑ Widowed

Employer: _____ Occupation: _____

How did you hear about us? ❑ Facebook ❑ YP.com ❑ Yelp ❑ Google ❑ Event ❑ Drive-By ❑ Referred

If referred, whom should we thank (first and last name)? _____

Emergency Contact: _____ Phone: (_____) _____-_____

Relationship To Patient: _____

Who is your primary medical physician? _____ Where? _____

Who is your insurance provider? ❑ Blue Cross ❑ United Healthcare ❑ Aetna ❑ Other _____

What is the policy holder's date of birth? _____/_____/_____

What brings you in today? **(check all that apply)**: ❑ NAET allergy elimination testing and treatment

❑ Chiropractic care ❑ Acupuncture session ❑ Consultation

Patient Initials _____ **Date: ____/____/_____**

HEALTH HISTORY

Have you had any ❑ surgeries, ❑ medical procedures, or ❑ hospitalizations? ❑ None

Please include approximate dates/year. _____

Please list any past and/or current illnesses and/or diseases with dates of diagnoses (cancers, tumors, infections, diabetes, aneurysms, etc). _____

Are you taking any medications? ❑ None ❑ Pain killers (including aspirin) ❑ Blood thinners ❑ Muscle relaxers ❑ Nerve pills ❑ Tranquilizers ❑ Insulin ❑ Other _____

Please list any significant family illnesses (past or present). _____

Do you smoke? ❑ Yes ❑ No ❑ Former

What are you allergic to? _____

Please list all vitamins/supplements you're taking. _____

Do you use essential oils? ❑ Yes ❑ No

If so, which oil(s) do you regularly use? _____

What brand do you use? ❑ DoTerra ❑ Young Living ❑ Eden's Garden ❑ Now ❑ Aura Cacia ❑ Plant Therapy ❑ Mountain Rose ❑ Other _____

Please indicate if you have ever experienced any of the following by placing a check:

❑ Allergies	❑ Pain b/w shoulders	❑ Ulcers or colitis	❑ Seizures
❑ Sinus Problems	❑ Low back pain	❑ Black or bloody stool	❑ Convulsion
❑ Sprains/Strains	❑ Herniated disc	❑ Hepatitis	❑ Dizziness
❑ Broken Bones	❑ Leg pain	❑ Excessive thirst	❑ Fainting
❑ Artificial bones	❑ Difficulty breathing	❑ Weight loss or gain	❑ Shingles
❑ Swollen joints	❑ Asthma / Emphysema	❑ Frequent urination	❑ AIDS / HIV / ARC
❑ Painful joints	❑ Spitting blood	❑ Excessive hunger	❑ Autoimmune
❑ Stiff joints	❑ Pacemaker	❑ Diabetes	❑ Fibromyalgia
❑ Pain behind eyes	❑ Heart murmur	❑ Poor appetite	❑ Cancer
❑ Ringing in ears	❑ High/low blood pressure	❑ Thyroid issues	❑ Chemotherapy
❑ Headaches	❑ Heart attack	❑ Swollen ankles	❑ Eczema
❑ Neck pain	❑ Stroke	❑ Painful urination	❑ Hives
❑ Numbness	❑ Vomiting blood	❑ Blood in urine	❑ Other _____
❑ Tingling	❑ Hernia	❑ Loss of bladder control	❑ Other _____
❑ Arm pain	❑ Constipation / Diarrhea	❑ Kidney infections	❑ Other _____

Patient Initials _____ **Date: ___/___/____**

FOR ALLERGY / NAET VISIT, PLEASE FILL OUT THE FOLLOWING:

Are you familiar with NAET? ❑ Yes ❑ No

Have you ever had any NAET treatments before? ❑ Yes ❑ No

If so, approximately when? _____ Where? _____

Have you ever had the needle prick allergy panel, blood work, or scratch test before? ❑ Yes ❑ No

If so, when? _____ What were you allergic to? _____

Do you get/have you ever gotten shots for your allergies? ❑ Yes ❑ No

Please list everything you would like for Dr. Bowers to address for treatment, including all seasonal, food and pet allergies, autoimmune disorders including arthritis, emotions, etc. _____

_____

Patient Initials _____ **Date: ___/___/____**

If no other services today, flip to page 5.

