2bwell, Inc

5935 Willow Lane, Lake Oswego, OR 97035
Phone: (503) 655-0044 / Fax: (503) 515-8099 / URL: www.2bwell.net

PATIENT INFORMATION

Today's date:	SS # (Strictly confidential):
Last name: First: Middle:	What should we call you?
	Marital status: Single Mar Div Sep Wid
Is this your first visit? ❑ Yes ❑ No	Weight: *Now* - *One year ago*
Height:	Birth date: / /
Age:	Sex: ❑ M ❑ F
Street address:	Home Phone: ( ) -
	Work Phone: ( ) -
City: State: ZIP Code:	Cellular Phone: ( ) -
Employer: Occupation:	E-Mail Address:
Chose 2bwell because/Referred to us by (please check one box): ❑ Dr.	❑ Insurance Plan: ❑ Direct Mail
❑ Yellow Pages ❑ Close to home/work ❑ Friend:	❑ Family: ❑ Other:

INSURANCE INFORMATION

Name of subscriber:	DOB, if other than the patient:	Relationship to patient:

As a service to our patients, 2BWell, Inc will finance the account and carry the balance while submitting the charges for medical treatment to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office.

We may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible, in addition to whatever amounts the insurance does not pay.

Please provide your insurance card to the receptionist at your initial visit to be copied. Also, please fill out the Insurance Verification Form to better provide us with the necessary information to verify your benefits.

IN CASE OF EMERGENCY

Name of local friend or relative (**not living at same address**):	Relationship to patient:	Home phone #: ( )	Cell phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize 2bwell, Inc or insurance company to release any information required to process my claims.

I agree to be responsible for payment of services in the event my insurance company doesn't agree to pay for these services. Not signing this document does not release you from responsibility of payment.

Patient/Guardian signature *Date*

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

PLEASE LIST IMPORTANT MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE GIVEN YOU CLEAR DIAGNOSES FOR:

1.	Dr's Name:	When:
2.	Dr's Name:	When:

What are your main complaints?

1.

2.

HOSPITALIZATIONS

Year	Reason	Hospital

PLEASE LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER SUPPLEMENTS.

Name	Strength	Frequency Taken

Lifestyle

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (at least 4x/week for 30 minutes)				
Diet	Are you on any diets at this time?			☐ Yes	☐ No
	If yes, is it a physician prescribed medical diet?			☐ Yes	☐ No
	Name of the diet and # of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	# of cups per day: ____
Alcohol	☐ None	☐ Occasionally	☐ 3 drinks a month	☐ drinks a week	☐ more
***Tobacco** (if using)*	☐ Cigarettes – pks./day ______	☐ Cigars - #/day _____	☐ Pipe - #/day ______	☐ Chew - #/day _____	
	☐ # of years	☐ Or years since quit			
Public safety	Do you have any contagious, or sexually / bodily fluids, transmitted disease?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH		AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH
FATHER			**CHILDREN**	☐ M ☐ F	
MOTHER				☐ M ☐ F	
SIBLINGS	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

WOMEN ONLY

Age at onset of menstruation:	Date of last menstruation:	Cycles are every _____ days

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your cycles?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night? If yes how many times? _____	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate exam?	☐ Yes	☐ No

Consent Form

All the therapeutic services performed by practitioners at 2bwell Clinic are aimed to prevent and treat pain, disease, or other dysfunctions. Adverse side effects may result. These include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to receiving treatments. Practitioners at 2bwell Clinic may recommend and perform Acupuncture and Oriental Medicine, Naturopathic Medicine, Massage Therapy, Chiropractic Medicine and utilize nutritional supplements as means of prevention or treatment modalities. Adverse side effects may result from taking nutritional supplements. These include, but are not limited to, changes in bowel habits, temporary abdominal pain or discomfort, and the possible temporary aggravation of existing symptoms. If I experience any problems to which I associate with these supplements, I understand that I should stop taking them and contact my practitioner.

