Bara Family Wellness Center – 3532 Independence Drive, Homewood, AL 35209
Dr. Stasi Bara, Holistic Chiropractor - 205.879.5799

Health and Wellness Profile

Date: ____________________

Name: ______________________________ Email Address: ______________________________

Address: ______________________________ City: ______________ State: _____ Zip Code: ________

Date of Birth: ____________ Social Security #: ________________ Marital Status: _____ Gender ☐ Male ☐ Female

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Employer Name:________________ Occupation: ____________ Spouse Name: __________ Children _______

How did you discover our office and the professional services we offer? ______________________________

Responsible Party (Complete this section if someone other than the patient is responsible for payment)

Person Responsible for Bill: ______________________________ Relationship: ______________

Address: ______________________ City: ________ State: ____ Zip Code: _______ Phone: ____________

Primary Insurance Information

Insurance Company Name: ______________________________ Group number: ______________________

ID Number: ______________ Insurance CO Phone: ____________ Name of Policy Holder: ______________

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐ Other ____________ Policy Holder's Date of Birth: ____________

Eligibility: To be completed by the office **Patient #** ____________________

Card Copied: ☐ Yes ☐ No **Chiro Coverage:** ☐ Yes ☐ No **Carry-Over**: ☐ Yes ☐ No **Acc. Rider**: ☐ Yes ☐ No

Effective Date: ________________ Deductible Amount: $____________ Deductible Amount Met: $___________

Maximum Visits per Year: __________ # of Visits used this Year: __________ Co-Pay Amount: $______________

Maximum Dollar Amount per Year: $___________ Amount Used: $__________ Percent of Coverage: __________%

Date Verified: ____________ verified Online ☐ Yes ☐ No Person's Name Spoke with: ____________________

Part I: Your Specific Needs and Hopes for Help in This Office

1) In a published study of over 2,800 patients in Network Spinal Analysis care, conducted within the Medical College at the University of California –Irvine, patients reported an overall improvement in all of the categories of health and wellness listed below. How do you hope to benefit from care in this office?

Please mark using this scale: a) very important to me b) important to me c) not so important to me d) does not apply

I) _____ Improvement of my physical symptoms
II) _____ Improvement of my emotional mental symptoms
III) _____ Improvement of my ability to react or respond to stress
IV) _____ Improvement in my enjoyment of life
V) _____ Overall improved quality of life

2) Currently, how inconvenient is your situation, condition or symptom? 0-not at all 1-slight 2-moderate 3-extreme

3) Please circle the one that best describes your current feeling about yourself and your situation, condition or symptom?

a) I feel helpless like little or nothing works
b) This is terrible, really bad, I am scared and hope you can fix it for me
c) I feel stuck and can't help myself right now
d) I deserve more than what I've been experiencing and would like you to assist me
e) Anything else? ______________________________________

Part II: Your Health Concerns or Symptoms and How They May Affect Your Life

Do you have any current health concerns, situations, conditions or symptoms? If so, please describe.________________________________

____

____

When did it begin? ____

Have you done anything about this situation or concern or gotten any advice or treatment for it? ☐ Yes ☐ No

If yes, who did you see, what were you told and what did you do? ____

____

Did it seem to work? ____

Is there any time, or activity you can be involved with when you totally or almost forget about this condition, symptom or concern? ________

____

Is there any time of the day or activity which makes you more aware of it? _______________________________________

Why do you think this has happened or continues to happen to you? ____

____

Have you had this similar condition before? ☐ Yes ☐ No When? ____

If this condition or symptom were to go away tomorrow, what would be different about your life? _____________________________

____

Is this injury related to: ☐ work accident ☐ auto accident, Please explain ______________________________________

What surgeries have you had? ____

List what drugs you take now. (Prescription and Over the Counter) ____

____

Is there anything else you would like Dr. Bara to know about you or your health history? __________________________________

____

How do you want us to handle your problem?

___Temporary Relief (Help the symptom but do not fix the cause of the problem)

___Maximum Correction (Correct the cause of the problem for maximum stability in the future)

On a scale of one to ten (10 being the most, 1 being the least),

______How committed are you at being at your maximum health potential?

______How important is it for your family to be at their optimum health potential?

Thank you for choosing our Holistic Chiropractic office. We are looking forward to helping you be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

Chiropractic is a lifestyle and a family affair. We give you the opportunity to have your immediate family members examined without any additional charges as long as these exams are done within two weeks and at Dr. Bara's discretion..

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________________ and assign Dr. Stanley J. Bara, III, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. 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 to secure the payment of benefits. I authorize the use if this signature on all insurance submissions. I understand that failure to pay my bill may result in my account being sent to collections. If my account is sent to collections, I am responsible for my balance from this office and any fees charged by the collection agency.

________________________________	________________________	____________________
Responsible Party Signature	Relationship	Date