Optimal Health
Chiropractic & Wellness Care

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

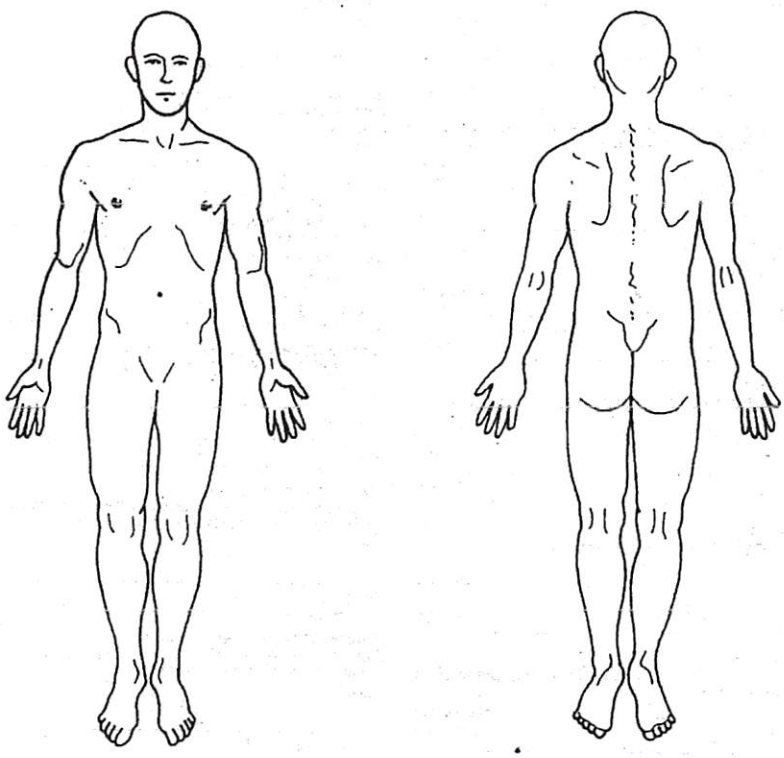
Is the problem affecting any of the following?
Employment Personal Care Social Life Exercise

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

X-Ray Assignment Agreement and Consent Form

I understand that my doctor is submitting my X-Rays for radiological interpretation and report by John R. Henry, DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I give my consent to Brookside Radiology Consultants, Inc. for use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice. I acknowledge that I have received or reviewed and understand the Notice of Privacy Practice of Brookside Radiology Consultants, Inc. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. **My signature authorizes the release of medical information.**

Patient Name	Today's Date
Patient Signature	Parent/Guardian Signature (if applicable)

TO BE MAINTAINED BY REFERRING DOCTOR

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. By signing below, I state that Ihave 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
Chiropractic & Wellness Care

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:** _____

HIPAA Privacy Practices:

I acknowledge that I have received and/or have been given the opportunity to review Optimal Health Chiropractic's Notice of HIPAA Privacy Practices for protected health information.

Patient Name: _____ **Signature:** _____

Consent to treat minor: (Minor's name): _____

Parent/Guardian Signature Authorizing Care: _____

NOTICE OF PRIVACY PRACTICES AVAILABLE UPON REQUEST

I understand and consent to the following appointment reminders that will be used by the Practice: a) postcards or letters mailed to the address I provided; b) phone calls made to the number I have provided and/or voicemails left on an answering machine or with the individual answering the phone; c) emails sent to the email address I have provided.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

You may release my health information to the following:

- ☐ **DO NOT RELEASE MY INFORMATION TO ANYONE**
- ☐ **ANYONE WHO REQUESTS IT**
- ☐ **SPOUSE**_____
- ☐ **CHILDREN** _____
- ☐ **FAMILY MEMBER**_____
- ☐ **FRIEND**_____
- ☐

ATTENTION PATIENT: If no one is checked on this form, we cannot give any information to anyone. If you sign this authorization, you can revoke it later. The exception to this is if we have already acted in accordance with the authorization. If you want to revoke your authorization later, simply send a written note to the office.

Signature:_____ **DATE:** _____

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Patient Name:_____ Date of Birth:_____

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 _____

How did this happen?_____

Have you ever had the same or a similar condition? YES NO

If yes, when and describe:_____

Do you have a history of stroke or hypertension? YES NO If YES, Date of stroke:_____

Date of last physical examination:_____ Are you pregnant? YES NO UNCERTAIN

Have you had any major illnesses, injuries, falls, auto accidents or surgeries?

