

# OPTIMAL HEALTH & WELLNESS

## PATIENT PERSONAL / CONFIDENTIAL DATA

No. \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Email \_\_\_\_\_ SSN \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female

Cell Phone \_\_\_\_\_ Alternative Phone \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Emergency Contact # \_\_\_\_\_ Name \_\_\_\_\_ Relationship \_\_\_\_\_

Method of Payment  Cash/Credit  Insurance (plan) \_\_\_\_\_  Other \_\_\_\_\_

How did you hear about us?  Yelp  Groupon  Internet (site) \_\_\_\_\_  Referral \_\_\_\_\_

Purpose of this appointment and list your complaints: \_\_\_\_\_

\_\_\_\_\_

How were you injured?  Auto Accident  On the Job  Other \_\_\_\_\_

Other Doctor seen for this condition \_\_\_\_\_ Phone number \_\_\_\_\_

Have you been treated by another Doctor for any health condition in the last year?  YES  NO

### CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X Ray studies, laboratory procedures, naturopathic, medical, injection or intravenous therapy, acupuncture, chiropractic care or any clinic services that he/she deems necessary in my case. I further authorize him/her to disclose all or any part of my (Patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member of the patient for all or part of the clinic charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient employer as stated in the Privacy Policy.

Patient's Signature \_\_\_\_\_ Parent's or Guardian's Signature \_\_\_\_\_

If sending informed consent electronically, I understand that by entering name above, it will constitute as the legal equivalent of your manual signature in this agreement.

Please Circle where you are at:  
 (No Complaint/Pain) (Worst Possible Complaint/Pain)  
 0 1 2 3 4 5 6 7 8 9 10

- Numbness == =
- Dull Ache 000
- Burning XXX
- Sharp/Stabbing ///
- Pins, Needles +++
- Other \_\_\_\_\_ ^^

**General Symptoms**

- Allergy
- Chills
- Dizziness
- Fainting
- Fever
- Loss of Sleep
- Loss of Weight
- Weight Gain
- Nervousness
- Anxiety
- Depression
- Sweats
- Numbness
- Excessive Thirst

**Head/Neck**

- Headaches
- Head Injury
- TMJ
- Stiff Neck

**Eyes**

- Vision Disturbance
- Dryness
- Tearing
- Pain in Eyes
- Itchy Eyes
- Sensitivity to Light

**Ears**

- Discharge
- Pain in Ears
- Loss of Hearing
- Ringing

**ARE YOU PREGNANT?**  
 YES  NO

**Urinary**

- Difficult Urination
- Painful Urination
- Blood in Urine
- Incontinence
- Frequent Urination
- Bladder Infection
- Discolored Urine
- Scanty Urination

**Women Only**

- Vaginal Pain
- Vaginal Discharge
- Vaginal Bleeding
- Breast Pain
- Lumps in Breast
- PMS Symptoms
- Painful Periods
- Menopause

**Musculoskeletal**

- Neck Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Arm Problems
- Leg Problems
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Muscle Spasms
- Paralysis
- Numbness/Tingling
- Shooting Pain
- Sprained Joints
- Broken Bones

**Health Habits**

- Tobacco
- Alcohol
- Caffeine
- Sugar
- Art. Sweetener

**Nose**

- Drainage
- Stuffiness
- Sneezing
- Sinus Infections
- Nosebleeds

**Cardiovascular**

- Chest Pain
- High Blood Pressure
- Low Blood pressure
- Palpitations
- Ankle Swelling
- Cold Hands/Feet
- Varicose Veins

**Throat**

- Pain in Throat
- Glands Enlarged
- Sore Throats
- Trouble Swallowing
- Change in Voice

**Gastro-Intestinal**

- Poor Appetite
- Excessive Hunger
- Constipation
- Diarrhea
- Hemorrhoids
- Blood in Stool
- Liver Trouble
- Gallbladder Trouble
- Heartburn
- Bloating
- Burping/Belching
- Gas
- Pain in Abdomen
- Cramps
- Nausea
- Poor Digestion

**Mouth**

- Loss of Taste
- Gum Problems
- Dryness
- Canker Sores

**Respiratory**

- Pneumonia
- Bronchitis
- Cough
- Shortness of Breath
- Asthma
- Wheezing
- Spitting Blood

**List Any Allergies**


**List Any Surgeries**


**List any Medications/Supplements**


I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

PRINTED NAME \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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