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

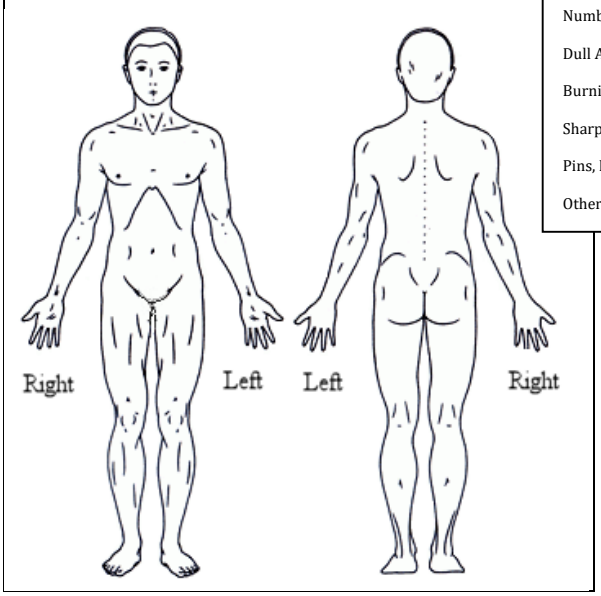
CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

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	OOO
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

ARE YOU PREGNANT?
☐ **YES** ☐ **NO**

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

Nose
- ☐ Drainage
- ☐ Stuffiness
- ☐ Sneezing
- ☐ Sinus Infections
- ☐ Nosebleeds

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

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

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

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

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

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

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

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

Health Habits
- ☐ Tobacco
- ☐ Alcohol
- ☐ Caffeine
- ☐ Sugar
- ☐ Art. Sweetener

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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