

**Dr. Leilani Bettencourt, B.S., D.C., C.C.P.**

Full Name: \_\_\_\_\_ Email Address: \_\_\_\_\_ Date: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Spouse/Significant Other: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Children's Names and Ages: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Emergency Name and Number: \_\_\_\_\_  
How did you hear about the doctor? If someone referred you, what is their name? \_\_\_\_\_  
Is there a specific reason for consulting our office at this time? \_\_\_\_\_

**YOUR HEALTH PROFILE**

As a full spectrum chiropractic office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

**YOUR CHILDHOOD YEARS**

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
Did you have any childhood illness?			_____
Did you have any serious falls as a child?			_____
Did you play youth sports?			_____
Did you take/use any drugs?			_____
Did you have any surgeries?			_____
Have you fallen/jumped from a height over three feet (i.e. crib, bunk bed, trees)?			_____
Were you involved in any car accidents as a child?			_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?			_____
Did you suffer any other traumas (physical or emotional)?			_____
Were you vaccinated?			_____
As a child, were you under regular chiropractic care?			_____

## YOUR ADULT YEARS

	YES	NO	COMMENTS
Do you drink water daily?			How much: _____
Do you drink caffeine?			How much: _____
Do/did you smoke?			How much: _____
Do/did you drink alcohol?			How much: _____
Any surgeries/hospitalizations?			_____
Do you take any supplements/vitamins?			What kind/which brand: _____
Do/did you play any adult sports?			_____
On a scale of 0 – 10 describe your stress level (0 = none / 10 = extreme):			Occupational _____ Personal _____
On a scale of Poor-Good-Excellent describe your:			Diet: _____ Exercise: _____ Sleep: _____ General Health: _____
Have you ever:			Bought bottled water: YES NO Belonged to a health club: YES NO

## ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no specific symptoms or complaints, and you are here for Chiropractic Wellness Services please (X) here \_\_\_\_\_ and skip to the Family Profile section of this form. All others please briefly describe your chief area of complaint:

Include the effect it has had on your life:

Yes, it interferes with...	Work	Sleep	Walking	Sitting	Hobbies	Leisure
If you are experiencing pain, is it...	Sharp	Dull	Comes and goes		Travels	Constant
Since the problem started, it is...	About the Same		Getting Better		Getting Worse	
What makes it worse?	_____					

Other Doctors seen for this problem (please list):

Chiropractors \_\_\_\_\_

Medical Doctors/Other \_\_\_\_\_

Please check (X) all symptoms you have ever had, even if they do not seem related to your current problem.

Headache	Pins and Needles in Leg	Fainting	Neck Pain
Fatigue	Loss of Smell	Back Pain	Loss of Balance
Dizziness	Fever	Ring in Ears	Nervousness
Numbness in Fingers	Numbness in Toes	Loss of Taste	Stomach Upset
Pins and Needles in Arms	Depression	Irritability	Tension
Sleeping Problems	Neck Stiffness	Cold Hands	Cold Feet
Diarrhea	Constipation	Buzzing in Ear	Hot Flashes
Cold Sweats	Ulcers	Problem Urinating	Heartburn
Menstrual Irritability	Menstrual Pain	Mood Swing	Eyes Sensitive to Light

List any medications you are currently taking: \_\_\_\_\_

## FAMILY HEALTH PROFILE

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns you may have about your...

Children \_\_\_\_\_

Spouse/Partner/Significant Other \_\_\_\_\_

Parents \_\_\_\_\_

Siblings \_\_\_\_\_

Others \_\_\_\_\_

**The statements made on this form are accurate to the best of my knowledge.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Dr. Leilani Bettencourt, B.S., D.C., C.C.P.**

PLEASE PRINT

Child's Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Child's SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Parent Email Address(es): \_\_\_\_\_  
Parent #1 Name: \_\_\_\_\_ Work /Cell Phone #: \_\_\_\_\_  
Parent #2 Name: \_\_\_\_\_ Work /Cell Phone #: \_\_\_\_\_  
Insured Parent's SSN: \_\_\_\_\_ Insured Parent's Date of Birth: \_\_\_\_\_

**BIRTH INFORMATION**

Type of Birth: Vaginal \_\_\_ Forceps \_\_\_ Breech \_\_\_ Cesarean \_\_\_ Home \_\_\_ Birthing Center \_\_\_\_\_ Hospital \_\_\_\_\_  
Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Apgar Scores: \_\_\_\_\_  
At Birth: Jaundice (yellow)? YES NO Cyanosis (blue)? YES NO  
Medication taken during pregnancy? \_\_\_\_\_ Epidural: YES NO  
Any problems during pregnancy and/or labor? \_\_\_\_\_

Congenital Anomalies/Defects: \_\_\_\_\_  
Infant Feeding: Breast \_\_\_\_\_ Bottle \_\_\_\_\_ Formula \_\_\_\_\_ Other Food or Drink Information: \_\_\_\_\_  
No. of Hours Child Sleeps Daily \_\_\_\_\_ Quality of Sleep: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_  
Explain: \_\_\_\_\_  
Number of Siblings \_\_\_\_\_ Siblings Name, Age and Sex \_\_\_\_\_

**ADOPTION INFORMATION**

Child's Age When Adopted \_\_\_\_\_ Date of Adoption \_\_\_\_\_  
Known Health History of Child \_\_\_\_\_

