

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Social Security #: _____

Driver's License #: _____

Business Employer: _____

Occupation: _____

Name of Spouse: _____

Type of Work: _____

Referred To This Office By: _____

Name & Number of Emergency Contact: _____

Who is Responsible for your bill, you and Spouse Worker's Comp

Personal Health Insurance Carrier: _____

Insured Person's Name: _____

Insured Person's Date of Birth: _____

Insured Person's Social Security #: _____

Birth Date: _____ Age: _____

Sex: Male / Female

Home Phone: _____

Cell Phone: _____

E-mail Address: _____

Fax #: _____

Business Phone: _____

Spouse's Employer: _____

Names & Ages of Children: _____

Relationship: _____

Auto Insurance Medicare Medicaid

Health Card ID #: _____

Group #: _____

Primary Care Physician: _____

Pharmacy: _____

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) _____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? Yes No

Is condition: Auto Related Work Related Other No Injury

Explain: _____

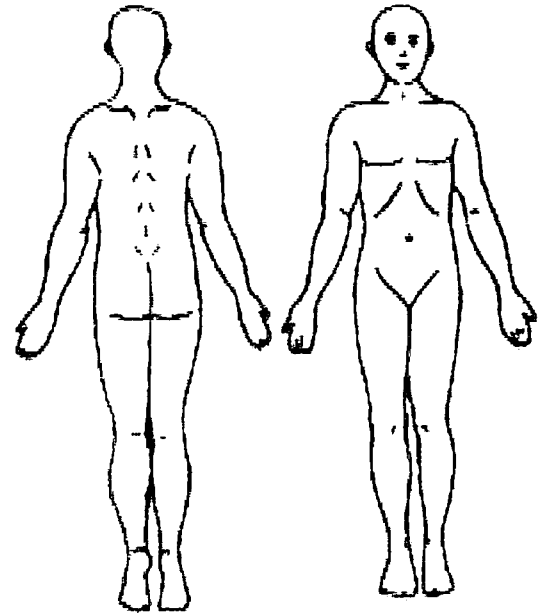
Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work: Have you filed an injury report with your employer? Yes No

Claim #: _____



PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: ADD Allergies/Hayfever Asthma Atopic Dermatitis Cerebral Palsy Chicken Pox
 None Depression Diabetes Fetal Drug Exposure Food Allergies Headaches Hepatitis
 Measles Mumps Rash Seizure Disorder Sickle Cell Anemia Spina Bifida
 Unusual Childhood Illnesses

Adult Illnesses: Anemia Arthritis Asthma Cancer Chicken Pox CRPS (RSD)
 None CVA (Stroke) Depression Diabetes (Insulin Dep) Diabetes (NIDDM - Noninsulin) Eye Problems Heart Disease
 Hepatitis Hypertension Kidney Disease Liver Disease Lung Disease Psychiatric Problems
 Seizures Similar Symptoms STD's Suicide Attempts Thyroid Problems

Surgeries: Angioplasty Appendectomy Caesarean Section Cardiac Catheterization Carpal Tunnel Repair Coronary Bypass
 None Cosmetic D&C Hemorrhoidectomy Hernia Repair Hysterectomy Joint Reconstruction
 Joint Replacement Laminectomy Mastectomy Pacemaker Insertion Spinal Fusion Tonsillectomy
 Gallbladder
 Other _____

Ob/Gyn: Describe: _____
 None

Injuries: Describe: _____
 None

Immunizations: Flu Hepatitis A Hepatitis B Hepatitis C MMR Pneumonia
 None PPD Small Pox TD Td Varivax

Non-Drug Allergies: Describe: _____
 None

FAMILY HISTORY

	Alive	Deceased	Condition
General Family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Son(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Daughter(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Alcohol: None Beer Liquor Social Consumption Wine Amount _____

Diet: High Fat Diet High Fiber High Protein High Salt Intake
 Low Calorie Intake Low Carbohydrate Low Fiber Low Salt Low Sugar

Education: Level or Degree Attained: _____

Substance: Denies Any Denies IV Drugs Not Used Since _____ Used Drugs For _____

Tobacco: Type _____ Amount _____

Other doctors seen for this condition? Yes No Who? _____

Type of treatment: _____ Results: _____

Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers Blood Pressure Medicine Insulin Allergy Medicine
 Anti-Depressants Other: _____

Do you wear heel lifts? Yes No Side Lift Yes No Inter Soles Yes No Arch Supports Yes No
Orthotics Yes No

Any other conditions you feel we should know about - even if unrelated? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if “NONE”.

