Submit by Email

New Patient Health History

Patient Information

Patient Name:_____
Last Name First Name MI

Date of Birth:_____/_____/_____ Sex: ❑ M ❑ F SSN:_____

Weight: _____ lbs Height: _____ ft _____ inches Marital Status: ❑ Single ❑ Married ❑ Other

Work Status: ❑ Employed ❑ Student ❑ Other Professional Title: _____

Address: _____

_____
City State Zip Code

Home: (_____) _____ Work: (_____) _____ Mobile: (_____) _____

Preferred Phone: ❑ Home ❑ Work ❑ Mobile Email:_____

EMPLOYMENT INFORMATION:

Employer Name: _____ Employer Phone: (_____) _____

Employer Address: _____

_____
City State Zip Code

EMERGENCY CONTACT:

Contact Name: _____ Relationship to Patient: _____

Home: (_____) _____ Mobile: (_____) _____

Whom may we thank for referring you?_____

Would you like to receive our email newsletter? ❑ Y ❑ N Best method to send appointment reminders:
❑ Text Message ❑ E-Mail ❑ Phone ❑ Don't Need Reminder

ACCIDENT INFORMATION:

Is condition due to an accident? ❑ Y ❑ N Date:_____ Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other_____

To whom have you made a report of your accident? ❑ Auto Insurance ❑ Employer ❑ Worker Comp ❑ Other_____

HEALTH INSURANCE INFORMATION:

Insurance Co: _____ Group #: _____ ID#: _____

Who is responsible for this account? ❑ Self ❑ Other If other, name of person responsible: _____

Is patient covered by additional insurance? ❑ Y ❑ N
Insurance Co: _____ Group #: _____ ID#: _____

Assignment and Release Statement
I certify that if I, and/or my dependent(s), have insurance coverage, I shall assign to Optimized Health and/or its affiliates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also understand that sending in my insurance claim is a courtesy and not a requirement. Optimized Health and its affiliates/agents may use my health care information and may disclose such information to the health care insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient Condition

Please identify the health concerns that have brought you here in order of importance below:

Condition(s)	Past Treatment

Date of last Physical Exam: _____ General Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Which of the following are you interested in hearing more about (check all that applies):

❑ Acupuncture ❑ Acupressure, Tui-Na ❑ Herbal Medicine ❑ Cosmetic Acupuncture ❑ Weight Loss
❑ Chiropractic ❑ Physiotherapy/Rehab ❑ Kinesiotaping ❑ Nutritional Analysis

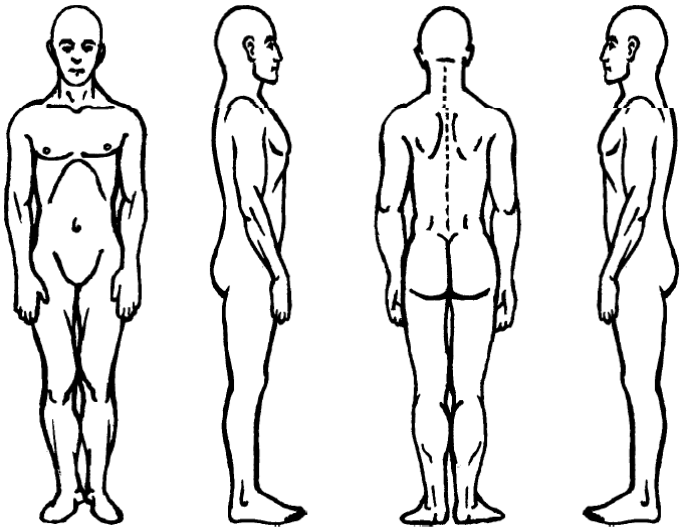
When did your symptom(s) appear? _____

Is the condition getting: ❑ better ❑ worse ❑ stayed the same ❑ don't know

Has this occurred before? ❑ Yes ❑ No If yes, when? _____

Sensations Types (Please mark appropriate symbols on the diagrams)

