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

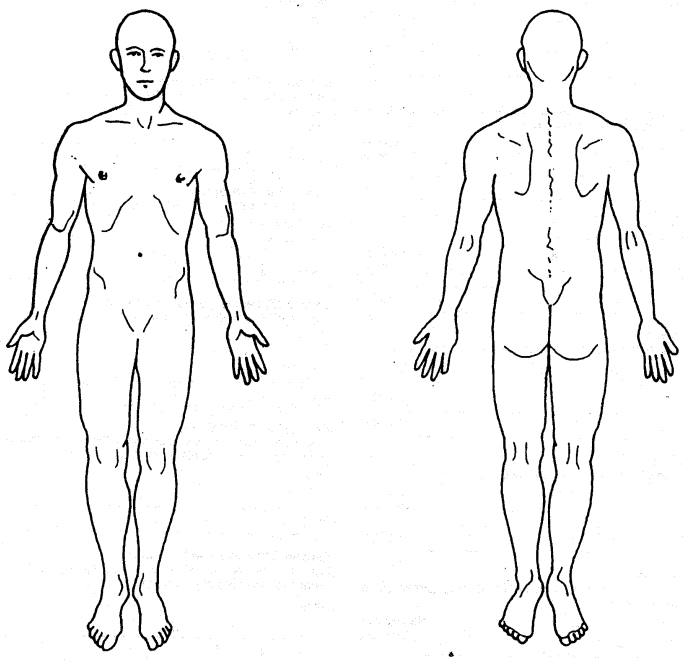
On a scale of 1-10 (1 is least amount, 10 is most), what is your level of pain? _____

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 ~ ~ ~ ~ ~ ~ ~



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.**

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.

_____ _____
Patient Name Today's Date

_____ _____
Patient Signature Parent/Guardian Signature (if applicable)

<u>This Section for Female Patients Only:</u>
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:_____

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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): _____

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:** _____

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

List 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

___Alcohol use

___Drug use

___Tobacco use

___Caffeine

___High stress activity

___Family pressures

___Other mental stresses

___Other (specify)

_____

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

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family.

_____Depression
_____Heart Attack
_____Diabetes
_____Thyroid Disease
_____Liver/Gallbladder Disease
_____Kidney Disease
_____Stroke
_____Fatigue
_____Brain Fog
_____Dizziness
____Hypoglycemia
____Anemia
____Cancer
____Heart Trouble
____Intestinal Problems
____Shortness of Breath
____High Cholesterol
____Headaches/Migraines
____High Blood Pressure
____Poor Sleep
____Osteoporosis
____Arthritis
____Carpal Tunnel
____Neuropathy
____Weight Gain
____Back Pain
____Neck Pain
____Shoulder Pain
____Knee Pain

☐ **I am interested in the practitioner presenting solutions for ALL checked ailments.**

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

Name:_____ Signature of Patient/Legal Guardian:_____

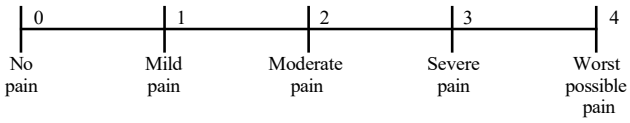
Patient Name:_____ Date of Birth:_____

Functional Rating Index

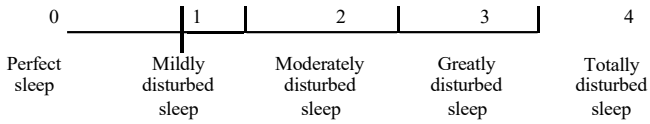
For use with **Neck and/or Back Problems** only.

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**.

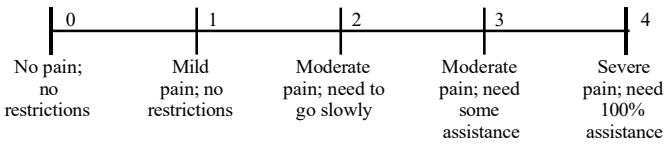
1. Pain Intensity



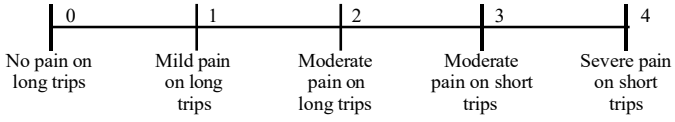
2. Sleeping



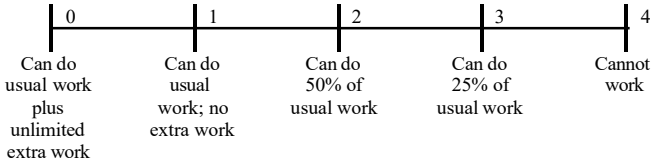
3. Personal Care (washing, dressing, etc.)



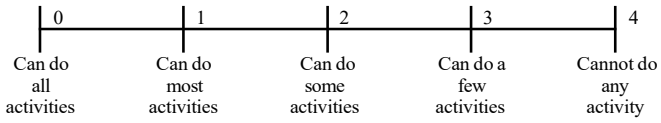
4. Travelling (driving, etc.)



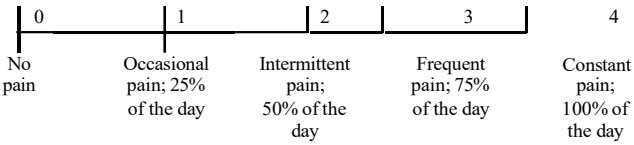
5. Work



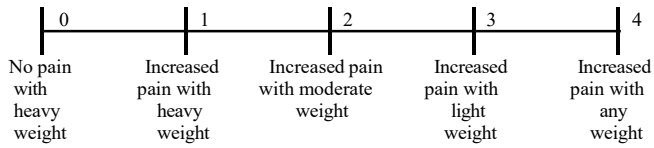
6. Recreation



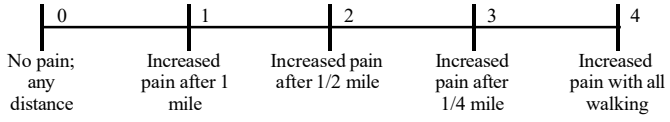
7. Frequency of Pain



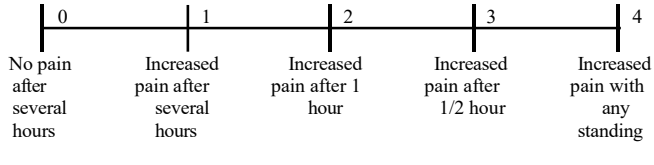
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ **Date** _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____