Optimized Wellness Center

PRACTICE MEMBER'S APPLICATION

WELCOME TO OUR WELLNESS CENTER

We specialize in assisting our practice members to achieve their highest level of health so that they can be their best self. We provide our practice members with a comprehensive consultation, evaluation, and assessment of their health. Armed with this information, we will devise a treatment plan to remove obstacles that may be impeding your full expression of health. Our treatment modalities may include:

- spinal and postural corrective programs
- natural weight loss plans
- nutritional programs
- B-vitamin and nutrient injections
- functional medicine
- detoxification programs
- pain management
- postural neurology
- brain balancing
- body contouring

The questionnaire below is one component of our approach, which may include topics that you have never covered with other healthcare providers. These questions will help us identify underlying causes of health challenges and formulate a tailored and personalized treatment plan. Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these questions. Health issues are usually influenced by many factors. Accurately evaluating and assessing all the factors and comprehensively managing them is the best way to achieve lasting resolution with superior results.

Please allow enough time to fill out the following information to the best of your ability and submit prior to your appointment so that your doctor can make the best use of your time while caring for you at your appointment. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____
Practice Member's Signature

_____
Practice Member's Name (print)

_____
Today's Date File #

Outlined Procedure for New Practice Members

Step One: All new practice members are requested to fill out *& submit* this application prior to your appointment.
Step Two: Consultation with a provider to discuss your health history, concerns and goals.
Step Three: Combination of objective and subjective diagnostic, orthopedic, and neurological examination procedures to determine if, and what kind of care is appropriate for your condition.
Step Four: Advised if there is the need for any additional procedures (x-rays, MRI, blood work, etc.) and/or if your case requires immediate attention.
Step Five: Schedule your Doctor's Report of Findings at which time the doctor will inform you of the results and findings from your consultation, examination, and assessment.
Step Six: Your custom tailored treatment plan will be reviewed with you immediately following your Doctor's Report of Findings.
Step Seven: Begin with care & feeling your best

PRACTICE MEMBER'S INFORMATION

Name: _____ Gender: ☐ M ☐ F Date _____/_____/_____

Home Address: _____ Home Phone:( )_____

City, State, Zip: _____ Work Phone:( )_____

Email Address: _____ Cell Phone:( )_____

I consent to these additional means of communication ☐Text ☐Email May we keep you informed with newsletters & promotions? ☐ Yes ☐ No

Birth Date: _____ / _____ / _____ (Age)_____ Social Security #: _____ - _____ - _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone:( )_____ Cell Phone:( )_____

Spouse's Occupation: _____ Employer Name: _____

Name(s) of Children: _____ Age(s):_____

EMERGENCY CONTACT

Name: _____ Relationship_____

Home Phone:( )_____ Cell Phone:( )_____

Physician's name:_____ Phone #(_____)_____

HOW DID YOU HEAR ABOUT Optimized Wellness Center

Referred by someone ☐ Whom can we thank? _____ How are you related to them? _____

Found in a professional directory ☐ Which directory? _____

Saw a print advertisement ☐ Where was the ad you saw? _____

Saw an online advertisement ☐ What site were you on? _____

Education series ☐ What topic, location and date? _____

Community event ☐ Which one? _____

PRACTICE MEMBER'S BACKGROUND & GOALS

So that we can cater our care to your specific needs, please share your **top three (3) health concerns** in order of importance.
On the following pages, you can describe these in greater detail.

