7726 Center Blvd SE, Suite 230 Snoqualmie, WA 98065 PH: 425.396.0613 FX: 425.396.0614

# Intake Form

OPTIMAL HEALTH CHIROPRACTIC

**Date_____**

Legal Name

D.O.B | SSN | Medicare only

Mailing Address

City, ST, ZIP

Home Phone Number | Cell Phone Number

Email | Marital Status S M W D

Employer | Occupation

Spouse's Name | Employer | Occupation

Emergency Contact Name | Phone

Children(s) Name(s)

Optimal Health Chiropractic communicates via text message and/or email.
Please choose the form of communication you would like us to use.

☐ Text Messages ☐ Email ☐ None

*Standard messaging rates may apply. Optimal Health is not responsible for any fees.

How did you find our office? (Be specific: friend, online, etc.) _____

What is the primary reason for visiting our office? _____

Have you seen other doctors for this condition? If yes, Please list their name and phone number below:

Dr. _____ Ph. _____

_____ _____

Have you been treated for any health condition by a physician in the last year? ☐ Y ☐ N

If yes, please describe: _____

_____

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Have any of the following happened to you? (Please check all that apply) Give approximate date and brief description:

☐ Falls or other injuries ☐ Broken bones or surgeries ☐ Spinal or neck injuries ☐ Knocked unconscious

_____

_____

Approximate date of last chiropractic treatment: _____

Is this work related injury? ☐ Y ☐ N Date of injury _____

Have you been in a car accident in the past 3 years? ☐ Y ☐ N When? _____

Have you ever experienced any of these condition(s) or a similar condition in the past? If yes, when _____

What treatment(s) did you receive?_____

Please list any medications you currently take including over-the-counter and prescription:

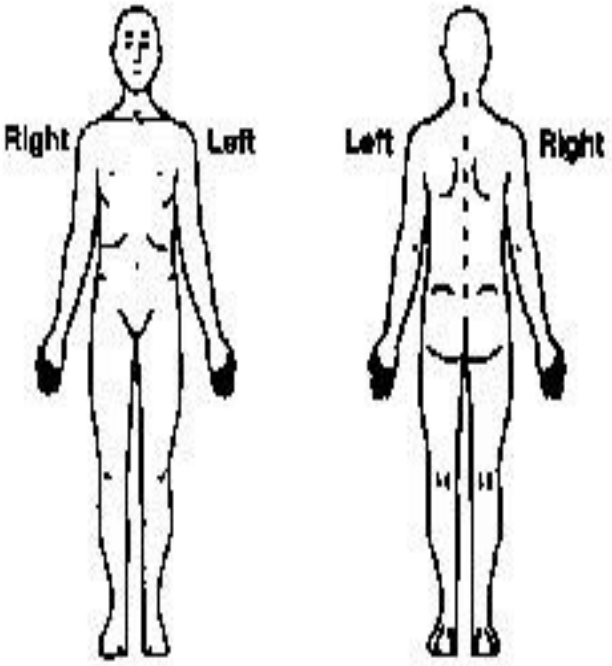
**For Women Only:**
Is there any possibility that you may be pregnant? YES NO

## Medical Health History

**Please check the line for all that apply from the list below. (P= PAST C= CURRENT)**

| P | C | | P | C | | P | C | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Asthma | ___ | ___ | Eczema/hives | ___ | ___ | Kidney stones |
| ___ | ___ | Heartburn | ___ | ___ | Difficulty swallowing | ___ | ___ | Achy abdomen |
| ___ | ___ | Hay Fever | ___ | ___ | Shortness of breath | ___ | ___ | Kidney infection |
| ___ | ___ | Migraines | ___ | ___ | Stroke | ___ | ___ | Painful tailbone |
| ___ | ___ | Headaches | ___ | ___ | Heart disease | ___ | ___ | Sciatica |
| ___ | ___ | Fainting | ___ | ___ | Chest pain | ___ | ___ | Stiff or painful neck |
| ___ | ___ | Nosebleeds | ___ | ___ | High/Low blood pressure | ___ | ___ | Leg pain |
| ___ | ___ | Fatigue | ___ | ___ | Rapid heart beat | ___ | ___ | Pain between shoulders |
| ___ | ___ | Loss of sleep | ___ | ___ | Ringing in ears | ___ | ___ | Arm pain |
| ___ | ___ | Allergies | ___ | ___ | Nausea | ___ | ___ | Knee pain |
| ___ | ___ | Thyroid trouble | ___ | ___ | Vomiting | ___ | ___ | Numbness in extremities |
| ___ | ___ | Diabetes | ___ | ___ | Changes in weight | ___ | ___ | Swollen joints |
| ___ | ___ | Enlarged glands | ___ | ___ | Excessive hunger | ___ | ___ | Bursitis |
| ___ | ___ | Itching | ___ | ___ | Bladder infection | ___ | ___ | Shoulder pain |
| ___ | ___ | Convulsions | ___ | ___ | Painful urination | ___ | ___ | Foot pain |
| ___ | ___ | Bruise easily | ___ | ___ | Tuberculosis | ___ | ___ | Swollen ankles |
| ___ | ___ | Depression | ___ | ___ | Bed wetting | ___ | ___ | Bad posture |
| ___ | ___ | Anemia | ___ | ___ | Stomach ulcers | ___ | ___ | Arthritis |
| ___ | ___ | Poor hearing | ___ | ___ | Frequent urination | ___ | ___ | Low backache |