**MEDICAL INFORMATION**

Obstetrician and/or Midwife Name: \_\_\_\_\_ Location: \_\_\_\_\_  
Pediatrician and/or Family MD Name: \_\_\_\_\_ Location: \_\_\_\_\_  
Date of Last Visit to Dr: \_\_\_\_\_ Purpose of that Visit: \_\_\_\_\_  
Immunization History: \_\_\_\_\_  
Has your child ever been treated on an emergency basis? \_\_\_\_\_ Please Describe: \_\_\_\_\_

# HEALTH INFORMATION

Purpose of the appointment today with the Chiropractor: \_\_\_\_\_

Pregnancy History: \_\_\_\_\_

Delivery/Birth History: \_\_\_\_\_

Developmental History – At What Age Did the Child:

Respond to Sound \_\_\_\_\_  
Crawl \_\_\_\_\_  
Follow an Object with their Eyes \_\_\_\_\_  
Hold Head Up \_\_\_\_\_  
Stand \_\_\_\_\_  
Sit Alone \_\_\_\_\_  
Walk Alone \_\_\_\_\_

Childhood Diseases – Age of the Child When Occurred:

Chicken Pox \_\_\_\_\_  
Rubella \_\_\_\_\_  
Rubeola \_\_\_\_\_  
Whooping Cough \_\_\_\_\_  
Mumps \_\_\_\_\_  
Measles \_\_\_\_\_  
Other \_\_\_\_\_

Has this child ever suffered from (please check any that apply):

Diabetes	Bed Wetting	Convulsions	Neck Problems
Fainting	Tuberculosis	Backaches	Heart Trouble
Dizziness	Stomach Aches	Allergies	Orthopedic Problems
Asthma	Walking Problems	Rheumatic Fever	Hypertension
Sugar Concentration	Headaches	Blood Disorders	Broken Bones
Sleeping Problems	Digestive Disorders	Sinus Trouble	Leg Problems
Diarrhea	Constipation	Paralysis	Joint Problems
Arm Problems	Hyperactivity	Chronic Earaches	Colds/Flu
Arthritis	Neuritis	Anemia	Poor Appetite
Behavioral Problems	Muscle Jerking	Ruptures/Hernias	“Growing Pains”
Any Other Problem _____			

Present Health History or Additional Information: \_\_\_\_\_

Surgery Information: \_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Family Health History: \_\_\_\_\_

***The statements made on this form are accurate to the best of my knowledge.***

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

# INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures on me, including various modes of physical therapy (or on the patient named below, for whom I am legally responsible) by the licensed doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or sending doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor or chiropractor named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. 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 judgment during the course of procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read or have had it read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

## TO BE COMPLETED BY PATIENT

Patient's Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_  
Date signed: \_\_\_\_\_

## TO BE COMPLETED BY PATIENT'S REPRESENTATIVE

IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name: \_\_\_\_\_ Name of Representative: \_\_\_\_\_  
Date signed: \_\_\_\_\_ Signature of Representative: \_\_\_\_\_  
Relationship or Authority of Patient's Representative: \_\_\_\_\_

## LICENSED DOCTOR

**Leilani Bettencourt, B.S., D.C., C.C.P. DC-29239**

1076 Meridian Ave.  
San Jose, CA 95125  
408-265-2663

# STATEMENT OF OFFICE POLICIES

Welcome to the office of Dr. Leilani Bettencourt, B.S., D.C., C.C.P. Please read and sign this policy statement below. Our staff will be happy to assist you with any questions or concerns you may have.

## FINANCIAL RESPONSIBILITY

We wish to stress that the financial responsibility for services rendered rests with the patient. Charges for treatment are due at the time the service is provided.

Accounts unpaid after 90 days may be referred to our collection agency unless payment arrangements have been made with our staff. If it becomes necessary for the doctor to retain an attorney or to commence legal action for collection of any outstanding charges on the account, the patient will be responsible for all reasonable fees incurred on the account, including collection fees, court costs and attorney fees.

We wish to stress that the financial responsibility for services rendered rests with the patient regardless of any insurance coverage. It must be understood that your medical insurance is a contract between you and your insurance carrier. The benefits quoted by your insurance carrier are not a guarantee of payment and are subject to review based on the terms of your individual contract. Please note that you are responsible for knowing the limitations of your coverage. Your treatment plan is based on medical necessity as deemed appropriate by the doctor of Chiropractic or your referring physician. It is not our policy to enter into a dispute between you and your insurance carrier over any unpaid portion of your bill.

Most insurance companies process claims within 30 days of receipt. Please be advised that any balance on the account over 60 days is due and payable in full by the patient. Accounts unpaid after 90 days will incur a 1.5% monthly charge. Any accounts which are over 120 days past due may be referred to our collection agency unless specific payment arrangements have been made with our staff.

## RETURNED CHECKS

There will be a \$35.00 fee imposed for all checks returned to this office.

## APPOINTMENT CANCELLATION POLICY

We require a minimum of 24 hours notice for any canceled or re-scheduled appointment. Failure to give the required notification may result in a \$50.00 charge. If you fail to show for an appointment without any prior notification, you may be charged for the full time set-aside for your appointment. These charges will be billed directly to you as a missed appointment. You are expected to re-schedule missed appointments in order to comply with your prescribed treatment plan. Please keep in mind that re-scheduling an appointment is always subject to availability.

## VOLUNTARY TERMINATION OF CARE

It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

I, the undersigned, have read the above stated office policies and agree to abide by these policies.

Print name: \_\_\_\_\_

Sign name: \_\_\_\_\_

Date: \_\_\_\_\_

# **PRIVACY PRACTICES ACKNOWLEDGEMENT**

## **ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If you would like a printed copy for your records please ask. Thank you.*