1) _____

2) _____

3) _____

How long do you think it took to get like this?_____

What other modalities have your tried to address the above health concerns: ☐ Rest ☐ Prayer ☐ Stretching ☐ Exercise ☐ Hot/Cold ☐ Water therapy ☐ Primary care doctor ☐ Specialist doctor ☐ Ayurveda ☐ Nutritionist ☐ Online resource (e.g. WebMD) ☐ Hypnotherapy ☐ Psychotherapy ☐ Meditation ☐ Homeopathy ☐ Aromatherapy ☐ Osteopathic medicine ☐ Acupuncture/Acupressure ☐ Feldenkrais ☐ Lymphatic therapy ☐ Physical/physio-therapy ☐ Massage ☐ Qi Gong ☐ Tai Chi ☐ Art/Color therapy ☐ Yoga ☐ Biofeedback ☐ Magnetic therapy ☐ Reiki ☐ Chinese medicine ☐ Electrotherapy ☐ Kinesiology ☐ Reflexology ☐ Other(s) _____

Are you currently receiving health care? ☐ No ☐ Yes, Please provide relevant *provider's contact information* so we can collaborate for your health.

Name: _____ Phone # _____ Date of last visit _____

Reason/outcome _____

Name: _____ Phone # _____ Date of last visit _____

Reason/outcome _____

Name: _____ Phone # _____ Date of last visit _____

Reason/outcome _____

Have you visited a Chiropractor or Functional Medicine Practitioner before? ☐ No ☐ Yes

Name: _____ Phone # _____ Date of last visit _____

Reason/outcome _____

If you have had any of the following done in the past or present, please let us know. *If available, please bring to your initial visit* so we may review.

X-Rays ☐ No ☐ Yes Date_____CT-scans ☐ No ☐ Yes Date_____

MRIs ☐ Yes ☐ No Date_____Mammogram ☐ No ☐ Yes Date_____

Electroencephalogram (EEG) ☐ No ☐ Yes Date_____ Ultrasound ☐ No ☐ Yes Date_____

Electrocardiogram (EKG) ☐ No ☐ Yes Date_____ Bone Density Scan (DEXA) ☐ No ☐ Yes Date_____

ALLERGIES/SENSITIVITIES

Are you aware of having any reactions to the following? ☐ No ☐ Yes Please describe.

Drugs: _____

Foods: _____

Chemicals/perfumes: _____

Animals: _____

Other: _____

GOALS

What are your **top three (3) short term & long term health goals** in order of importance? These are different than your concerns. The goals are where you would like to be health-wise, rather than the concerns that you would like to address.

1) _____

2) _____

3) _____

What do you think is keeping you from experiencing your full expression of health and being your best self? _____

If you did nothing, what do you think would happen?_____

How would your life be different/better with full expression of your health? _____

_____

How can we help you achieve your health goals?_____

Why are you seeking treatment now versus last week, month, year? What has changed?

People seek care for a variety of reasons. Some simply want relief from discomfort or pain, others to correct the cause of the pain / discomfort, some want to look better, and others wish to correct whatever is malfunctioning in their body. Our practioners will weigh your needs and desires when recommending your care program. Please check the type of care desired: ☐ **Chiropractic Care** ☐ **Functional Medicine** ☐ **Natural Weight Loss** ☐ **Detoxification** ☐ **Nutrition** ☐ **Pain Relief** ☐ **Body Contouring** ☐ **Comprehensive Wellness**

Please rate your level of:	Happiness	Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent
	Nutrition	Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent
	Exercise	Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent
	Rest	Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent
	Stress	High ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Low
	Overall Health	Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent
	Family's Health	Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent
How satisfied are you with your current state of health?		Not ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely
How committed are you to changing your situation?		Not ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Totally

How many hours of uninterrupted sleep do you get a night? ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9-10 Do you wake feeling rested? ☐ No ☐ Yes

Do you take medication to assist sleeping at night? ☐ No ☐ Yes Do you take naps during the day? ☐ No ☐ Yes

Do you predominantly sleep on your ☐Back ☐Stomach (with head to ☐left or ☐right) ☐Side (☐left or ☐right)

Are you satisfied with your weight? ☐ No ☐ Yes If not, do you wish to ☐ lose or ☐ gain weight? How much?_____

How many sick care visits to the medical doctor did you make last year? ☐ 0 ☐ 1-2 ☐ 3-4+ For what?_____

How do you deal with stress? _____

Did you know posture influences your health? ☐ No ☐ Yes Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine causing stress to the spinal cord and the delicate nerves that pass between the vertebrae.

