# OptimumHealth
An Integrative Approach To Healing

Date _____

## PATIENT INFORMATION

_____
Last Name First Name Middle Initial

Address_____

City_____

State_____ Zip_____--_____ (9 digit zip required)

Email Address_____

Cell(_____)_____ Home(_____)_____

Work(_____)_____ SS#_____

Date of Birth_____ Age_____ Gender ☐ M ☐ F

Height____ Weight____ ☐ Married ☐ Widowed ☐ Single

Occupation:_____

Employer:_____

Who is responsible for account?_____

In case of emergency please contact:

Name_____ Phone(_____)_____

**How did you hear about us?**_____

☐Google ☐Facebook ☐Website ☐Referral ☐BodyPlex

## INSURANCE INFORMATION

**Primary Insurance Company**_____

Subscriber's Name_____

Relationship to Patient_____

Subscriber's Employer_____

Member #_____

Group #_____

Subscriber's DOB___/____/____ SS#_____

**Secondary Insurance Company**_____

Subscriber's Name_____

Relationship to Patient_____

Subscriber's Employer_____

Member #_____

Group #_____

Subscriber's DOB___/____/____ SS#_____

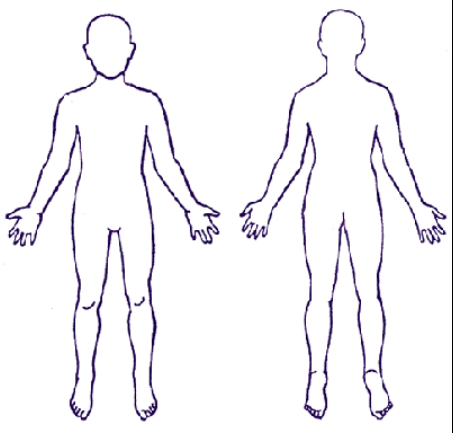
(1) Primary health complaint?_____

(2) When did your symptoms appear?_____

(3) Are these symptoms progressively worse? ☐ Yes ☐ No

(4) Mark an **X** on the picture where you are having symptoms.

Front Back



Type of Symptoms: ☐ Sharp Pain ☐ Dull Pain ☐ Throbbing Pain
☐ Burning ☐ Numbness ☐ Tingling ☐ Aching
☐ Cramping ☐ Stiffness ☐ Swelling

(5) Rate the severity of your pain on a scale from 1 (least) to 10 (severe) _____

(6) How often do you have this pain?_____

(7) Is the pain constant or does it come and go?_____

(9) Does the pain interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

(10) Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending

## ACCIDENT INFORMATION

Are any of the above conditions due to an accident? ☐ Yes ☐ No (If so) Date_____/_____/_____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Signature_____ Date_____

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# HEALTH HISTORY

**Patient Name** _____ **Date**_____

**What treatment have you already received for your condition?**

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other_____

Name of the doctor(s) who has (have) treated you for your condition: _____

Date of Last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____ Chest X-Ray _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

**Please check "Yes" to indicate if you have had any of the following:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **AIDS/HIV** | ☐ Yes | **Edema** | ☐ Yes | **Hyperglycemia** | ☐ Yes | **Polio** | ☐ Yes |
| **Alcoholism** | ☐ Yes | **Emphysema** | ☐ Yes | **Hypoglycemia** | ☐ Yes | **Prostate Cancer** | ☐ Yes |
| **Allergy Shots** | ☐ Yes | **Epilepsy** | ☐ Yes | **Ischemia** | ☐ Yes | **Prostate Enlargement** | ☐ Yes |
| **Anemia** | ☐ Yes | **Exercise – Arm Pain** | ☐ Yes | **Kidney Disease** | ☐ Yes | **Prosthesis** | ☐ Yes |
| **Appendicitis** | ☐ Yes | **Exercise – Leg Pain** | ☐ Yes | **Kidney Stones** | ☐ Yes | **Psychiatric Care** | ☐ Yes |
| **Arthritis (Osteo)** | ☐ Yes | **Fractures** | ☐ Yes | **Liver Disease** | ☐ Yes | **Rheumatic Fever** | ☐ Yes |
| **Arthritis (Rheumatoid)** | ☐ Yes | **Gall Stones** | ☐ Yes | **Measles** | ☐ Yes | **Shortness Breath** | ☐ Yes |
| **Asthma** | ☐ Yes | **Glaucoma** | ☐ Yes | **Menopause** | ☐ Yes | **Skin Disorders** | ☐ Yes |
| **Auto Immune Disorder** | ☐ Yes | **Goiter** | ☐ Yes | **Migraines** | ☐ Yes | **STD** | ☐ Yes |
| **Bleeding Disorder** | ☐ Yes | **Gout** | ☐ Yes | **Miscarriage** | ☐ Yes | **Stroke** | ☐ Yes |
| **Blood Clot** | ☐ Yes | **Headaches** | ☐ Yes | **Mononucleosis** | ☐ Yes | **Suicide Attempt** | ☐ Yes |
| **Breast Lump** | ☐ Yes | **Heart Disease** | ☐ Yes | **Multiple Sclerosis** | ☐ Yes | **Thyroid Problem** | ☐ Yes |
| **Bronchitis** | ☐ Yes | **Hepatitis** | ☐ Yes | **Mumps** | ☐ Yes | **Tonsillitis** | ☐ Yes |
| **Cancer** | ☐ Yes | **Hernia** | ☐ Yes | **Murmur/Palpitation** | ☐ Yes | **Tuberculosis** | ☐ Yes |
| **Cataracts** | ☐ Yes | **Herniated Disk** | ☐ Yes | **Osteoporosis** | ☐ Yes | **Tumors** | ☐ Yes |
| **Chemical Dependency** | ☐ Yes | **Herpes** | ☐ Yes | **Parkinson's** | ☐ Yes | **Typhoid Fever** | ☐ Yes |
| **Chicken Pox** | ☐ Yes | **High Blood Pressure** | ☐ Yes | **Pinched Nerve** | ☐ Yes | **Ulcer** | ☐ Yes |
| **Eating Disorder** | ☐ Yes | **High Cholesterol** | ☐ Yes | **Pneumonia** | ☐ Yes | **Varicose Veins** | ☐ Yes |
| **Diabetes (please circle) (Type 1, Type 2 )** | ☐ Yes | **History of Extensive Antibiotic Use** | ☐ Yes | **PVD-Peripheral Vascular Disease** | ☐ Yes | **Yeast Infections** | ☐ Yes |
| | | | | | | **Other**_____ | |

