



www.optimalperformclinic.com

Confidential Patient Information

Name _____ Date ____/____/____

Date of Birth ____/____/____ Sex (Circle): M F Marital Status (Circle): S M W D

Address _____

Street City State Zip
Phone: (Home) _____ (Work) _____ (Cell) _____

E-mail address: _____

Name of Spouse/ Parent / Guardian: _____ Phone number: _____

E-mail address: _____ Date of Birth _____

In case of emergency contact: _____

How did you hear about our clinic? Referred by _____
Internet/Website _____ Other _____

What is your present complaint? _____

Briefly describe your symptoms: _____

How did the symptoms start? _____

Average Pain intensity-LAST 24 HOURS: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

-PAST WEEK: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

___Constantly(76-100% of the time) ___Frequently(51-75% of the time) ___Occasionally(26-50% of the time) ___Intermittently(0-25% of the time)

How much have your symptoms interfered with your usual daily activities?

___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

In general, would you say your overall health right now is...

___Excellent ___Very good ___Good ___Fair ___Poor

Is your visit due to: Auto Accident? ___ Work-related Injury? ___ Slip and Fall? ___

Sports Injury? ___ Other Reason? _____

Has this condition affected your: WORK ___ REST ___ SLEEP ___ RECREATION ___

Other doctors seen for this condition: _____

MEDICAL HISTORY: Please check any conditions relevant to your past or present medical condition)

<input type="checkbox"/> Anemia	<input type="checkbox"/> CVA/Stroke	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Arthritis/joint disease	<input type="checkbox"/> Dementia	<input type="checkbox"/> HIV or AIDS
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Infection
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney / Liver Disease
<input type="checkbox"/> Backaches / Neck pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> COPD/Lung disease	<input type="checkbox"/> DVT/Blood Clot	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Concussion(s)	<input type="checkbox"/> Headache	<input type="checkbox"/> Numbness or Tingling
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Skin Disorder

List any other important medical condition(s) you have/had (include date of initial diagnosis if possible)

List surgeries performed or significant injuries:

Have you been treated by a doctor for any health reason in the past year? (circle one) **YES - NO**

Describe the condition_____

Date of last medical physical exam_____

Are you allergic to any medications?_____

Females:

Are you pregnant? (circle one) **YES - NO** Date of last menstrual period____/____/____

INSURANCE INFORMATION (Please supply your insurance card)

Name of Insurance carrier: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that *Optimal Performance LLC* will prepare standardized forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit *Optimal Performance Clinic, LLC* to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that any and all services rendered to me are charged directly to me and that I am personally responsible for timely payment. I also understand that if I suspend or terminate my care and treatment, all fees for professional services rendered to me will be immediately due and payable.

PATIENT'S SIGNATURE_____DATE_____

OR

GUARDIAN SIGNATURE_____DATE_____

Consent to evaluate and adjust a minor child (under 18 years old)

I, _____(Relationship to the minor:_____), being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance. I have also answered all the questions to the best of my knowledge and hereby grant permission for my child to receive chiropractic evaluation (including X-ray examination) and care (including laser therapy).

Signature_____ **Date**_____

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I, _____ give consent for *Optimal Performance Clinic, LLC* (the practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocations cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/e-mail address:

The Practice may communicate confidential information about me to the following individual(s):

Patient/Patient Representative

____/____/____
Date

I give permission to *Optimal Performance Clinic, LLC* to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information. If *Optimal Performance Clinic, LLC* contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

By signing this form you are giving *Optimal Performance Clinic* permission to use and disclose your Protected Health Information in accordance with the directives listed above. The use of this format is intended to make your experience at *Optimal Performance Clinic* more efficient and productive and enhance your access to quality Chiropractic & rehab Care and health information. This authorization will remain in effect for the duration of my care at *Optimal Performance Clinic* plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to *Optimal Performance Clinic*.

Patient/Patient Representative

____/____/____
Date