Are you aware of any of your poor posture habits? ☐ No ☐ Yes Explain: _____

Are you aware of any poor posture habits in your spouse or children? ☐ No ☐ Yes Explain: _____

Please provide more information regarding your Top 3 Health Concerns

(*as you listed on Page 2*) Even if your complaints are not physical in nature, please describe below.

1) Regarding 1st Health Concern (Main Complaint):_____ When did this condition begin?_____/___/_____

Is this related to an auto accident / work injury? ☐ No ☐ If Yes, contact front desk.

What do you think caused this concern?_____

How long do you think it will take to resolve? ☐ Weeks ☐ Months ☐ Years

Did it begin: ☐ Gradually ☐ Suddenly ☐ Progressed over time

What makes it **worse**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting

☐ Exercise (Moving) ☐ Lying Down ☐ Other_____

What makes it **better**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting

☐ Exercise (Moving) ☐ Lying Down ☐ Other_____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Spasm ☐ Numb

☐ Tingling ☐ Shooting Is the pain on one side (☐ L / ☐ R) or ☐ both?

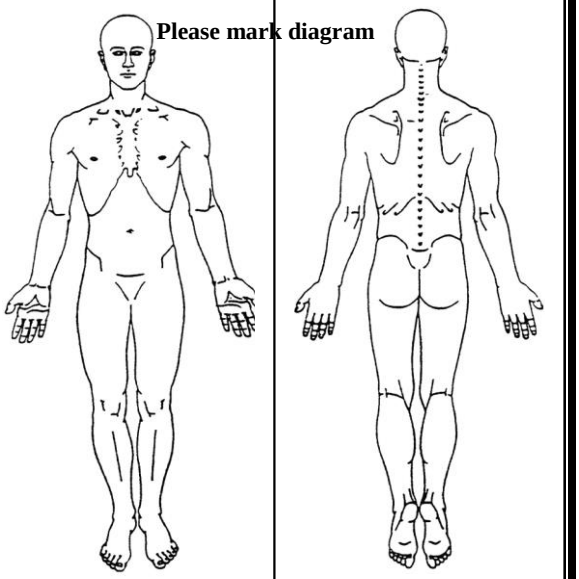
Does the Pain Radiate to your: ☐ Arm ☐ Leg ☐ Does not radiate

Is this condition getting: ☐ Better or ☐ Worse ☐ Staying the same

Now your discomfort/pain: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Normally its: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Please mark diagram



How often do you experience these symptoms throughout the day?

☐ 100% Constant ☐ 75% Frequent ☐ 50% Often ☐ 25% Seldom ☐ 10% Rare or ☐ Only with Activity ☐ At Night ☐ In the Morning

Does your complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Explain: _____

Have you experienced this condition before? ☐ No ☐ Yes If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Notes: _____

2) Regarding 2nd Health Concern:_____ When did this condition begin?__/____/_____

Is this related to an auto accident / work injury? ☐ No ☐ If Yes, contact front desk.

What do you think caused this concern?_____

How long do you think it will take to resolve? ☐ Weeks ☐ Months ☐ Years

Did it begin: ☐ Gradually ☐ Suddenly ☐ Progressed over time

What makes it **worse**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting

☐ Exercise (Moving) ☐ Lying Down ☐ Other_____

What makes it **better**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting

☐ Exercise (Moving) ☐ Lying Down ☐ Other_____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Spasm ☐ Numb

☐ Tingling ☐ Shooting Is the pain on one side (☐ R / ☐ L) or ☐ both?