Symbol	Sensation
XXX	Sharp, Stabbing, Burning
>>>	Shooting, Radiating
NNN	Numbness, Tingling
OOO	Edema, Swelling
AAA	Dull/Achy
TTT	Throbbing
	Other _____



What percentage of the time do you experience this problem? <25% 25% 50% 75% 100%

What relieves the pain? (heat, cold, massage, rest, exercise, other) _____

What makes the pain worse? (weather, heat, cold, movement, other) _____

Activities or movements that are painful to perform: ❑ lying down ❑ sitting ❑ standing ❑ walking ❑ bending ❑ other

Rate your complaint today on a scale of 0 to 10 (0=no pain; 10=worst pain): _____

Does it interfere with your: ❑ work ❑ sleep ❑ daily routine ❑ recreation ❑ Other_____

Health History

ALLERGIES - Please list any foods, drugs, or medications you are hypersensitive or allergic to (include reaction):

_____

_____

MEDICATION- Please list any medications, vitamins, and supplements you are currently taking:

_____

_____

_____

FAMILY HISTORY - Does your family have any conditions like cancer, diabetes, heart diseases, high blood pressure or cholesterol, stroke, mental illness, asthma, arthritis, kidney or liver disorders, or any other conditions that effect them?

Family member	Present or past health conditions
Mother	_____
Father	_____
Siblings	_____
Grandparents	_____

Explain if you have (or had) any of the following:

AID/HIV_____
Allergy shots_____
Anemia_____
Appendicitis_____
Arthritis_____
Asthma_____
Bleeding disorders_____
Breast lump_____
Bronchitis_____
Cancer_____
Chemical dependency_____
Diabetes_____
Emphysema_____
Epilepsy_____
Fractures_____
Glaucoma_____
Goiter_____
Gout_____
Heart disease_____
Hepatitis_____
Hernia_____
Herniated disc_____
High cholesterol_____
Infertility_____
Kidney disease_____
Liver disease_____
Menstrual problems_____
Mental disorders_____
Migraine/Headaches_____
Miscarriage_____
Osteoporosis_____
Pacemaker_____
Parkinson's disease_____
Pinched nerve_____
Prostate problems_____
Prosthesis_____
Rheumatoid arthritis_____
Stroke_____
Sexual dysfunction_____
Thyroid problems_____
Tuberculosis_____
Tumors, Growths_____
Ulcers_____
Vaginal infections_____
Others_____

Do you have any infectious diseases? ❑ Yes ❑ No If yes, please identify: _____

PREVIOUS INJURIES, SURGERIES, HOPITALIZATIONS – Please describe below (if any):

	Description	Date
Accidents/Falls	_____	_____
Head Injuries	_____	_____
Fractures	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Hospitalizations	_____	_____

LIFESTYLE

How many meals per day do you eat? _____ Do you snack often? ❑ Yes ❑ No

How many hours per night do you sleep? _____ Do you wake rested? ❑ Yes ❑ No

Exercise (explain)
❑ None
❑ Moderate _____
❑ Daily _____
❑ Heavy _____

Work Activity (explain)
❑ Sitting _____
❑ Standing_____
❑ Light Labor_____
❑ Heavy Labor _____

Habits (explain)
❑ Smoking Packs/day_____
❑ Alcohol Drinks/week_____
❑ Soft drinks Cans/day_____
❑ Coffee Cups/day_____
❑ Tea Cups/day_____
❑ Water Cups/day_____
❑ Stress level Rate(0-10)_____

Symptoms

GENERAL

	severe	mild	none
Allergy	❑	❑	❑
Chills/Fever	❑	❑	❑
Cold hands or feet	❑	❑	❑
Convulsions/Epilepsy	❑	❑	❑
Dizziness	❑	❑	❑
Fainting	❑	❑	❑
Fever	❑	❑	❑
Headache	❑	❑	❑
Loss of sleep	❑	❑	❑
Loss of weight	❑	❑	❑
Nervousness	❑	❑	❑
Shooting pain	❑	❑	❑
Numbness/Tingling	❑	❑	❑
Unclear thinking	❑	❑	❑

