OPTIMIZED LIVING: WHAT ARE WE ALL ABOUT?

Optimized Living Institute (OLI) practices in a holistic manner, analyzing for suboptimal behaviors and/or physical stressors.

SUBOPTIMAL BEHAVIORS/ STRESSORS:

As a part of the patient history we may ask about:

___ headaches	___ racing/ foggy brain	___ irritable/aggressive behavior
___ back/neck pain	___ enlarges pupils	___ difficulty relaxing
___ trouble sleeping	___ sweating easily/often	___ difficulty digesting foods
___ difficulty concentrating	___ flushed/ rosy cheeks	___ often anxious or worries
___ poor energy	___ Other: _____	

To monitor these behaviors/stressors we use the science of appropriate testing, known as functional medicine/nutrition. Testing gives objective evidence of your current state of health. We can then reuse these same tests to re-measure for positive functional changes as your symptoms decrease.

ANALYSIS / EXAMINATION:

As a part of the analysis, examination, and testing procedure we may recommend:

___ vital signs & palpation	___ basic neurological testing	___ blood work analysis
___ range of motion testing	___ orthopedic testing	___ salivary testing
___ postural analysis	___ radiographic studies (x-rays)	___ genetic testing
___ muscle strength testing	___ MRI scan	___ stool testing

TREATMENT:

OLI's care is directed towards the *cause* of dysfunction in the body and not to eliminate or mask symptoms. By no means do we claim to prevent, treat, or cure any specific ailments, as neither doctor nor medication can truly heal the body.

True healing takes place from within the body, not by external forces. Through physical evaluation, chiropractic care, patient-centered education & guidance we offer manageable steps to help regulate the body. By using specific, customized nutritional and dietary interventions, with lifestyle modifications the body will do what it was meant to do…*heal itself*.

If you are currently on prescription medication, we ask you *not* to make any changes, nor go off of these medications *without* first consulting with your primary care physician or prescribing doctor. It is the responsibility of your prescribing doctor to make any medication changes and to work with us toward helping you become as drug-free as possible

WANT US TO SHARE YOUR PROGRESS WITH YOUR PHYSICIAN?

If so, please list the name and/or contact information of your treating physician.

_____ Physician's Name

_____ Physician's Office

_____ Phone Number

_____ Email

PATIENT INTAKE FORM

Patient Information

Legal Name: _____ Please Call Me: _____
First MI Last

Address: _____ City:_____ State: _____ Zip: _____

Age: _____ Birth Date: _____ ***Pregnant?*** Y /N **Due Date:** _____

Sex (circle): Female /Male / Intersex / DSD **Pronouns *(circle):*** He/Him She/Her Them/They _____

Gender Identity: Female / Male / FTM / MTF / NB/GNC / Agender / Decline to Answer

Social Security Number or Driver's License #: _____ LA / TX / MS/ Other: _____

Email Address: _____ Social Media /Other: _____

Cell Phone: _____ Work Phone: _____

I prefer to be contacted (circle): text / call / email / social media /other ***at*** Cell / Home/ Work

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

I am (circle) Under Age18 / Single / Married / Partnered / Divorced / Widowed / Separated / Decline to Answer

Partner/ Spouse's Name: _____ Partner /Spouse's Date of Birth: _____

Emergency Contact: _____Emergency Contact Phone Number: _____

Consent for Treatment

Assignment & Release *- By signing below, I authorize Optimized Living Institute to collect payment for services rendered. I understand that I am responsible for the amount owed for service rendered, for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed _____ Date _____

Health Questionnaire

Patient Information

Today's Date: _____

Patient Name: _____ **Date of Birth**: _____

Height: _____ **Weight**: _____ **Normal Blood Pressure**: _____

List all *prescription,* non prescription *medications* and other *supplements* you take as well as the *associated condition*:

_____

_____

_____Birth Control? Y/ N _____

List any *surgeries* or *hospitalizations* you have had complete with *the month and year for each*:

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

_____

Do you exercise? ☐ Yes ☐ No **Hours per week** _____**What activity(s)?** _____

_____

Are you dieting? ☐ Yes ☐ No Since:_____ **Do you smoke?** ☐ Yes ☐ No _____packs per day

How many years have you been smoking? _____ **Do you drink alcoholic beverages?** ☐ Yes ☐ No ____drinks per day.