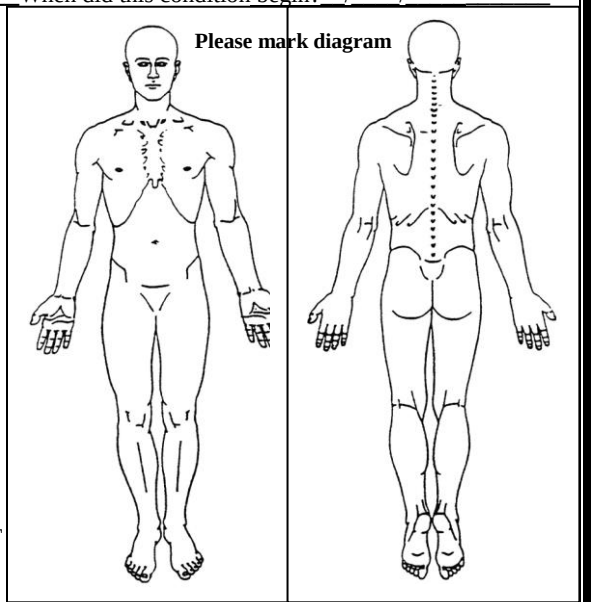
Does the Pain Radiate to your: ☐ Arm ☐ Leg ☐ Does not radiate

Is this condition getting: ☐ Better or ☐ Worse ☐ Staying the same

Now your discomfort/pain: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Normally its: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Please mark diagram



How often do you experience these symptoms throughout the day?

☐ 100% Constant ☐ 75% Frequent ☐ 50% Often ☐ 25% Seldom ☐ 10% Rare or ☐ Only with Activity ☐ At Night ☐ In the Morning

Does your complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Please explain: _____

Have you experienced this condition before? ☐ No ☐ Yes Please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Notes: _____

3) Regarding 3rd Health Concern:_____ When did this condition begin? ____/___/_____

Is this related to an auto accident / work injury? ☐ No ☐ If Yes, contact front desk.

What do you think caused this concern?_____

How long do you think it will take to resolve? ☐ Weeks ☐ Months ☐ Years

Did it begin: ☐ Gradually ☐ Suddenly ☐ Progressed over time

What makes it **worse**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting

☐ Exercise (Moving) ☐ Lying Down ☐ Other_____

What makes it **better**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting

☐ Exercise (Moving) ☐ Lying Down ☐ Other_____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Spasm ☐ Numb

☐ Tingling ☐ Shooting Is the pain on one side (☐ R / ☐ L) or ☐ both?

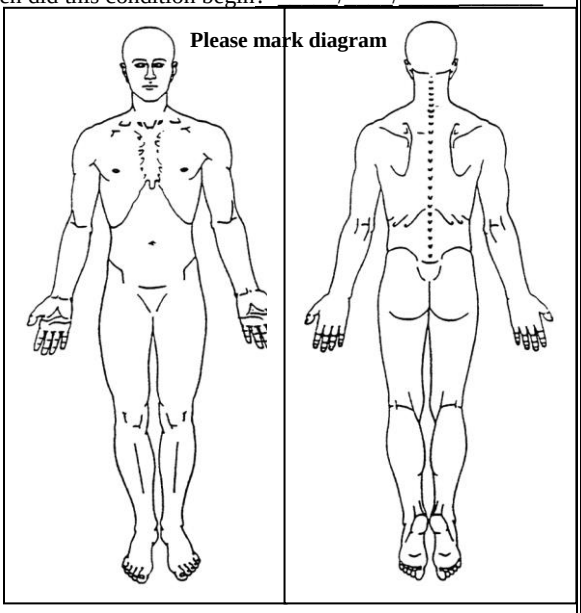
Does the Pain Radiate to your: ☐ Arm ☐ Leg ☐ Does not radiate

Is this condition getting: ☐ Better or ☐ Worse ☐ Staying the same

Now your discomfort/pain: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Normally its: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Please mark diagram



How often do you experience these symptoms throughout the day?

