Optimal Health

Name: _____ Date: _____

Date of Birth: _____

How often are you feeling the pain?
Constantly (76%-100% of the day) Frequently (51%-75%) Occasionally (26%-50%) Intermittently (0%-25%)

What makes your symptoms worse?
Bending Exercising Lifting Sitting Sleeping Standing Travelling Walking

What relieves your symptoms?
Ice Heat Exercise Massage Chiropractic Medication

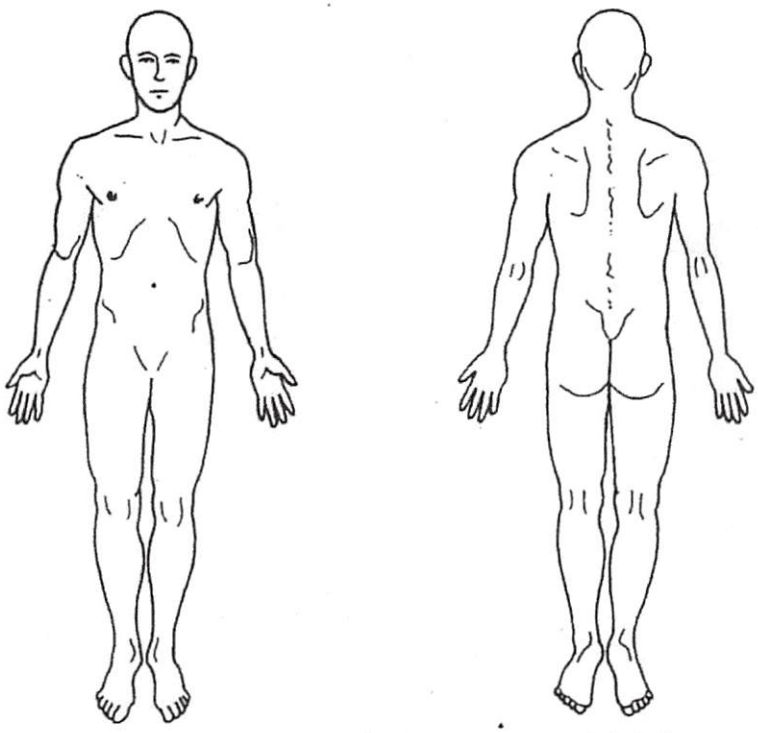
Is the problem affecting any of the following?
Employment Personal Care Social Life Exercise

On a scale of 1-10 (1 is least amount, 10 is most), what is your level of pain? _____

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



2575 Old Glory Road, Suite 300, Clemmons NC 27012

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (800) 442-1202

Patient:_____ Age:_____ Date of Birth:_____ Sex: M F

Patient Address:_____ City:_____ State:_____ Zip:_____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to ensure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from Optimal Health Chiropractic where I am receiving care and the $45 fee will be collected at the time of service.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions.

SIGNATURE:_____ DATE:_____

WITNESS:_____

PATIENT HISTORY—Doctor to complete the information below

PATIENT PRESENTATION: _____

_____

Trauma? Yes No Explain:_____

Past Medical History: _____

_____

Malignancy? Yes No Details:_____

Diagnosis/Concerns/Questions (No ICD Codes Please):_____

_____

Optimal Health

INFORMED CONSENT FORM

PATIENT NAME:_____ **DATE:** _____

To the patient: Please read this entire document prior to signing it. It is Important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical Instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination/ Treatment

As a part of the analysis, examination, and treatment. you are consenting to the following procedures:

- spinal manipulative therapy
- range of motion testing
- muscle strength testing
- pressure wave medical wave
- radiographic studies
- whole body vibration
- palpation
- orthopedic testing
- postural analysis testing
- hot/cold therapy
- mechanical traction
- extremity manipulative therapy
- vital signs
- basic neurological
- myofascial release
- electrical stim
- cold laser therapy
- TENS units

Other:_____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there an, certain complications which may arise during chiropractic manipulation and therapy. These complications, though ***extremely rare,*** include but are not limited to fractures, there have been reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and bums. Some manipulations of the upper spine have been associated with Injury to the arteries in the neck which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke Is one in several million. Stroke has been the subject of tremendous disagreement and cause is yet to be determined. Some patients will feel some stiffness and soreness following the first few days of treatment.

I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Overall, compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed It with Dr. Adam J. Williams and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that It Is In my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment and extend this consent to Include all Doctors of Optimal Health Chiropractic, PLLC.

Dated:_____ **Printed Name:** _____

Patient Signature (Or Signature of Parent or Guardian): _____

Optimal Health

Patient Name: _____ Date: _____

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 this 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 $35 fee for all returned checks.
- Balances over 30 days may be subject to additional collection fees.
- All accounts not paid within 90 days will receive final notification and be turned over to a collection agency for further action.
- If the schedule of care is suspended or terminated, all outstanding fees for professional services will be immediately due and payable.

