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 superior 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
- body contouring
- nutritional programs
- detoxification programs
- B-vitamin and nutrient injections
- brain balancing
- collagen rejuvenation for aesthetics

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 understand your 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 fill out the following information to the best of your ability 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.

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.

Signature____ Date __________/_________/__________

If not signed by the patient, please indicate your relationship.

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Your name (print): ____Signature: ____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained herein will not be released without your written authorization. Please take the time to fill out this questionnaire carefully. If you have a question, please ask for help. The completed form will greatly help in a complete evaluation of your health.

This questionnaire is solely for screening. ***It is limited in scope and not a replacement for a personal physician.***

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: ____ Ages: ________________________

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? ______________

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. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of **care desired**:

☐ **Chiropractic** ☐ **Weight Loss / Nutrition** ☐ **Detoxification** ☐ **Natural Aesthetics** ☐ **Body Contouring** ☐ **Comprehensive Wellness**

Are you **interested in learning about** any of the other services we provide here? ☐ No ☐ Yes, which ones? ______________

Practice Member's Background

So, that we can cater to your specific needs, please share your top health concern.

Primary health concern: ______________

Did it begin: ☐Gradually ☐Suddenly ☐Progressed over time Began ____/____/____

Is there discomfort/pain ☐No ☐If yes, please rate: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

How often do you experience these symptoms throughout the day? ☐100% Constant ☐75% Frequent ☐50% Often ☐25% Seldom ☐10% Rare ☐Only with Activity ☐Other______________

Have you ever been given a diagnosis for your condition? ☐ No ☐If yes, by whom______________when ____/____/____

What was the diagnosis?______________What treatment(s) have you tried?______________

How did you respond?______________

Are there other health concerns you would like us to discuss? ☐No ☐If Yes, what are they?______________

____

What are your goals while here at Optimized Wellness Center?______________

____

Allergies / Sensitivities

Are you aware of having any reactions to the following? ☐No ☐If yes, please describe:

Drugs: ______________

Foods: ______________

Chemicals/perfumes: ______________

Animals: ______________

Other: ______________

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: ______________

Do you smoke? ☐No ☐Yes, How much? ________ Do you use any recreational drugs ☐No ☐Yes, How much? ______________

Do you drink alcohol? ☐No ☐Yes, How many/day?_____ Do you drink coffee, soda, energy drinks? ☐No ☐Yes, 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 ☐ 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) ______________

Do you take any supplements (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:______________

 Practice Member's Name ______________ Exam Date ______________ Dr. Initials ______________

Lifestyle Continued

Do you take any medication (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 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	Completely

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

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

Are you satisfied with your weight? ☐Yes ☐No 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 __________________________________

Check any condition you have NOW or have HAD:

- ☐ Stroke when___/___/____current effects ______________________
- ☐ Heart Disease when____/___/_____type ______________________
- ☐ Pacemaker when ___/___/____where________________________
- ☐ Disc Herniation when___/___/___ level(s)_____________________
- ☐ Joint Fusion when ____/___/___where_______________________
- ☐ Spinal Fusion when ____/___/___where_______________________
- ☐ Seizures since when____/__/____ how often_______type__________
- ☐ Cancer when____/___/____type ______________________________
- ☐ Scoliosis Osteoporosis ☐Osteomalacia ☐RA where_____________
- ☐ Artificial Joint when ___/___/____what_______________________
- ☐ Spinal Fracture when___/___/____where_______________________
- ☐ Dislocation when ___/___/____what__________________________

Review of Systems: Please check any symptoms that you are experiencing now or have experienced in the last 3 months.