☐ 100% Constant ☐ 75% Frequent ☐ 50% Often ☐ 25% Seldom ☐ 10% Rare or ☐ Only with Activity ☐ At Night ☐ In the Morning

Does your complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Please explain: _____

Have you experienced this condition before? ☐ No ☐ Yes Please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Notes: _____

ACTIVITIES OF DAILY LIVING

Please identify how your current health concern(s) is affecting your ability to carry out your routine activities:

Activity	No Effect	Painful (can do activity)	Painful (limits activity)	Unable to Perform
Lifting Groceries				
Carrying Groceries				
Sit to Stand				
Climbing Stairs				
Pet Care				
Driving				
Extended Computer Use				
Household Chores				
Lifting Children				
Concentration (reading)				
Bathing				
Dressing				
Shaving				
Sexual Activity				
Sleep				
Static Sitting				
Yard Work				
Walking				
Washing/Bathing				
Sweep/Vacuuming				
Dishes				
Laundry				
Garbage				
Other				

What hobbies / interests do you have? _____

_____

What clubs / organizations do you belong to? _____

LIFESTYLE

Do you exercise? ☐ No ☐ Yes, How often/week? ☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X other: _____

What activities? ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ other _____

List any other activities you engage in regularly to promote health: _____

How many hours/day do you *sit* at home, work *and* school? ☐3-4 ☐5-6 ☐7-8 ☐9+ Do you get up every hour? ☐ No ☐ Yes

Do you smoke? ☐ Never ☐ Past ☐ Currently, How much? _____ Do you use any recreational drugs & how often?_____

Do you drink alcohol? ☐No ☐ Yes, How many/day?___ Please circle if you drink: coffee, soda, energy drinks, none? How many cups /day?____

How many 8oz glasses of water do you drink daily? ☐1-2 ☐3-4 ☐5-6 ☐7-8 ☐9+ How many servings of vegetables/day? ☐1-2 ☐3-4 ☐5-6

How many meals/day do you eat? ☐1 ☐2 ☐3 ☐4 ☐5 How many times a week do you prepare meals from scratch? ☐1 ☐2 ☐3 ☐4 ☐5+

What is a typical Breakfast?_____Lunch_____Dinner_____

Are you on a special diet (e.g. vegan, diabetic, etc)? ☐ No ☐ Yes If yes, which one? _____

What are the three (3) healthiest foods you eat regularly?

1) _____ 2) _____ 3) _____

What are the three (3) worst foods you eat regularly?

1) _____ 2) _____ 3) _____

Please list any supplements you are taking (i.e. vitamins, minerals, herbs)? ☐ No ☐Yes Please describe

Name:_____ How much/day:_____Reason:_____

Name:_____ How much/day:_____Reason:_____

Name:_____ How much/day:_____Reason:_____

Name:_____ How much/day:_____Reason:_____

Please list any medications you are taking (prescription or over the counter)? ☐ No ☐ Yes Please describe

Name:_____ How much/day:_____Reason:_____

Name:_____ How much/day:_____Reason:_____

Name:_____ How much/day:_____Reason:_____

Name:_____ How much/day:_____Reason:_____

Please list all past surgeries/ hospitalizations & dates: _____

_____

Please list all previous accidents/falls & dates: _____

_____

Have you ever broken a bone? ☐ No ☐ Yes, If so, when & describe:_____

_____

Were you ever in an auto accident? ☐ No ☐ Yes, If so, when & describe:_____

_____

Have you ever been knocked unconscious? ☐ No ☐ Yes, If so, when & describe: _____

How often have you taken antibiotics?	<5 times	>5 times
Infancy/childhood	☐	☐
Teens	☐	☐
Adulthood	☐	☐

Have you ever taken oral steroids (e.g. Cortisone, Prednisone, etc)? If so, how often?