FOR ACUPUNCTURE VISIT, PLEASE FILL OUT THE FOLLOWING:

Are you familiar with acupuncture? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If so, how many weeks? _____

****Please let the doctor and CA know if there is a chance you could be pregnant!**

Have you ever had acupuncture performed before? ❑ Yes ❑ No

If so, approximately when? _____ Where? _____

Please list everything you would like for Dr. Bowers to address for treatment, including any pain, autoimmune disorders, emotional issues, infertility, digestive related disorders, etc. _____

_____

Patient Initials _____ **Date: ___/___/____**

If no other services today, flip to page 5.

FOR CHIROPRACTIC VISIT, PLEASE FILL OUT THE FOLLOWING:

Have you had previous Chiropractic care? ❑ Yes ❑ No If so, where? _____

Have you had injuries in the past? ❑ Yes ❑ No

Please include all auto accidents, head injuries, falls, sports trauma, etc. _____

_____

Have you had spinal x-rays, MRIs, or CT scans in the past 2 years? ❑ No ❑ X-ray ❑ MRI ❑ CT scan

If yes, what were the diagnose(s)? _____

May we request copies? ❑ Yes ❑ No If so, where were they taken? _____

Phone number: (_____) _____-_____

****Do you have a pacemaker? ❑ Yes ❑ No If so, please alert the doctor and CA!****

Have you been medically diagnosed with osteoporosis or rheumatoid arthritis? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If so, how many weeks? _____

What is the reason for today's visit? ❑ General Pain ❑ Fall ❑ Auto Injury ❑ Work Injury

If fall, auto, or work injury, approximately when did it happen? _____

What is your worst complaint? _____ How long have you had it? _____

Have you ever had it before? ❑ Yes ❑ No

Have you been treated for this condition by anyone else? ❑ Yes ❑ No

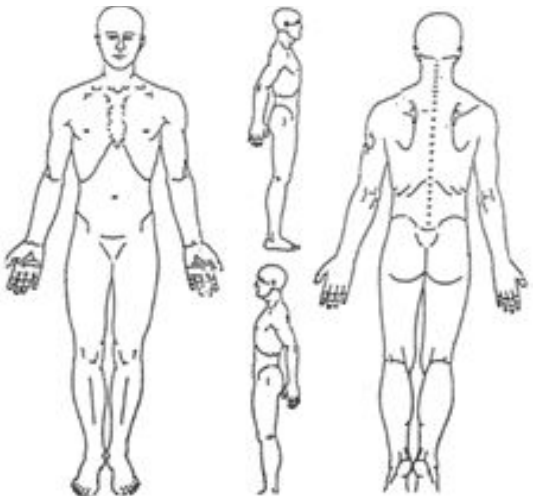
If so, who? ❑ MD ❑ Physical Therapist ❑ Chiropractor ❑ Other: _____

Where? _____ When? _____ Diagnosis? _____

Are you currently in pain? ❑ Yes ❑ No

If so, rate your pain from 1 (discomfort) to 10 (intense): _____

Using the charts below, please circle the area(s) affected:



What percentage of the day do you have pain?

❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Is your condition: ❑ Getting better ❑ Getting worse

❑ Staying the same ❑ Comes and goes

Is your condition: ❑ Mild ❑ Moderate

❑ Severe ❑ Unbearable

Is your condition interfering with: ❑ Work ❑ Sleep

❑ Daily routine ❑ Not interfering with any

Patient Initials _____ **Date: ___/___/____**

What aggravates it? **(check all that apply):** ❑ Walking ❑ Using a computer/desk work

❑ Prolonged sitting ❑ Getting up from a chair ❑ Bending over ❑ Lifting

❑ Lying down/sleeping ❑ Moving wrong ❑ Sports/ Exercise/Yoga ❑ Work activities

❑ General everyday activity ❑ Bright lights ❑ Loud noises

What makes it better? **(check all that apply):** ❑ Chiropractic care ❑ Heating pad ❑ Ice pack