Others _____

GASTROINTESTINAL

	severe	mild	none
Acid reflux	❑	❑	❑
Belching or gas	❑	❑	❑
Colitis	❑	❑	❑
Colon trouble	❑	❑	❑
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
Difficult digestion	❑	❑	❑
Abdomen distention	❑	❑	❑
Excessive hunger	❑	❑	❑
Gall bladder trouble	❑	❑	❑
Hemorrhoids	❑	❑	❑
Worms/Parasites	❑	❑	❑
Liver trouble	❑	❑	❑
Stomach pain	❑	❑	❑
Poor appetite	❑	❑	❑
Vomiting	❑	❑	❑

Others _____

RESPIRATORY

	severe	mild	none
Chronic cough	❑	❑	❑
Difficult breathing	❑	❑	❑
Shortness of Breath	❑	❑	❑
Spitting up Blood	❑	❑	❑
Wheezing/Phlegm	❑	❑	❑

SKIN

	severe	mild	none
Boils	❑	❑	❑
Bruises easily	❑	❑	❑
Dryness	❑	❑	❑
Eczema/Psoriasis	❑	❑	❑
Hives	❑	❑	❑
Itching	❑	❑	❑
Sensitive skin	❑	❑	❑
Varicose veins	❑	❑	❑

Others _____

MUSCLES & JOINTS

	severe	mild	none
Back pain/Sciatica	❑	❑	❑
Elbow/Shoulder	❑	❑	❑
Knee/Foot	❑	❑	❑
Hernia	❑	❑	❑
Painful tailbone	❑	❑	❑
Spinal curvature	❑	❑	❑
Neck pain/Stiffness	❑	❑	❑
Tremors	❑	❑	❑
Swollen joints	❑	❑	❑

Others _____

CARDIOVASCULAR

	severe	mild	none
Atherosclerosis	❑	❑	❑
Blood pressure	❑	❑	❑
Pain over heart	❑	❑	❑
Poor circulation	❑	❑	❑
Irregular heart beat	❑	❑	❑
Stroke	❑	❑	❑
Ankle swelling	❑	❑	❑

Others _____

E.E.N.T.

	severe	mild	none
Asthma	❑	❑	❑
Deafness	❑	❑	❑
Dental decay	❑	❑	❑
Ear/Eye trouble	❑	❑	❑
Enlarged glands	❑	❑	❑
Enlarged thyroid	❑	❑	❑
Failing vision	❑	❑	❑
Far sightedness	❑	❑	❑
Near sightedness	❑	❑	❑
Frequent colds	❑	❑	❑
Sore throat	❑	❑	❑
Hay fever	❑	❑	❑
Hoarseness	❑	❑	❑
Gum trouble	❑	❑	❑
Nose bleeds	❑	❑	❑
Sinus infection	❑	❑	❑

Others _____

GENITOURINARY

	severe	mild	none
Bed wetting	❑	❑	❑
Blood in urine	❑	❑	❑
Frequent urination	❑	❑	❑
Can't control urine	❑	❑	❑
Kidney infection/stones	❑	❑	❑
Painful urination	❑	❑	❑
Prostate problems	❑	❑	❑
Pus in urine	❑	❑	❑
Urinary tract infections	❑	❑	❑

Others _____

MEN ONLY

Burning with urination ❑ Y ❑ N
Difficulty starting urine ❑ Y ❑ N
Dribbling after urination ❑ Y ❑ N
Prostate trouble ❑ Y ❑ N
Get up at night to urinate ❑ Y ❑ N
How many times/night:_____
Feeing incomplete bowel evacuation ❑ Y ❑ N
Others _____

WOMEN ONLY (Are you pregnant? ❑ No ❑ Yes Due Date:)