Infancy/childhood	☐	☐
Teens	☐	☐
Adulthood	☐	☐

Do you have any mercury amalgam fillings or history of them? ☐ No ☐ Yes, Please describe: _____

Do odors affect you? ☐ No ☐ Yes, What symptoms and for how long? _____

As a child, did you avoid any foods because they gave you symptoms? ☐ No ☐ Yes, please name food & symptoms:_____

_____

Have you lived or traveled outside of the United States? ☐ No ☐ Yes, when and where? _____

Please fill in (√) the chart below with information about your **bowel movements**:

Frequency	√	**Color**	√	**Consistency**	√
More than 3x/day		Very dark or black		Soft and well formed	
1-3x/day		Dark brown		Often floats	
4-6x/week		Medium brown		Difficult to pass	
2-3x/week		Yellow, light brown		Diarrhea	
1 or fewer x/week		Varies a lot		Thin, long or narrow	
		Blood visible		Small and hard	
		Greenish		Loose but not watery	
		Greasy, shiny appearance		Alternating between hard and loose/watery	

Do you often experience ☐ Gas ☐ Bloating ☐ Flatulence

Any recent changes in bowel and/or bladder functions? ☐ No ☐ Yes, please describe:_____

Check any condition you have NOW or have HAD:

☐ **Stroke** when___/___/___ current effects _____ ☐ **Seizures** since when____/__/___ how often_____type_____

☐ **Heart Disease** when____/___/_____type _____ ☐**Cancer** when____/___/_____type _____

☐ **Pacemaker** when ___/___/___when_____ ☐ **Scoliosis** ☐**Osteoporosis** ☐ **Osteomalacia** ☐ **RA** where_____

☐ **Dislocation** when ___/___/___where_____ ☐ **Artificial Joint** when ___/___/____what_____

☐ **Joint Fusion** when ____/___/___where_____ ☐ **Spinal Fracture** when___/___/____where_____

☐ **Spinal Fusion** when ____/___/___where_____ ☐ **Disc Herniation** when___/__/___ level(s)_____

☐ **HBP** when ____/___/___Type_____ ☐ **Diabetes** ☐ **Type I** ☐ **Type II** when ____/___/_____

☐ **Immune Disorders** when ____/___/___what_____ ☐ **Night Sweats** when ____/___/___where_____

☐ **Unexpected Weight Gain/Loss** when ____/___/___amount_____ ☐ **Blurred Vision** when ____/___/___where_____

Notes:_____

Have you ever been treated for: **Alcoholism** ☐ No ☐ Yes, when_____/__/____ **Drug abuse** ☐ No ☐ Yes, when_____/__/_____

Unfortunately, **physical and emotional abuse** are leading contributors to chronic stress, illness and immune system dysfunction. Have you witnessed or been subjected to physical or emotional abuse? ☐ No ☐ If Yes, are you under psychological or psychiatric care ☐ No ☐ Yes

Are you currently on any mood altering or anti-depression medications? ☐ No ☐ Yes If yes, please list _____

_____

What is your opinion as to why you are having these health problem(s)? _____

Please list any health conditions not mentioned: _____

Is there any additional information that you think may assist us in your care? _____