❑ Rest/Lying down ❑ Movement ❑ Massage ❑ Nothing

❑ OTC meds _____ ❑ Rx meds _____

When is it worse? **(check all that apply)**: ❑ AM ❑ PM ❑ Steady throughout day ❑ Off and On

What does it feel like? **(check all that apply)**: ❑ Dull and achy ❑ Tight and stiff ❑ Shooting

❑ Sharp and stabbing ❑ Numb and tingly/pins and needles ❑ Burning ❑ Cramping

Do you have a second complaint? ❑ Yes ❑ No

Briefly describe. _____

Is there anything else you would like Dr. Bowers to know? ❑ Yes ❑ No

Briefly describe. _____

By signing below, you have read and reviewed the information contained herein and represent that it is true, correct and complete. You understand that the doctor is relying upon the information presented in rendering treatment.

_____ _____/_____/_____

Patient Printed Name **Date**

_____

Patient or Legal Guardian Signature

The Allergy & Spine Center
Consent to Privacy Policy

I understand that my health information is private and confidential. I understand that the staff of The Allergy & Spine Center works hard to protect my privacy and preserves the confidentiality of my personal health information.

I understand that signing this document means that The Allergy & Spine Center may use and disclose my personal health information to help provide my healthcare, to handle my billing and payment and to take care of other health care operations.

Under the terms of this consent, I can ask The Allergy & Spine Center to restrict how my personal health information is used or disclosed to carry out treatment, payment or other health care operations. I understand that The Allergy & Spine Center does not have to agree with my request. If The Allergy & Spine Center does agree with my request, I understand that agreed limits would be followed.

I understand that I have the right to cancel this consent in writing to The Allergy & Spine Center. If I cancel the consent, I understand that The Allergy & Spine Center may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.

I understand that if I cancel this consent, The Allergy & Spine Center does not have to provide further health care services to me.

_____ _____/_____/_____

Patient Printed Name **Date**

_____

Patient or Legal Guardian Signature

The Allergy & Spine Center
Disclosure and Informed Consent For Care

You have the right as a patient to be informed about your condition, the recommended course of care, and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure, after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of Chiropractic adjustments, acupuncture, NAET treatment(s), and/or other procedures deemed necessary for care by the doctor, including but not limited to various modes of physical therapy and diagnostic x-rays on me or the patient named below, for whom I am responsible for, by Brittany Bowers, D.C. and/or other licensed doctors of Chiropractic, or those working at the clinic who now or in the future treat me while employed by, working or associated with, or serving as a fill-in for Brittany Bowers, D.C.

I have had the opportunity to discuss my diagnosis, the nature and purpose of Chiropractic, acupuncture, NAET, and other procedures and alternatives with the above doctor of Chiropractic.

I understand and I am informed that, in the practice of Chiropractic, there are some risks to examination and treatment including, but not limited to fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain, or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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 Printed Name **Date**

_____
Patient or Legal Guardian Signature

The Allergy & Spine Center
General/Financial Policy

We strive to provide you with excellent care in a clean, friendly, professional setting, and our goal is to make your visits as comfortable as possible.

Please initial below to ensure your understanding and agreement to the following:

_____ It is your responsibility to inform our office of any address, telephone number, or insurance changes.

_____ Your account is to be kept current. All payments will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.

_____ If you do not have your payment, your appointment may be rescheduled.

_____ If you are unable to keep a scheduled appointment, please notify us ***at least 24 hours ahead of time*** so that we may offer that time to another patient. Failing to do so will result in a $40 fee.

_____ A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.

_____ There is a $35.00 charge for the completion of paperwork (ex: if you are incapable to do so yourself due to a disability, FMLA, etc).

If you have any questions about the above information, please do not hesitate to ask us.
WE ARE HERE TO HELP YOU. 😀

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____/_____/_____
Patient Printed Name **Date**

_____
Patient or Legal Guardian Signature