I understand the risks involved in receiving the above treatment modality. I hereby consent to:

__ ***Acupuncture and Oriental Medicine treatments***
__ ***Naturopathic Medicine treatments***
__ ***Massage Therapy***
__***Chiropractic Medicine treatments***

Signature of Patient, Parent or Guardian Date

Systems Review

For the following, please check the box next to:
Y=a condition you now have **P**=a condition you had before **N**=a condition you never had

Headaches	□ Y	□ P	□ N	Difficulty breathing	□ Y	□ P	□ N	Diabetes	□ Y	□ P	□ N
Migraines	□ Y	□ P	□ N	Palpitation/Fluttering	□ Y	□ P	□ N	Seizure	□ Y	□ P	□ N
Spots in eyes	□ Y	□ P	□ N	Swelling in ankles	□ Y	□ P	□ N	Rashes	□ Y	□ P	□ N
Blurring	□ Y	□ P	□ N	Fainting	□ Y	□ P	□ N	Itching	□ Y	□ P	□ N
Ringing in ears	□ Y	□ P	□ N	Heart Disease	□ Y	□ P	□ N	Glaucoma	□ Y	□ P	□ N
Numbness/Tingling	□ Y	□ P	□ N	Heartburn	□ Y	□ P	□ N	Nausea/Vomiting	□ Y	□ P	□ N
Jaw/TMJ problems	□ Y	□ P	□ N	Constipation	□ Y	□ P	□ N	Diarrhea	□ Y	□ P	□ N
Glasses or contacts	□ Y	□ P	□ N	Blood in stool	□ Y	□ P	□ N	Gall bladder disease	□ Y	□ P	□ N
Tearing or dryness	□ Y	□ P	□ N	Pain on urination	□ Y	□ P	□ N	Kidney stones	□ Y	□ P	□ N
Impaired hearing	□ Y	□ P	□ N	Frequent urination	□ Y	□ P	□ N	Joint pain or stiffness	□ Y	□ P	□ N
Cough	□ Y	□ P	□ N	Frequent infections	□ Y	□ P	□ N	Weakness	□ Y	□ P	□ N
Asthma	□ Y	□ P	□ N	Sleep soundly	□ Y	□ P	□ N	Fatigue	□ Y	□ P	□ N
Shortness of breath	□ Y	□ P	□ N	Trouble falling asleep	□ Y	□ P	□ N	Depression	□ Y	□ P	□ N
Chest pain	□ Y	□ P	□ N	Dream excessively	□ Y	□ P	□ N	Easily stressed	□ Y	□ P	□ N
Bronchitis	□ Y	□ P	□ N	Arthritis	□ Y	□ P	□ N	Anxiety/Nervousness	□ Y	□ P	□ N

Effective Date: February 25, 2003

Notice of Patient Privacy Health Insurance Portability and Accountability Act (HIPPA)

2BWell Clinic is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. Required by law: We must have your written consent before we use or disclose to others your Medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact 2BWell Clinic via email: office@2bwell.net or phone: (503) 655-0044. You may also send a written complaint to the US Department of Health and Human Services.

____ ________________

Patient or Guardian Signature Date

____

Please Print Name

Your first appointment:

At 2bwell, we are committed to address the root cause of your illness rather than just treating the presenting symptoms. To identify the cause(s) of your condition, our practitioners will proceed with a preliminary consultation, question and answer, examination, and other assessment techniques required for your case. At the end of the evaluation process, and if the practitioner feels you will respond favorably to the treatment, he/she will prescribe a course of care that may include educational materials, specific therapies, diet and lifestyle recommendations, nutritional supplements, consultations, and subsequent re-evaluation and treatments. These reassessments and follow-up treatments are crucial to the practitioner's ongoing evaluation of your progress, and to the final outcome of your care. They are necessary to help differentiate whether changes in your treatment plan are needed or if the current course of action is appropriate. Please keep in mind that some symptoms may resolve before the actual underlying causes of disease have been eliminated completely.

Appointment changes:

2bwell requires a minimum of 24 hours advance notice in order to reschedule or cancel an appointment. We reserve the right to charge patients who cancel with less than 24 hours notice.

Payments:

All payments and co-payments are due at the time of service unless arrangements are made in advance. Based on experience, this policy is effective for both our patients and our providers. Outstanding balances can cause embarrassment and disruption of care for the prescribed treatment program. We are open to discuss financial arrangements if you anticipate any financial challenges.

I have read, understand and agree with the above statement regarding my health care and payment policy.

__________________________________ ______________________

Signature *Date*

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