Optimal Health
Chiropractic & Wellness Care

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____ **City** _____

State _____ **Zip Code** _____ **Home Phone (**_____**)** _____-_____

Cell Phone (_____**)** _____-_____ **Email** _____

Date of Birth: _____ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Other

Primary Care Physician _____ **Phone #** _____

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data_____
Name _____ **Address**_____

City _____ **State** _____ **Zip Code** _____

Spouse Data ___

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (_____**)** _____-_____ **Work Phone (**_____**)** _____-_____

Emergency Contact_____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____**)** _____-_____ **Cell Phone (**_____**)** _____-_____

Financial Responsibility

The privilege of insurance assignment begins when our office has qualified your insurance coverage. For your convenience, Optimal Health Chiropractic will bill your insurance company directly and accept assignment. Your insurance is not a guarantee of payment for services rendered in this office. It is your responsibility to pay any remaining balance with our office and seek reimbursement from your insurance company. Your fees are due and payable at the time of examination, x-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

- All co-payments and deductibles must be paid when services are rendered.
- There will be a fee of $30 for all returned checks. Balances over 30 days may be subject to additional collection fees.
- All accounts not paid within 90 days will receive financial notification and be turned over to a collection agency for further action.

A special note for our Medicare patients:

Medicare will ONLY cover and reimburse for manipulation of the spine. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

Please print: I, _____, have read and fully understand the above statements and undertake Chiropractic care on this basis.

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_____ _____
Signature Date

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _____			

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other _____			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _____

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

Other _____

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care

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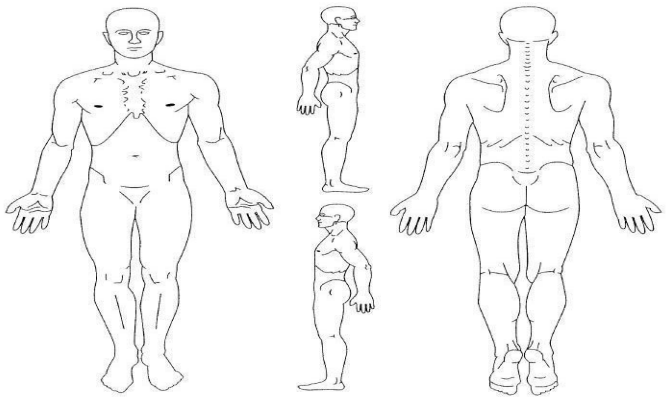
□ Food Service Industry □ Medium Manual Labor □ Manufacturing □ Home Services
□ Heavy Manual Labor □ Light Manual Labor □ Executive/Legal □ Housekeeper
□ Other _____

Patient Name_____**Date**_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness
B=Burning
S=Stabbing
T=Tingling
A=Dull Ache



1. **On a scale of 1-10 (1=least amt; 10= most severe) scale what is your level of pain: _____**

2. **Describe your symptoms in order of severity, with worse symptom being #1:**
   _____

3. **When did your symptoms begin? Month_____ Day _____Year _____**

4. **How often do you experience your symptoms?**
   □ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

5. **What describes the nature of your symptoms?**
   □ Sharp □ Dull ache □ Numb □ Shooting □ Burning □ Tingling □ Stabbing □ Other _____

6. **What relieves your symptoms?** □Ice □Heat □Massage □Exercise □Chiro □Medication

7. **What makes your symptoms worse?**
   □Bending □Dressing □Driving □Exercising □Lifting □Sitting □Sleeping □Standing

8. **Activity of daily life most affected?** Employment Personal Care Social Life Exercise

9. **Have you been treated for these symptoms previously? _____ How long ago?_____**

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10. **What kind of treatment did you receive? _____**

11. **Are you pregnant?** Yes _____ No_____ N/A _____

12. **List any other major injuries/concussions: _____**

13. **List any current medications you are currently takinf_____**