Head, Ears, Eyes, Nose, Throat

- ☐ Dizziness/Vertigo
- ☐ Headaches/Migraines
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Jaw Click/Teeth Grinding
- ☐ Teeth/Gum Problems
- ☐ Poor Vision/Eye Pain
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Loss of Smell
- ☐ Sores on Lips or Tongue
- ☐ Recurrent Colds/Sore Throat
- ☐ Allergies
- ☐ Other __________________

Respiratory

- ☐ Recurring Cough
- ☐ Asthma/Bronchitis
- ☐ Shortness of Breath
- ☐ Tightness in Chest
- ☐ Pneumonia
- ☐ Production of Phlegm
  What color? ______________
- ☐ Other

Cardiovascular

- ☐ High/Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Chest Pain/Pressure
- ☐ Blood Clots
- ☐ Cold Hands/Feet
- ☐ Swelling in Hands/Feet
- ☐ Fainting/Dizziness
- ☐ Varicose Veins
- ☐ Pain or Cramping in Legs
- ☐ Other __________________

Gastrointestinal

- ☐ Nausea/Vomiting
- ☐ Poor Appetite
- ☐ Belching/Indigestion
- ☐ Abdominal Pain/Cramps
- ☐ Flatulence/Gas
- ☐ Diarrhea/Constipation
- ☐ Hemorrhoids
- ☐ Blood in Stool
- ☐ Rectal Pain
- ☐ Other __________________

Musculoskeletal

- ☐ Joint Pain/Stiffness
- ☐ Muscle Pain
- ☐ Numbness/Tingling
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Other __________________

Neuro-Psychological

- ☐ Headaches
- ☐ Poor Memory
- ☐ Seizures
- ☐ Depression
- ☐ Fear/Anxiety
- ☐ Irritability/Anger
- ☐ Concussion
- ☐ Easily Stressed
- ☐ Poor Coordination
- ☐ Other __________________

Genito-Urinary

- ☐ Problems with Urination
- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Scanty/Dark Urine
- ☐ Wake at Night to Urinate?
  How Often? ______________
- ☐ Other __________________

Skin and Hair

- ☐ Dry/Oily/Itchy
- ☐ Moles/Lumps
- ☐ Rashes/Hives
- ☐ Sores/Ulcers
- ☐ Other __________________

Men

- ☐ Date of Last Prostate Exam
  ______/_____/______
- ☐ Other __________________

 Practice Member's Name ______________________ Exam Date ____________ Dr. Initials ____________

Review of Systems Continued: Please check any symptoms that you are experiencing now or have experienced in the last 3 months.

Women

Pregnancies ____________________

Births _________________________

Premature/Miscarry ______________

☐ Other ______________________

First Menses ____________________

Last Pap _______________________

Last Menses ____________________

Duration of menses ______________

Days between menses ____________

☐ Birth Control

What kind? ______________________

☐ Vaginal discharge

☐ PMS

☐ Breast Soreness/Lumps

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 **medication**? ☐No ☐ If Yes, Please list____

____

Please list ALL surgeries and dates: ____

____

Please list all aesthetic procedures and dates (laser, peels, Botox, etc.): ____

____

You may discuss the above with the doctor instead of indicating your concern(s) on this form.

CONSENT TO CARE

I do hereby authorize the doctors of Optimized Wellness Center to administer care that is necessary and/or elected 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 physic-therapy and Low Level Light Laser, hydrotherapy, whole body vibration, nutritional recommendations including supplementation, blood/urine/saliva/stool/breath lab procedures, IM nutrient injections, collagen induction therapy, prolotherapy, bio-identical hormone replacement therapy, pharmaceuticals (if needed), B-12 injections, ionic foot baths, whole body vibration, nutritional and weight loss protocols, body contouring services, or any other procedure that is advisable, and necessary for my health care. **Initial__________**

When a person seeks adjunctive therapies only, it is essential for both parties to be working towards the same objective. We offer these services to assist in the process so that you can achieve true health and be your best self. When these services are elected on their own, Optimized Wellness Center is not acting as primary care, thus our intake is very limited in scope. If we are not able to measure progress or feel that additional therapies may enhance your healing process, we may need to refer you for consultation by one of the other doctors providing those services. **Initial__________**

Furthermore, I authorize and agree to allow the doctor of chiropractic or naturopathic named below and/or other licensed doctors 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 Dr. Heath to confer with 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 Drs. Heath and/or Campagna 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 certain treatments 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__________**

I, ____(print), have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. 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.

Signature____ *(If under age 18) Parent's signature* Date ______/_____/________

Consent To Evaluate And Treat 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 ______/_____/________

PI/ WC

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____ *(If under age 18) Parent's signature* Date ______/_____/________

For Office Use Only: Signed form received by: ____

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

Dr. Signature:____Dr. Tim Heath, D.C.