Do you wear? ☐ Heal lifts ☐ Arch supports ☐ Prescription Orthotics ☐ Brace / Supportwear: _____

FOR WOMEN: Are you pregnant or nursing? ☐ Yes ☐ No **If pregnant, How many weeks?** _____

Date of last menstrual period: _____

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Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

Are you here because of an accident? _____ **What type?** _____

When did your symptoms start? _____ **How did your symptoms begin?** _____

_____

How often do you experience symptoms? *(Circle one)* Constantly Frequently Occasionally Intermittently

Describe your symptoms? *(circle all that apply)* Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? *(Circle one)* Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

_____

_____

History of Treatment

Primary care physician: _____ **Phone:** _____

Date last seen: _____ **May we update them on your condition?** ☐ Yes ☐ No

Have you seen a chiropractor before? ☐ Yes ☐ No **Who referred you to us?** _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

_____

_____

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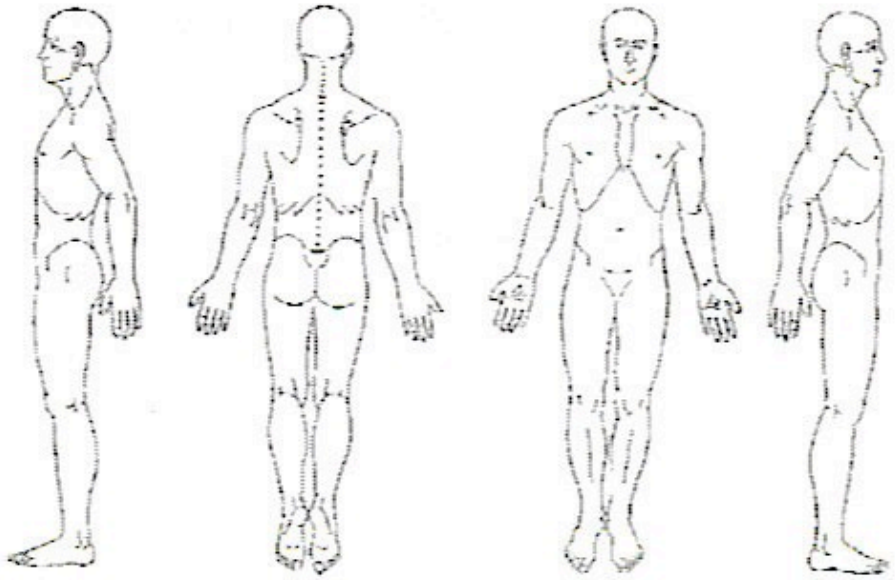
Description of Condition



Left Back Front Right

Mark any area(s) of discomfort with the following key:

A =Ache

N =Numbness

B = Burning

T = Tingling

S = Stiffness

O = Other

On a scale of 1-10 how intense are your symptoms?

Last 24 hours: **NO PAIN** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **UNBEARABLE / WORST PAIN**

Past week: **NO PAIN** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **UNBEARABLE / WORST PAIN**

How often do you experience your symptoms?

①**Constantly** (76-100% of the time) ②**Frequently** (51-75% of the time) ③**Occasionally** (26-50% of the time) ④**Intermittently** (0-25% of the time)

How much have your symptoms interfered with your usual daily activities? (including both work outside the home & housework)

①**Not at all** ②**A little bit** ③**Moderately** ④**Quite a bit** ⑤ **Extremely**

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

①**Excellent** ②**Very good** ③**Good** ④**Fair** ⑤ **Poor**

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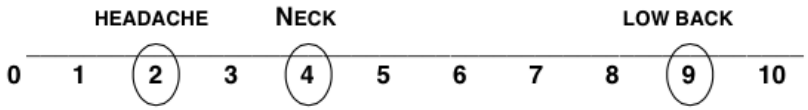
QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:



1. What is your pain RIGHT NOW?

_____

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

_____

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

5. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Have these symptoms changed in the quality of pain or the duration of pain recently? If so, please explain.