Irregular periods ❑ Y ❑ N
Hot flashes ❑ Y ❑ N
Vaginal discharge ❑ Y ❑ N
Hysterectomy ❑ Y ❑ N
Headaches with period ❑ Y ❑ N
Menstrual cramps ❑ Y ❑ N
Excessive flow ❑ Y ❑ N
Menopausal symptoms ❑ Y ❑ N
Premenstrual depression ❑ Y ❑ N
Painful breasts ❑ Y ❑ N
Lumps in breasts ❑ Y ❑ N

Last menstrual date:_____ Amount of days:_____ Amount of flow: ❑ Scanty ❑ Moderate ❑ Heavy
Sticky? ❑ Y ❑ N Clots? ❑ Y ❑ N Pain? ❑ Y ❑ N Color of menses: ❑ Pink/Light Red ❑ Bright Red ❑ Brown/Dark Red

Please use the following lines to further explain any of the above conditions: _____

_____

Informed Consent Statement

I hereby authorize the staff of Optimized Health and its affiliates to conduct examinations, chiropractic adjustments, and other procedures necessary, including but not limited to various modalities of physiotherapy, soft-tissue techniques on me or on the patient for whom I am legally responsible.

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the staff of Optimized Health and its affiliates to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner and/or his staff to exercise judgment during the course of the procedures which he feels at the time, based on the fact then known, are in my best interests. I have had an opportunity to discuss with the doctor of chiropractic and/or acupuncturist and/or with other office or clinic personnel the nature and purpose of chiropractic related procedures. I understand that results are not guaranteed.

Patient's Bill of Rights Statement

Patient has the right to: a considerate and respectful care and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis; the opportunity to discuss & request information related to specific procedures and/or treatments, risks involved, possible length of recuperation, and medically reasonable alternatives and their accompanying risks and benefits; know identity of providers, and others involved in his or her care, as well as when those involved are students, residents, or other trainees. Also financial implications of treatment choices, insofar as they are known; make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care. The patient also has the right to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services; privacy (discussion, consultation, examination, & treatment should be conducted to protect each patient's privacy); expect that all communications and records pertaining to his/her care will be treated confidentially, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the provider will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records; review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law; expect that, within its capacity & policies, a provider will make reasonable response to patient's request for appropriate/medically indicated care & services. Provider must provide evaluation, service, and/or referral as needed ask and be informed of the existence of business relationships among the provider, other health care providers, or payers that may influence the patient's treatment and care; consent to or decline to participate in proposed research studies or human experimentation affecting care & treatment or requiring direct patient involvement, and to have those studies fully explained prior to consent. A patient who declines to participate in research or experimentation is entitled to effective care that provider can otherwise provide; expect reasonable continuity of care when appropriate and to be informed by providers and other caregivers of available and realistic patient care options when the current course of care is no longer appropriate; and be informed of providers' policies & practices that relate to patient care, treatment, and responsibilities. Patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. Patient has the right to be informed of the provider's charges for services and available payment methods.

Collaborative nature of healthcare requires that patients/their families/surrogates, participate in their care. Effectiveness of care & patient satisfaction with the course of treatment depend, in part, on the patient fulfilling certain responsibilities. Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision making, patients must be encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand information & instructions. Patients are responsible for informing their providers and other caregivers if they anticipate problems in following prescribed treatment. Patients should also be aware of the provider has to be reasonably efficient and equitable in providing care to other patients and the community. Patients and their families are responsible for making reasonable accommodations to the needs of the provider, other patients, staff, and employees. Patients are responsible for providing necessary information for insurance claims, when necessary. A person's health depends on more than healthcare service. Patients are responsible for recognizing impact of their life-style on their personal health.

I certify that information on these forms has been answered truthfully and completely to the best of my knowledge. I certify to the health insurance Assignment and Release statement. I certify to the Informed Consent and Patient Bill of Rights statements.

Patient/Guardian Signature _____ Date _____