_____

_____

_____

PM Name:_____Exam Date:_____ Dr. Initials:_____

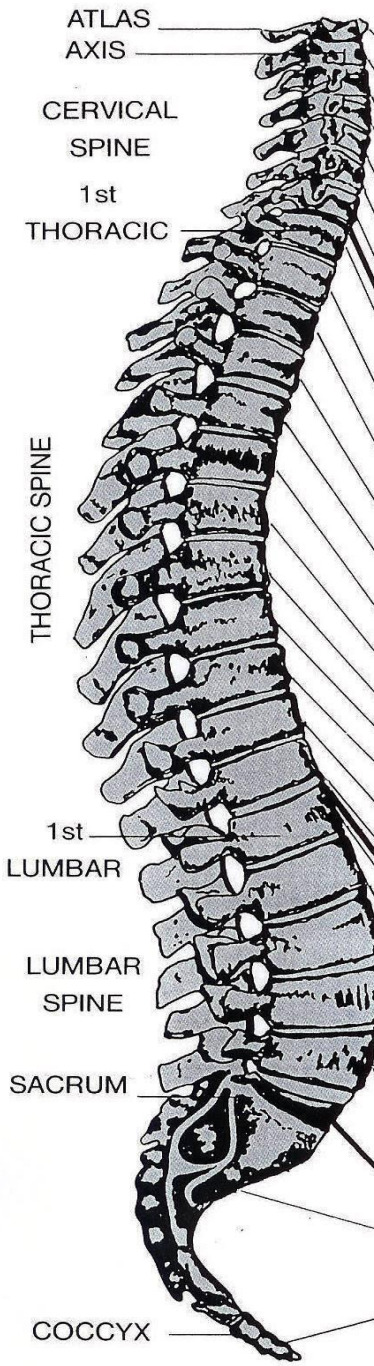
HEALTH CONDITIONS

Please mark the possible health effects below as follows:
Write "P" in the box if experienced in the Past, OR "C" if Currently experiencing the health condition.

Please Mark with P or C Below

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy,* 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.



Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction	
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.	NECK REGION
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.	
3C	Cheeks, outer ear, face bones, teeth, trifacial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.	
4C	Nose, lips, mouth, eustachian tube.	☐hay fever,☐runny nose,☐hearing loss,☐adenoids.	
5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.	
6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.	
7C	Thyroid gland, bursae in the shoulders, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.	
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.	MID-BACK
2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions and certain chest conditions.	
3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.	
4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.	
5T	Liver, solar plexus, circulation (general).	☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.	
6T	Stomach.	☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.	
7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.	
8T	Spleen.	☐ lowered resistance.	
9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.	
10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.	
11T	Kidneys, ureters.	☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.	
12T	Small intestines, lymph circulation.	☐rheumatism,☐gas pains, ☐certain types of sterility.	
1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.	LOW BACK
2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.	
3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.	
4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.	
5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.	
SACRUM	Hip bones, buttocks.	☐ sacro-iliac conditions, ☐ spinal curvatures.	PELVIS
COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.	

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor.

PM Name:_____ Exam Date:_____ Dr. Initials:_____

FAMILY HISTORY

Does anyone in your family suffer from the same condition(s) as you? ☐ No ☐ Yes If yes, whom:_____
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes, what:_____ **Please tick the boxes below if relevant.**

CONDITION	Grandmother	Grandfather	Mother	Father	Spouse	Sister(s)	Brother(s)	Children
Age (if living)								
Age (@ death & cause)								
ADD/ADHD								
Alcoholism								
Allergies								
Alzheimer's								
Anemia								
Arm Pain								
Arthritis								
Asthma								
Autoimmune Dx								
Back Trouble								
Bed Wetting								
Cancer								
Carpal Tunnel								
Celiac								
Depression								
Diabetes								
Digestive Problems								
Disc Problem								
Ear Infections								
Epilepsy								
Fibromyalgia								
Glaucoma								
Headaches								
Heart Disease								
Heartburn								
Hepatitis								
High Blood Pressure								
Hip Pain								
HIV/AIDS								
Hyperthyroid								
Hypothyroid								
Kidney Disease								
Leg Pain								
Liver Disease								
Menstrual Disorder								
Mental Illness								
Migraines								
Multiple Sclerosis								
Neck Pain								
Osteoporosis								
Overweight/ Obese								
Parkinson's Dx								
Psoriasis								
Scoliosis								
Shoulder Pain								
Sinus Trouble								
Stroke								
TMJ								
Other:								

CONSENT TO CARE

I do hereby authorize the doctors of Optimized Wellness Center (OWC) to administer care that is necessary for my particular case. This care may include a consultation, examination, spinal and extremity adjustments and other chiropractic and therapeutic procedures, including but not limited to various modes of physio-therapy and Low Level Light Laser, hydrotherapy, whole body vibration, nutritional recommendations including supplementation, blood/urine/saliva/stool lab procedures, IM and/or IV nutrient injections, collagen induction therapy, prolotherapy, bio-identical hormone replacement therapy, pharmaceuticals (if needed) or any other procedure that is advisable, and necessary for my health care. **Initial**_____