Please fill out
**ONE** for **EACH Complaint**




**Name**_____
**Date**_____

Symptom (please use drawing to indicate location): _____

Onset (when did the symptom start):_____

What were you doing when you noticed the symptom (lifting, sleeping, yard work):

_____

How often does it occur: Constant Frequent Intermittent Occasional
What is the Frequency (1x/Day, 1x/Week, 1x/Month, etc.):_____

How long does it last: _____

Does the discomfort radiate anywhere: _____

Describe your pain or symptoms (please circle all that apply):

Sharp Achy Burning Stabbing Pins/Needles Fatigue Dizziness Dull Other:

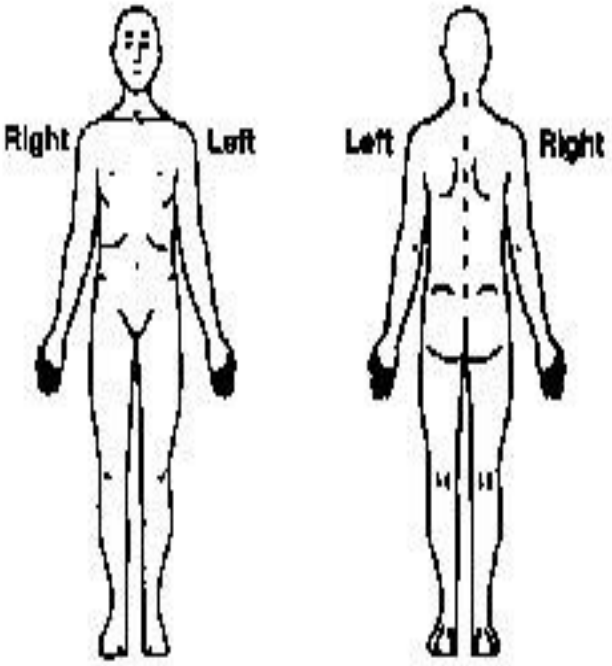
What makes it feel better: _____

What makes it feel worse: _____

Any additional comments:_____

Rate your level of discomfort/pain: 0 1 2 3 4 5 6 7 8 9 10
Comments: _____

Examiner's notes:

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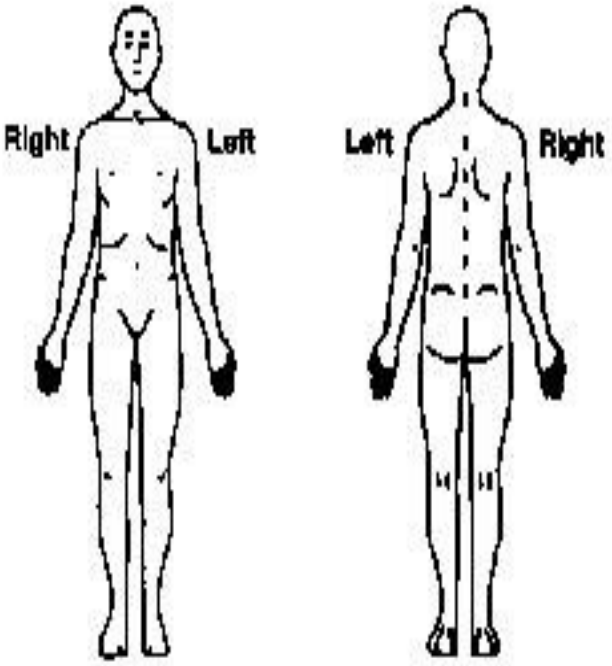


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Any additional comments: _____

Rate your level of discomfort/pain: 0 1 2 3 4 5 6 7 8 9 10
Comments: _____

Examiner's notes:

## Please Read the following and sign and date at the bottom for ALL statements

**Accuracy Statement:**
I certify that I have answered the preceding intake forms honestly and to the best of my knowledge. Optimal Health Chiropractic will not be liable because of any misinformation or any information that I have not disclosed to my doctor.

**Terms of Acceptance:**
We do not offer to diagnose or treat any Disease. We diagnose vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you toward the appropriate referral. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you follow this referral. Our practice objective is to eliminate major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body with adjustments.

**HIPAA Notification:**
Under HIPAA, health information may be used only for treatment, payment or health care operations unless the patient gives written permission or federal law specifically allows the use. Apart from treatment activities, providers must use only the "minimum necessary" information to accomplish the intended purpose.

***By signing below I acknowledge that I read understand and agree with the above three statements.***

Name (printed) Signature Date

**Insurance Verification:**
Insurance Verification is information found on online databases desinged to help inform patients of payments required per visit. Although we are using trusted databases we ask that you take the step to contact your insurance personally to get the desired information about payments directly from them as well. We are not responsible for any charges that may not be covered in copays or coinsurace decided by your insurance on their time.

***By signing below I acknowledge that I read understand and agree with the above statement.***

Signature Date

Patient Name _____ Date_____

**Instructions:** The following scales have been designed to find out about your pain/discomfort and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your **pain/discomfort**?

   No pain Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain/discomfort **interfered with your daily activities** (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

   No Interference Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain/discomfort **interfered with your ability** to take part in recreational, social, and family activities?

   No Interference Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, **how anxious** (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, **how depressed** (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have **you felt your work** (both inside & outside the home) has affected (or would affect) your pain?

   Have made it no worse Have made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been **able to control** (reduce/help) your pain/discomfort on your own?

   Completely control it No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

_____ _____

**Patient Signature** **Total Score**

**Other Comments:**_____