Patient Name: _____ Signature: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____Date: _____

This Section for Female Patients Only:

X-rays are contraindicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or the assistant know right now.

Are you pregnant? ____Yes ____No

Tubal Ligation? ____Yes _____No

Hysterectomy? _____Yes ____No

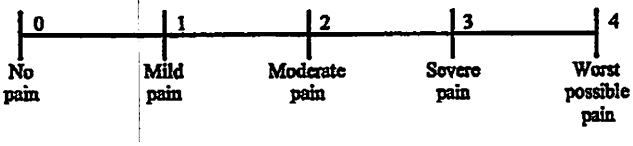
Patient Name: _____ Signature:_____

Functional Rating Index

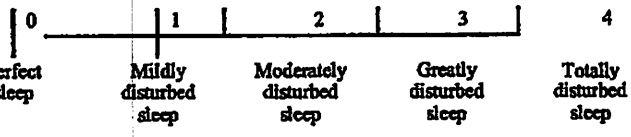
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

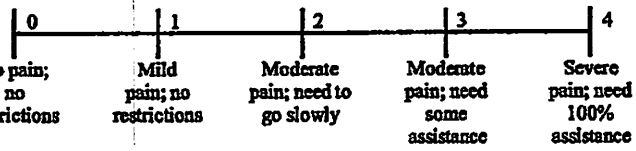
1. Pain Intensity



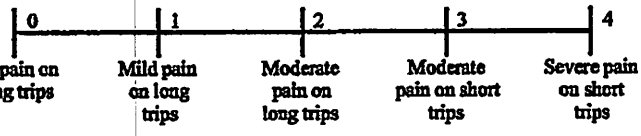
2. Sleeping



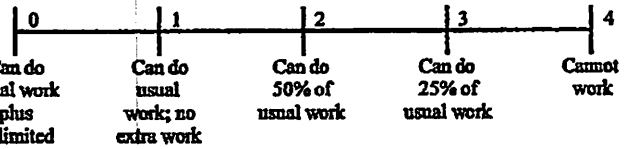
3. Personal Care (washing, dressing, etc.)



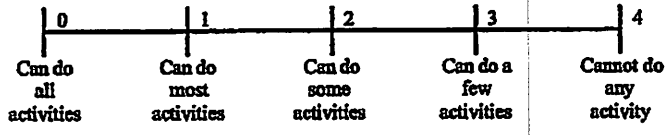
4. Travelling (driving, etc.)



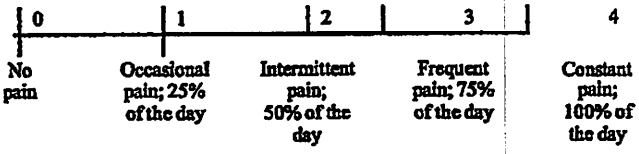
5. Work



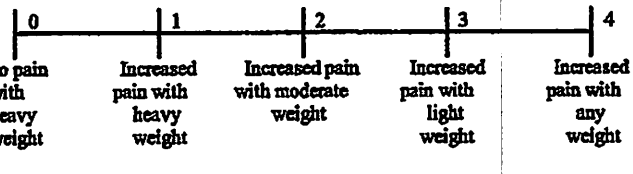
6. Recreation



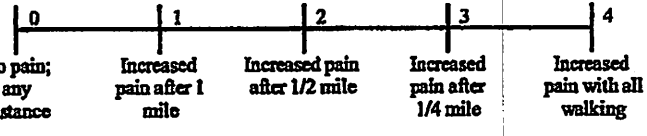
7. Frequency of Pain



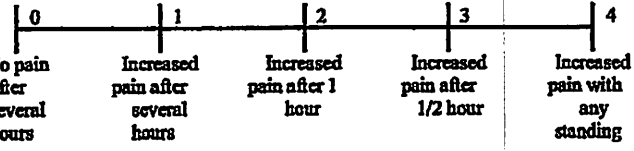
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ **Date** _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

Optimal Health

PATIENT NAME _____ Patient #_____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? Yes No If yes, when and describe:_____

_____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

_____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

Optimal Health

Chiropractic Case History/Patient Information

Date: _____ Patient #_____ **Doctor:** _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Cell Phone: _____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

_____

Emergency Contact: _____ Relationship: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Please circle all insurance coverage that may be applicable in this case:

-Major Medical -Worker's Compensation -Medicaid -Medicare -Auto Accident
-Medical Savings Account & Flex Plans -Other_____

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we can help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services.
- My case may not be accepted for care at this office.
- If the doctor believes that I may respond to their care, additional service may be recommended, and I will be advised of applicable cost.

Patient Signature: _____ Date: _____

Optimal Health

PATIENT NAME _____

DATE _____ Doctor_____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

2575 Old Glory Road, Suite 300, Clemmons NC 27012

Optimal Health

PATIENT NAME _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____