Women, please include information about childbirth/dates:

_____

_____

What medications and/or drugs are you currently taking?_____

Do you have allergies of any kind? YES NO

If yes, describe:_____

Do you have a congenital condition? YES NO

If yes, describe:_____

Social History

Please indicate beside each activity whether you engage in it:

OFTEN=O SOMETIMES= S NEVER=N

___Exercise	___High stress activity
___Alcohol use	___Family pressures
___Drug use	___Other mental stresses
___Tobacco use	___Other (specify)
___Caffeine	_____

_____

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Chiropractic Case History/Patient Information

Patient Name:_____ Date:_____

Home Address:_____ City:_____ State:___ Zip:_____

Email:_____ Phone number:_____

Age:____ Date of Birth:_____ Race:_____ Marital Status: M S W D

Occupation:_____ Employer:_____

Employer's Phone:_____ EXT:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Family Medical Doctor:_____ Phone:_____ Fax:_____

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

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

Family and Personal Health History

Please review the below listed diseases and conditions and indicate those that are current health issues of the *family member or yourself.* Leave blank those spaces that do not apply.

CONDITION	SELF	PARENT	SIBLING	CHILD
Arthritis				
Asthma/Hay Fever				
Cancer				
Diabetes				
Emphysema/Breathing problems				
Epilepsy/Seizures				
Headaches/Migraines				
Heart Trouble/Pacemaker				
High Blood Pressure				
Kidney Trouble				
Liver Trouble/HIV positive				
Scoliosis				
Constipation				
Osteoporosis				
Weight loss/gain				

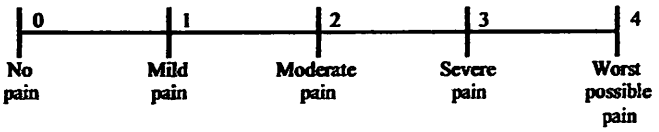
I certify the information provided is accurate to the best of my knowledge.
Name:_____ Signature of Patient/Legal Guardian:_____

Functional Rating Index

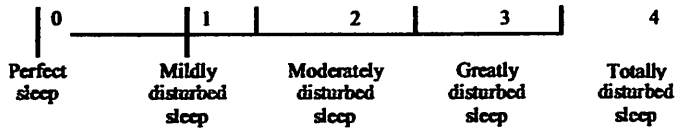
For use with Neck and/or Back Problems only.

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.**

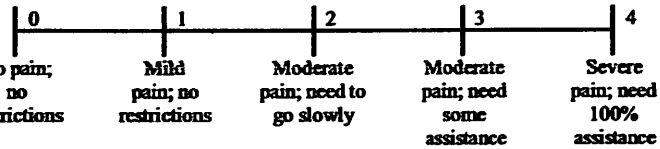
1. Pain Intensity



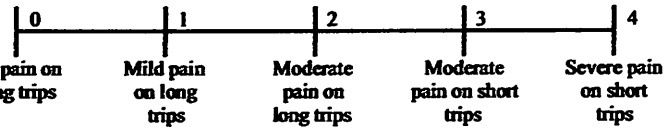
2. Sleeping



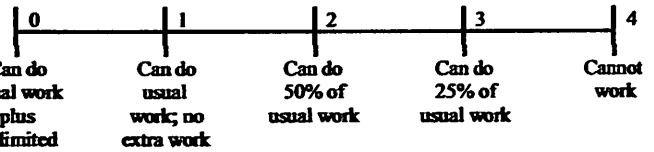
3. Personal Care (washing, dressing, etc.)



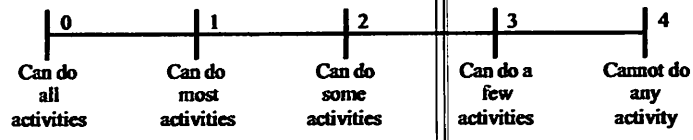
4. Travelling (driving, etc.)



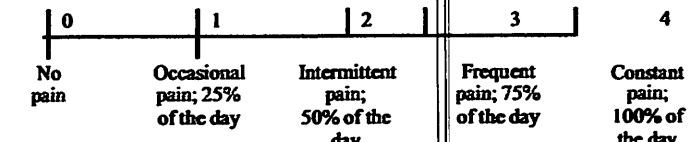
5. Work



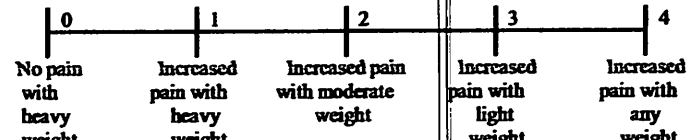
6. Recreation



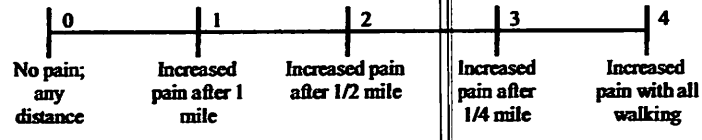
7. Frequency of Pain



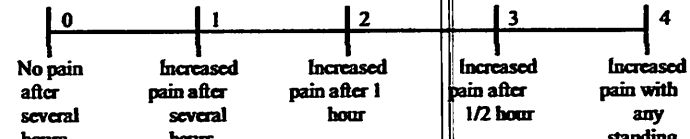
8. Lifting



9. Walking



10. Standing



_____ _____

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____