OPTIMUM HEALTH CHIROPRACTIC

Electronic Health Records Intake Form

Name: _____ Sex : □ M □ F D.O.B. ____/____/____

Phone Number: _____ Height: _____ Weight: _____

Mailing Address: _____ City: _____ ST: _____ Zip:_____

Preferred Language: _____ Race: _____ Ethnicity: _____

Social Security # _____/_____/_____ Driver's License # _____

Status: □ Single □ Married □ Divorced □ Widowed **Smoking Status:** □ Presently □ Past □ Never

How did you hear about us:_____

E-Mail Address: _____@_____

Employer: _____ Occupation: _____

Work Phone: _____ May we contact you at work? □ YES □ NO

Emergency Contact: _____ Phone Number: _____

Name of Insurance 1. _____ 2. _____

Insured's Name _____ Insured's D.O.B. ____/____/____

Patient Relationship to Insured: Self ____ Spouse ____ Dependent ____ Other ____

*__Female Patients:__ To your knowledge, are you pregnant at this time? **Yes or No**

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease				

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

Primary Care Physician: _____ Phone Number: _____

OPTIMUM HEALTH CHIROPRACTIC

Patient Name: _____ D.O.B. ____/____/____

Briefly describe your chief complaint (symptoms): _____

Start Date? _____ Is this your first episode of pain in this area? Y N

Any falls, accidents, or injuries? If yes, please list: _____

Have you received treatment for your symptom(s): _____

What makes the symptoms better? _____ Worse?_____

Please list any surgeries: _____

Please indicate the average intensity of your symptoms 1 (Mild) to 10 (Unbearable):

_____Neck ____ Middle Back _____Lower Back _____Headaches _____Arm & Hand

_____Legs ____ Shoulders _____Ribs _____ Hip Joints _____ Feet

Please circle any current symptoms and past problems:

Arthritis

Painful Joints/ Swollen Joints

Rheumatic Fever

Headaches/ Shooting Head Pains

Lights Bother Eyes

Twitching of Face

Strokes

Loss of Balance/ Dizziness

Cold Sweats

Fatigue/ Sleeping Problems

Stress/Nerves

Loss of Memory/Ringing in Ears

Loss of Taste

Sinus Trouble/ Allergies

Neck Pain/ Grating in Neck

Tight Shoulders

Thyroid Trouble

Chest Pains/ Heart Problems

High or Low Blood Pressure

Anemia

Shortness of Breath/ Asthma

Tuberculosis (TB)

Pins & Needles in Arms/Hands

Cold Hands/ Cold Feet

Gall Bladder

Mid Back Pain/ Low Back Pain

Liver Trouble

Kidney and/or Bladder Trouble

Constipation/Diarrhea

Pinched Nerves in Back

Disc Problems

Sexual Dysfunction

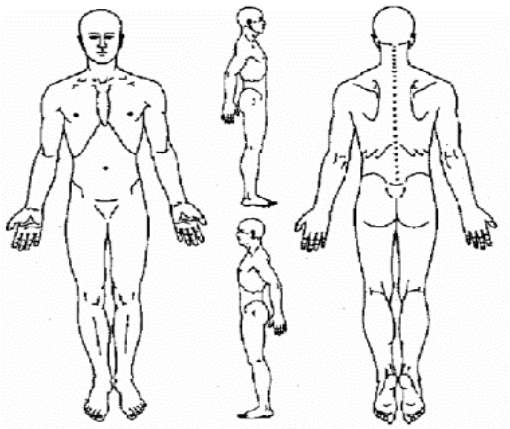
Pains in Feet and/or legs

Cancer

Stomach Trouble/ Indigestion

Diabetes

Please indicate the location of your chief complaint by circling below:



OPTIMUM HEALTH CHIROPRACTIC

Who is responsible for your bill?
You and: Personal Insurance Medicare Workers Comp Auto

In order to receive the best care possible within your benefits, it is important that you comply with our financial policy:

1. Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment.
***It is illegal to waive these fees.**
2. Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office.

- I understand that I am responsible for my bill.
- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize direct payment to my doctor.
- I authorize the release of information to the following individuals (Ex: Spouse, Children, other Family Members):

* _____ * _____ * _____ * _____

"I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all payments for services rendered to me or my dependents."

Optimum Health Chiropractic
HMO/PPO Limitation of Liability

Your insurance plan may have limitation for services covered in our office. According to your specific plan, the following services may not be covered:

- **Examinations, Re-examinations, Diagnostic Tests, Massage Therapy, Vitamins, Supplements, or Supports, and Modalities (Such as EMS, Ultrasound, Hot/Cold Packs).**

Should any of these determinations be made by your plan, you agree that you have been informed before the services were rendered and you agree to be responsible for payment of the specific services listed above.

Consent to Treat and Notice of Privacy Practices

My signature stands as proof that I give Optimum Health Chiropractic my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice (If you would like to obtain a copy of this notice, please feel free to ask the front desk).

Clinical Summary

I agree to waive my clinical summary after each visit, as these summaries are often repetitive as a nature and frequency of chiropractic care (If you would like to obtain a clinical summary, please feel free to ask the front desk).

Xrays

I understand that any Xrays taken will remain property of Optimum Health Chiropractic, and I will have the ability to check them out on loan if necessary.