- Constitutional:** Chills Daytime Somnolence Fatigue Fever Night Sweats Weight Gain
 None Weight Loss
- Eyes/Vision:** Blindness Blurred Vision Cataracts Change in Vision Double Vision Eye Pain
 None Field Cuts Glasses/Contacts Glaucoma Itching Photophobia Tearing
- ENT:** Bleeding Dentures Difficulty Swallowing Discharge Dizziness Ear Drainage
 None Ear Pain Fainting Frequent Sore Throats Headaches Hearing Loss History of Head Injury
 Hoarseness Loss of Smell Nasal Congestion Nose Bleeds PND (Post Nasal Drip) Rhinorrhea (Runny Nose)
 Sinus Infections Snoring Tinnitus (Ringing in Ears) TMJ
- Respiration:** Asthma Cough Coughing up Blood Shortness of Breath (SOB) Sputum Production Wheezing
 None
- Cardio:** Angina Chest Pain Claudication Heart Murmur Heart Problems Orthopnea
 None Palpitations PND SOB with Exertion Swelling of Legs Ulcers Varicose Veins
- Gastro:** Abdominal Pain Belching Black Tarry Stools Constipation Diarrhea Difficulty Swallowing
 None Heartburn Hemorrhoids Indigestion Jaundice Nausea Rectal Bleeding
 Regurgitation Stool Caliber Stool Color Stool Consistency Vomiting Vomiting Blood
- Female:** Breast Lumps/Pain Burning Urination Cramps Frequent Urination Irregular Menstruation Urine Retention
 None Vaginal Bleeding Vaginal Discharge
- Male:** Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate Urine Retention
 None
- Endocrine:** Cold Intolerance Diabetes Excessive Appetite Excessive Hunger Excessive Thirst Frequent Urination
 None Goiter Hair Loss Heat Intolerance Unusual Hair Growth Voice Changes
- Skin:** Changes in Nail Texture Changes in Skin Color Hair Growth Hair Loss History of Skin Disorders Hives
 None Itching Paresthesias Pruritis Rash Skin Lesions/Ulcers Varicosities
- Nervous:** Dizziness Facial Weakness Headache Limb Weakness Loss of Consciousness Loss of Memory
 None Numbness Seizures Sleep Disturbance Slurred Speech Stress Strokes
 Tremor Unsteadiness of Gait
- Psychologic:** Anhedonia Anxiety Appetite Behavioral Change Bipolar Confusion
 None Depression Insomnia Memory Loss Mood Change
- Allergy:** Anaphalaxis Food Intolerance Itching Nasal Congestion Sneezing
 None
- Hematology:** Anemia Bleeding Blood Clotting Blood Transfusions Bruising Fatigue
 None Lymph Node Swelling

Optimal Health Chiropractic Center

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO) Subsequent rejection of a claim as a result of this admission, due to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized payments be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Date _____ File # _____
Date of L.M.P. _____

By my signature on this form I do hereby
State that to the best of my knowledge, I am
Not pregnant, nor is pregnancy suspected
Or confirmed at this particular time

X _____
Print Patient's Name
X _____
Patient's Signature
X _____
Other than patient, Print name & relationship
X _____
Witness

OPTIMAL HEALTH CHIROPRACTIC CENTER
10255 Industrial Blvd., Suite J
Covington, GA 30014
770-788-6955
770-788-6641 (Fax)

Patient Authorization for contact regarding chiropractic care, related health services and/or related health products.

It is our desire to for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. If you choose not to authorize this information use your decision will have no adverse effect on your care from Optimal Health Chiropractic Center, P.C. or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name(printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Patient Authorization for appointment reminders and scheduling related matters.

It is our desire to for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information use your decision will have no adverse effect on your care from Optimal Health Chiropractic Center, P.C. or on your relationship with our staff.

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Covington, GA 30014
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PATIENT CONSENT TO X-RAY

I _____ authorize the performance of diagnostic x-ray examination of myself, which the above doctor or his associates may consider necessary or advisable in the course of my examination and treatment.

_____ Signed _____ Date

CONSENT TO X-RAY MINOR CHILD

I _____ authorize the performance of diagnostic x-ray examination of myself, which the above doctor or his associates may consider necessary or advisable in the course of my examination and treatment. The patient _____ is a minor, _____ years of age.

_____ Signed _____ Date

VERIFICATION OF NOT PREGNANT

This is to certify to the best of my knowledge that I am not pregnant and the above doctor and his associates have my permission to perform diagnosis x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of period last menstrual _____

_____ Signed _____ Date