

Welcome to Optimal Spine Chiropractic

Please Print Clearly & Fill In Completely

Date: _____

Print Name _____ Nickname _____

Email _____ SS# _____

Street Address _____ Date of Birth _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Please Check Male Female Right handed Left handed Married Single

Health History:

Describe **chief complaint** and any **additional** problems. Rate the symptoms on a scale of **1-10 (10 being the worst)**

1. _____ (1-10)
2. _____ (1-10)
3. _____ (1-10)
4. _____ (1-10)

Are you under the care of any other doctor? Yes No

If **Yes**, the conditions being treated for: _____

List any current medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Employer _____

Work Duties _____

Spouse/Partner's Name _____ Health Status _____

Children's Ages And Health Status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes No If yes, Doctor's name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? Yes No Who? _____

Wellness Commitment

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this; we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%,

Please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Where did you hear about our clinic, or who referred you? _____

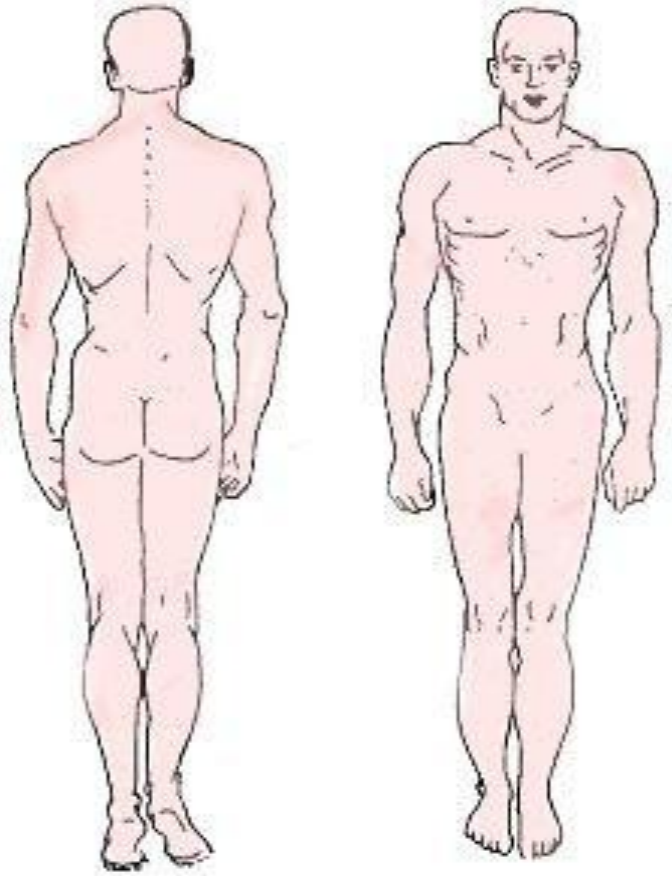
FEMALES: Please Check One Is there a possibility of you being pregnant? Yes No

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check*

Condition, Symptom, or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing In Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

**Circle the areas where you have any problems.
Please also describe these problems.**



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Thank You For being Complete And Thorough

YOUR SIGNATURE BELOW PLEASE

Date: _____

Optimal Spine Chiropractic

X-Ray Consent Form

Name _____ **Date** _____

I understand that the doctor may feel it is necessary to take x-rays in order to diagnose and/or rule out contraindications to chiropractic care. I give my consent for x-ray examination as requested by my chiropractor.

Signature _____ **Date** _____

Parent /Guardian if minor

FEMALES ONLY

I understand that if I am pregnant and undergo x-rays it poses a risk to the developing fetus.

I have been advised that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With these factors in mind, I am advising my chiropractor that:

I am pregnant	yes _____	no _____	don't know _____
I could be pregnant	yes _____	no _____	don't know _____
My menstrual period is late	yes _____	no _____	don't know _____
I have an IUD	yes _____	no _____	
I have had a tubal ligation	yes _____	no _____	
I have had a hysterectomy	yes _____	no _____	
I have irregular menstrual periods	yes _____	no _____	
I have begun menopause	yes _____	no _____	

My last menstrual period began _____

With full understanding of the above, and believing that I am not currently pregnant, I wish to have an x-ray examination if requested by my chiropractor.

Signature _____ **Date** _____

Parent/Guardian if minor

PRIVACY NOTICE
NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review carefully.

Disclosure of your protected health information without authorization is strictly limited in defined situations that include emergency care, quality assurance activities and public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practical operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in this office.

You may file a complaint about privacy violations by contacting our Office Manager.

Signature

Date

Parent/Guardian if minor

Optimal Spine Chiropractic
998 Hospitality Way Suite 202
Aberdeen, MD 21001
410-273-5351

ASSIGNMENT OF BENEFITS
AND
INTENT TO PAY DOCTOR

I hereby assign all my medical benefits available for the services rendered by Optimal Spine Chiropractic. I authorize direct payment of these services to the above office address.

I also acknowledge that I am responsible for any difference in the payment between insurance benefits and the total health care bill for the services being rendered. I have agreed with this provider of health care to make payment on this balance of aforementioned services.

Signature _____

Date _____