Are you pregnant? ☐ Yes ☐ No ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester Due Date?_____

Do you have a pacemaker? ☐ Yes ☐ No

**Previous Injuries/Surgeries (Include Date):**

Falls _____ Head Injuries _____

Surgeries _____ Broken Bones _____

**List any medications** (prescription or non-prescription), vitamins, or supplements you are currently taking. _____

_____

_____

**List any allergies** (including food) of which you are aware. Were you tested for these allergies? ☐ Yes ☐ No

_____

Pharmacy Name_____ Pharmacy # (_____)_____

**Family Medical History** (please include which family member – mother (m), father (f), aunt (a), uncle (u), grandparent (g):

Diabetes _____ Hypoglycemia _____ Food Allergies (please specify) _____ Rheumatoid Arthritis _____ Thyroid _____ Digestive Disorders _____

Heart Disease _____ Hypertension _____ Stroke _____ High Cholesterol _____ Cancer(please specify) _____ Osteoporosis _____ Other _____

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## WELLNESS SURVEY

**PATIENT NAME** _____ **DATE**_____

**EXERCISE:** ☐ None ☐ Moderate ☐ Daily ☐ Heavy **HABITS:**

**WORK ACTIVITY:** ☐ Sitting ☐ Standing ☐ Light ☐ Heavy ☐ Tobacco Use Packs/Day _____

Do you have high stress in your life? ☐ Yes ☐ No ☐ Alcohol Use Drinks/Week _____

Reason_____ ☐ Caffeine Use Cups/ Day _____

***Please complete the following questionnaire. Describe each symptom based upon your experiences over the last 60 days.***

**Symptom Scoring System (please circle the appropriate number below):**

**0 = No Symptoms (zero points)**
**1 = Experience Mild Symptoms (one point)**
**2 = Experience Moderate Symptoms (two points)**
**3 = Severe Symptoms (three points)**

**Head/Ears**

| | |
|---|---|
| 0 1 2 3 | Migraines |
| 0 1 2 3 | Headaches |
| 0 1 2 3 | Earaches |
| 0 1 2 3 | Ear Infection |
| 0 1 2 3 | Ringing in Ears |

**Digestive**

| | |
|---|---|
| 0 1 2 3 | Stomach Pains / Cramping |
| 0 1 2 3 | Constipation / Diarrhea |
| 0 1 2 3 | Reflux / Heartburn |
| 0 1 2 3 | Bloating / Gas |
| 0 1 2 3 | Nausea / Vomiting |
| 0 1 2 3 | GI Upset from Specific Foods |

**Musculo-Skeletal**

| | |
|---|---|
| 0 1 2 3 | Joint Pain |
| 0 1 2 3 | Arthritis |
| 0 1 2 3 | Tendonitis |
| 0 1 2 3 | Muscle Aches |
| 0 1 2 3 | Loss of Height |