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s), including those working at the clinic or office listed below or any other office or clinic, to work with me through the use of the aforementioned treatments and other necessary treatments for the purposes of restoration and optimization of my health. **Initial**_____

Please sign below if you give permission to the OWC doctors to confer with each other, clinical personnel & other health care providers (not limited to your primary care, a lab pathologist, a radiologist, your oncologist, your child's pediatrician, your physical therapist, massage therapist, etc). This is helpful if we need to refer OR to discuss your treatment plan and progress. If labs are run, it will be helpful if we can send your labs/reports to your primary care/specialists, for confirmation on suggested treatment plan and/or to discuss treatment options on complex cases. By signing below, you give the OWC doctors the ability to confer with healthcare providers for your best interest and to treat you and share your healthcare information among themselves when one is on vacation and you need care. **Initial**_____

I have had an opportunity to discuss with a doctor below and/or with other office or clinic personnel the nature and purpose of and procedures proposed related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. **Initial**_____

I understand that there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and other adverse reactions. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the conditions treated at this clinic. **Initial**_____

I also clearly understand that if I do not follow the doctor's specific recommendations at this wellness center that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to Optimized Wellness Center for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor. **Initial**_____

Due to the uniqueness of each health concern and each individual, including his or her willingness & ability to implement the treatment plan, no guarantees of successful treatment can be offered. **Initial**_____

The doctor is not available on a 24-hour basis at all times. If you have a serious health problem that requires immediate attention, you should call your other doctor(s), 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then call OWC and inform us of what occurred. **Initial**_____

Please let us know if you are being treated by any other healthcare providers (physician, counselor, therapist, etc.) so we can collaborate for your best results. It is not necessary to discontinue treatment with other providers as this may carter adjunctive value to you and your health outcomes. Consult your prescribing doctor before discontinuing medications. **Initial**_____

I, _____(print), have read or have had read to me, the consent on page 10. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures, therapies, and services. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment at OWC. All information provided in the forms are true and complete. I agree to inform OWC on subsequent visits if any medical history or other details have changed or need to be revised. My signature will be used as the "signature on file" in the event of needing to process a claim. I give permission for medical images to be taken and used for educational purposes.

Signature_____Date _____
(If under age 18) Parent's signature

PM Name:_____Exam Date:_____ Dr. Initials:_____

PREGNANCY RELEASE

This is to certify that, to the best of my knowledge, I am **NOT** pregnant and the doctors and his/her associates have my permission to recommend an x-ray evaluation if deemed necessary. I have been advised that x-ray can be hazardous to an unborn child. If I am pregnant, or become pregnant, I will notify the doctors at Optimized Wellness Center immediately, as this is in my best interest.
Date of last menstrual cycle:_____

Signature_____ Date _____
(If under age 18) Parent's signature

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____(print) being the parent of legal guardian of _____(print) have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care.

Signature_____Date _____

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. Optimized Wellness Center will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Signature_____ Date _____
(If under age 18) Parent's signature

Insurance Information
Company _____ ID # _____

Phone number _____ Address _____

Plan Name/Number _____ Effective Date _____

PERSONAL INJURY or WORKER'S COMPENSATION

I certify that this office visit is **not** related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature_____ Date_____
(If under age 18) Parent's signature

Optimized Wellness Center

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures and that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I have the following rights and privileges:

- ❑ The right to review the notice prior to signing this consent,
- ❑ The right to object to the use of my health information for directory purposes, and
- ❑ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Health Care Information Authorization

Optimized Wellness Center and its staff may need to use your name, address, phone number, and your clinical records to contact you with information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your voicemail. By signing this form, you are giving us authorization to contact you with such information.

Practice Member's Signature: Date:

If not signed by the practice member, please indicate your relationship.

- ❑ Parent or guardian of minor practice member
- ❑ Guardian or conservator of an incompetent practice member
- ❑ Beneficiary or personal representative of deceased practice member

Your name (print): _____Signature: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to Obtain/ Reasons for refusal)

_____
_____
_____