# *Novel Wellness Clinic*

***Dr. Rupa Mehta [MBBS, Advanced Proficiency Rated (USA)]***

**(Please use Capital letter)** Date_____

| Patient Name | Age | Birth date | Marital Status M/S/W/D | Height/Weight |
|---|---|---|---|---|
| | | | | |

Cell Phone _____Home Phone_____ Work Phone_____

Home Address _____

City, State, Pin Code _____ Email _____

Your Occupation _____

Work Address _____

City, State, Pin Code _____ Email _____

**Details of other family members**

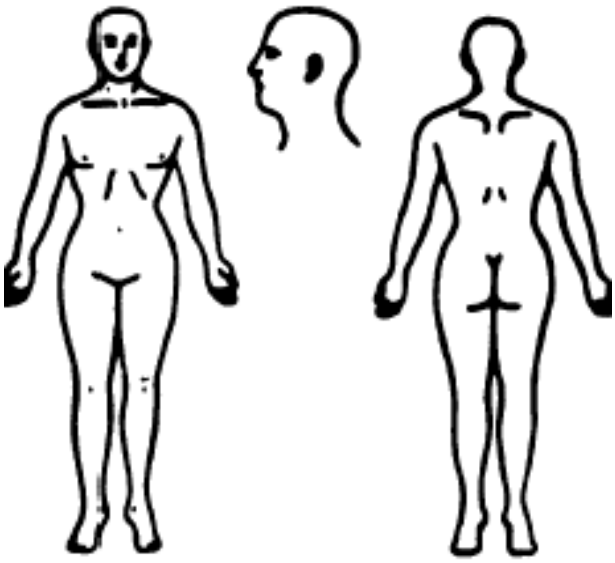
| Name | Relationship | Birth date | Age | Marital Status M S W D | Occupation | E Mail | Phone |
|---|---|---|---|---|---|---|---|
| | Husband | | | | | | |
| | Wife | | | | | | |
| | Father | | | | | | |
| | Mother | | | | | | |
| | Brothers | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Sisters | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Family Doctor | | | | | | |
| | | | | | | | |
| | | | | | | | |

| Chief Complaint in order of severity and past surgery | Since How long | Treatment at Home / By Other doctor | Current Medicines |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**DO U SUFFER OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:**

| | |
|---|---|
| ☐Stroke | ☐Pregnant at this time |
| ☐Fatigue | ☐Numbness or pain in arms/legs/hands |
| ☐Migraine | ☐Pain between shoulders |
| ☐Nervousness | ☐Spinal curvature |
| ☐Arthritis | ☐High blood pressure |
| ☐Heart disease | ☐Heart Attack |
| ☐Headache | ☐Cancer |
| ☐Shingles (Herpes zoster) | ☐Diabetes |
| ☐Dizziness | ☐Sinus |
| ☐Stiff Neck | ☐Backache |
| ☐Swollen Joints | ☐Stomach |
| ☐Heel Pain | ☐Hip pain |
| ☐Knee Pain | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |

Please mark your areas of pain on the figures below.



**0——————— 5 ——————— 10**

Please rate your pain: "0" for No Pain to 10 for Extreme Pain

| | |
|---|---|
| Are symptoms | □ Getting Worse □ Getting Better □ Staying the same □ Do Not know |
| How often do your symptoms occur? | □ Occasional(0–25%) □ Intermittent(25– 50%) □ Frequent(50– 75%) □Constant (75– 100%) |
| How would you describe your symptoms? | □ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Other |
| When are your symptoms worst? | □ Morning □ Afternoon □ Evening |
| Do your symptoms wake you up at night? | □ Yes □ No |
| Are your symptoms aggravated by: | □ Coughing □ Sneezing □ Movement □ Straining to stool □ Lifting □ Bending □ Sitting □ Standing □ Other _____ |
| Are your symptoms relieved by: | □ Nothing □ Rest □ Ice □ Heat □ Stretching □ Exercise □ Sitting □ Standing □ Other _____ |
| Do your symptoms remain local? | □ Yes □ No |
| Do your symptoms radiate? | □ Yes □ No □Left leg □Right leg □Left arm □Right arm □ Back of head □ Other ____ |
| How long has pain been present? | _____ |
| How did the pain begin? | □ Gradual □ Sudden |

Please explain:

_____

Chief Complaints: Duration:

**Back Pain** □ Upper □ Lower

□ Leg Pain □ Right □ Left □ Both
□ Claudication
□ Neck Pain
□ Arm Pain □ Right □ Left
□ Paraesthesia
□ Numbness
□ Weakness
□ Bladder/Bowel Symptoms

## Investigation

- X-Ray
- MRI
- EMG/NCS
- CT Spine
- ESR
- RA
- HLA B2
- Vit B12
- Vit D3
- TFTs

## Treatment

- Analgesics
- Muscle Relaxants
- Steroids
- Lumber Belt
- Cervical Collar
- Bed Rest
- SWD/IFT
- Physiotherapy
- Epidural Injection
- Facet Blockers
- Reference

## Surgery

**Other Medical and Health Information:** _____

We know there can be various reasons for your office visit today, and more than one of the following question might apply. However, please pick only the ONE that most relates to you currently.

1. Are you here today because although you feel healthy you want to have an even greater level of health?
2. Are you here today because although you feel healthy you want to help prevent an illness or possible injury?
3. Are you here today because although you feel healthy you have a tendency to be at risk for injuring yourself and want to prevent that from happening?
4. Are you here today because you are injured or ill and want help so that you will feel better, without having to do any home therapies or modify activities out of this office?
5. Are you here today because you are injured or ill and want help so that you will feel better, and want to have home therapies and activities that you can do to help yourself outside this office.

# Informed Consent

Health care is associated with some degree of risk for potential side-effects or unanticipated problems. We perform adjustments with the low-force adjusting Instrument only.

It is possible that you may develop very small areas of superficial bruising at the point of contact of the adjusting instrument on the skin, but this is minimal and goes away in a day or two. This is rare, but can happen in patients with fragile skin or those who are taking blood thinners.

Post-treatment soreness: There may be “soreness” following an adjustment. This is due to the muscles beginning to contract correctly again and the joints being re-aligned. It is similar to the soreness and stiffness one gets when they start exercising after a long period of no exercise. We have found that the patients who do develop soreness following the first treatment are the patients who usually heal the fastest.

By signing this form I acknowledge that I am aware of these possible complications and agree to allow the doctor to adjust me.

Further, I understand that any expenses incurred with NWC (Novel wellness Clinic) for myself or any of my minor, dependents are my responsibility and not that of any other person.

I understand that payment is due in full at the time of service.

I understand there are times a phone consultation with the doctor may be necessary and that such a consultation are placed on the doctor’s schedule and billed as a regular appointment.

I understand that all information given to NWC now or at any point in the future is entirely confidential. The Medical records (information) will be released if legally required to do so, or demanded by IMA (Indian Medical Association) or for Medical data publication without name.

At times, e-mail or fax may be the best option to communicate confidential medical information between myself and my doctor. I understand these are not secure forms of communication and my records will not be protected when using these forms of communication.

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Date Patient’s / Guardian/s Signature
(Signature of patient, or one parent or guardian if patient is under 18)