_____

_____

_____

_____

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

Previous History Concerns

Please carefully read the following. *If you are unsure, check the "?" box.*

☐ Yes ☐ No ☐ ? A past history of cancer?

☐ Yes ☐ No ☐ ? Unexplained weight loss?

☐ Yes ☐ No ☐ ? Does your pain fail to improve with rest?

☐ Yes ☐ No ☐ ? Are you over 50 years old?

☐ Yes ☐ No ☐ ? Failure to respond to a course of conservative care? (lasting 4-6 weeks)

☐ Yes ☐ No ☐ ? Have you had spinal pain greater than 4 weeks?

☐ Yes ☐ No ☐ ? Prolonged use of corticosteroids (such as an organ transplant Rx)?

☐ Yes ☐ No ☐ ? Intravenous drug use?

☐ Yes ☐ No ☐ ? Current of recent urinary tract, respiratory tract or other infections?

☐ Yes ☐ No ☐ ? Immunosuppressive medication and/or condition?

☐ Yes ☐ No ☐ ? History of significant trauma?

☐ Yes ☐ No ☐ ? If over 50 years old, history of minor trauma?

☐ Yes ☐ No ☐ ? History of osteoporosis (soft bones)?

☐ Yes ☐ No ☐ ? Are you over 70 years old?

☐ Yes ☐ No ☐ ? Acute onset urinary infection or overflow incontinence (wet underwear)?

☐ Yes ☐ No ☐ ? Loss of anal sphincter tone or fecal incontinence (bowel accidents)?

☐ Yes ☐ No ☐ ? Saddle paresthesia (numbness in the groin region)?

☐ Yes ☐ No ☐ ? Global or progressive muscle weakness in the legs (legs give out)?

Additional Patient Comments/Concerns:

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	*Past*	Present	Condition	*Past*	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

_____

Date: _____ **Date:** _____

Patient's signature: _____ **Doctor's signature:** _____

Dr. Derek or Rebekah Bruner

Financial Policy

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

- If we are a *participating provider* in your health plan.
- If you are covered by a state or federal program with *a mandated fee schedule.*
- If you are a member of *Preferred Chiropractic Doctor (PCD), ChiroHealthUSA* or any other *Discount Medical Plan Organization* we may join. Patients who are uninsured, or underinsured *(limited benefits for chiropractic care)*, may join in our office and will be entitled to network discounts similar to our insured patients.
    - Ask our staff for more information.
- If you are eligible & choose a payment plan that allows for *"prompt payment" discounts.*

Payments

Private Pay: ***(please initial)***

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, *but I wish to file my claims personally*, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: ***(please initial)***

C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment. *At this time, OLI is in-network with the VA only.

Missed Appointments

It is the policy of **Optimized Living Institute** to assess a **$25.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ *My initials here indicate that I understand the above missed visit policy.*

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____

Signature Date

Patient Identification

In an effort to maintain compliance with various state and federal regulations, we require a photocopy of the following information:

- The patient's driver's license
- Insurance card (front & back) *if you would like for us to bill your health insurance provider if we are in-network with the insurance.*

Drivers License Photo

Photo of FRONT of drivers license

Health Insurance Card / PCD card / ChiroHealth USA card

Photo of FRONT of insurance card

Photo of BACK of insurance card

Group #: _____

Identification #: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" & involves your understanding & agreement regarding the care we recommend, the benefits & risks associated with the care, alternatives, & the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.
The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper & lower) GI tract was 1219 events/ 1,000,000 persons/year and risk of death has been estimated as 104/ 1,000,000 users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent or Guardian: _____ **Signature:**_____ **Date:** _____

Witness Name: _____ **Signature:**_____ **Date:** _____