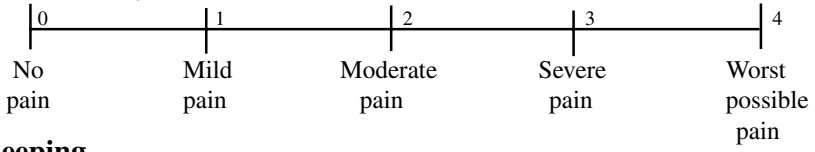
Patient Name (Printed) _____ DOB ___ / ___ / ___
X Patient/ Guardian Signature _____ Date ___ / ___ / ___
X Authorized Representative Signature _____ Date ___ / ___ / ___

Functional Rating Index

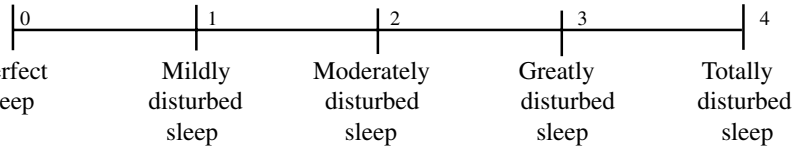
For use with **Neck and/or Back Problems** only.

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

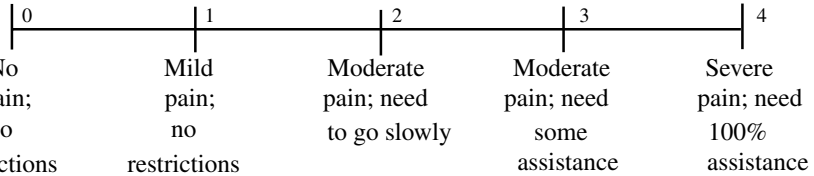
1. Pain Intensity



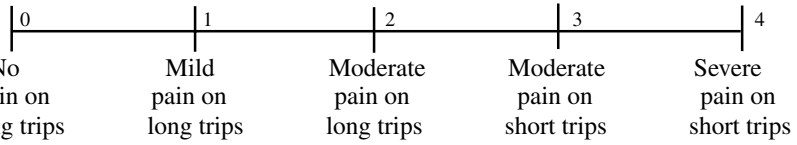
2. Sleeping



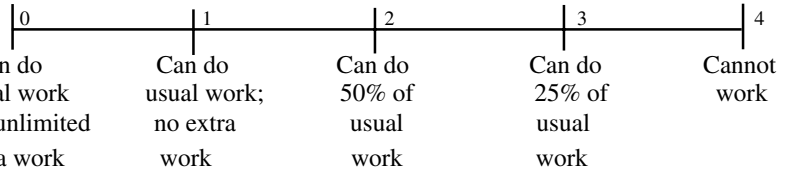
3. Personal Care (washing, dressing, etc.)



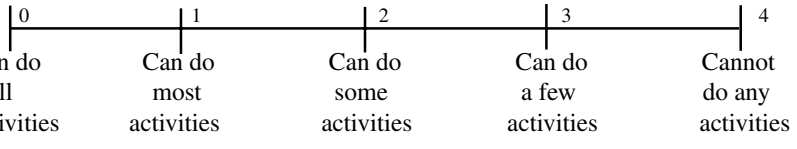
4. Travel (driving, etc.)



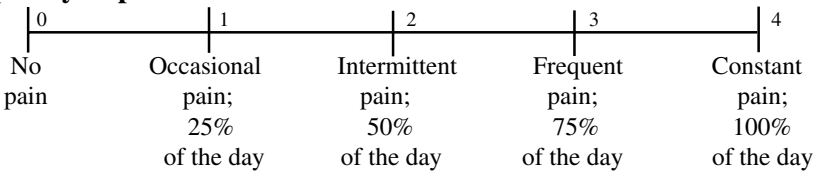
5. Work



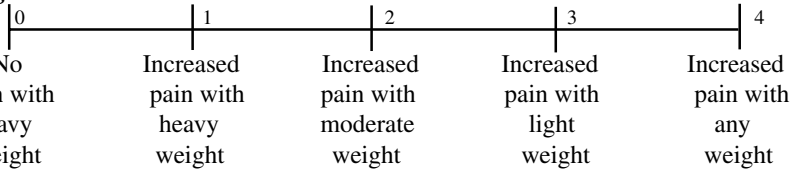
6. Recreation



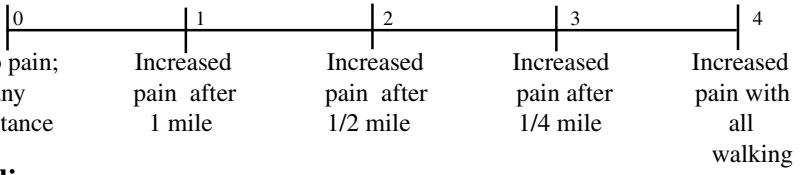
7. Frequency of pain



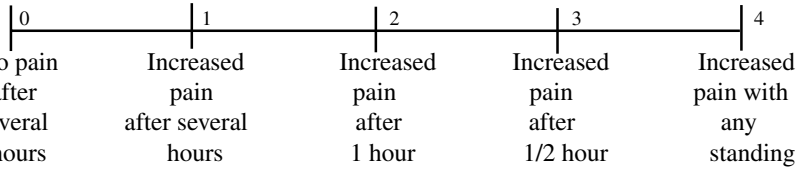
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date