**Energy**

| | |
|---|---|
| 0 1 2 3 | Fatigue |
| 0 1 2 3 | Hyperactivity |
| 0 1 2 3 | Lethargy |
| 0 1 2 3 | Restlessness |
| 0 1 2 3 | Difficulty Sleeping |
| 0 1 2 3 | Low strength / Endurance |

**Respiratory/Sinus**

| | |
|---|---|
| 0 1 2 3 | Stuffy or Runny Nose |
| 0 1 2 3 | Chest Congestion |
| 0 1 2 3 | Chronic Cough |
| 0 1 2 3 | Wheezing |
| 0 1 2 3 | Frequent Sneezing |

**Skin Disorders**

| | |
|---|---|
| 0 1 2 3 | Eczema / Psoriasis |
| 0 1 2 3 | Dermatitis |
| 0 1 2 3 | Excessive Sweating |
| 0 1 2 3 | Rashes / Hives |
| 0 1 2 3 | Dry Skin |
| 0 1 2 3 | Acne |

**Eyes/Throat**

| | |
|---|---|
| 0 1 2 3 | Itchy / Dry Eyes |
| 0 1 2 3 | Watery Eyes |
| 0 1 2 3 | Sore Throat |
| 0 1 2 3 | Persistent Canker Sores |

**Cardio-Vascular**

| | |
|---|---|
| 0 1 2 3 | Irregular Heartbeat |
| 0 1 2 3 | Heart Palpitations |
| 0 1 2 3 | Chest Pains |

**Genito-Urinary**

| | |
|---|---|
| 0 1 2 3 | Bladder Irritation / Pain |
| 0 1 2 3 | Frequent UTIs |
| 0 1 2 3 | Yeast Infections |
| 0 1 2 3 | Increase Frequency Urination |
| 0 1 2 3 | Blood in Urine |

**Emotional/Mental**

| | |
|---|---|
| 0 1 2 3 | Depression |
| 0 1 2 3 | Anxiety |
| 0 1 2 3 | Mood Swings |
| 0 1 2 3 | Irritability |
| 0 1 2 3 | Poor Memory |

**Weight**

| | |
|---|---|
| 0 1 2 3 | Inability to Lose Weight |
| 0 1 2 3 | Food Cravings |
| 0 1 2 3 | Binge Eating |
| 0 1 2 3 | Abdominal Fat |

**Other Symptoms**

| | |
|---|---|
| 0 1 2 3 | Thyroid Issues |
| 0 1 2 3 | High Blood Pressure |
| 0 1 2 3 | Blood Sugar Control |
| 0 1 2 3 | Libido Issues |
| 0 1 2 3 | Declined Intimacy |

**Please list any symptoms not mentioned above:** _____

_____

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**FOR OFFICE USE ONLY**

| | | | | |
|---|---|---|---|---|
| ☐ Musculo-Skeletal | ☐ GI Effects | ☐ Fatigue Panel | ☐ Male Hormone Panel | ☐ Weight Loss ☐ hCG |
| ☐ ALCAT | ☐ Cyrex Array3/Array4 | ☐ Thyroid Panel | ☐ Other _____ | Weight _____ |
| ☐ ASI | ☐ Genetic Celiac Panel | ☐ Female Hormone Panel | ☐ Other _____ | Body Fat % _____ |

**Comments:**_____

_____

_____

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# CONSENT & AUTHORIZATIONS

**Consent to Obtain Medical Records:**
I hereby authorize Optimum Health to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

**Consent to Release Medical Information and/or Records:**
I hereby authorize Optimum Health to release my medical records to other physicians or medical facilities necessary in the course of my treatment. I now hold harmless other physicians or medical facilities from any and all claims resulting from this release.

**Pregnancy Disclaimer (for females only):**
X-Rays are *not* performed on patients during pregnancy due to the health risks to the unborn fetus. Also, massage therapy is not recommended during the first trimester due to potential risk for miscarriage. I certify that I have been informed of these risks.

**Authorizations:**
I give permission to Optimum Health to use my address, email address, and phone numbers to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives, newsletters, discounts/specials, testimonials, or other health related information.

**Nutrition Disclaimer:**
I understand that the Optimum Health nutritional program or supplement suggestions made to me by the wellness coach are for educational purposes only. Supplements are not intended to diagnose, treat, cure, or prevent any disease, and have not been evaluated by the FDA.

**Consent for Treatment:**
I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment in this office. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. In the case of an un-emancipated minor, the consent below is being given on his/her behalf.

**Acknowledgment of Privacy Rights:**
I acknowledge that Optimum Health has made available to me the *Notice of Privacy Practices and Individual Rights*. I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging that I have been informed of my rights to privacy.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name (printed) | Patient Signature | Date |
| _____ | _____ | _____ |
| Parent/Guardian Name (printed) | Parent/Guardian Signature | Date |
| _____ | _____ | _____ |
| Witness Name (printed) | Witness Signature | Date |