## 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: _____ Social Security Number: _____

Hand Dominance *(circle)*: Right / Left/ Ambidextrious

***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

## Guardian Information

Caregiver 1: _____ Relation to Patient: _____

Occupation: _____ Cell Phone: _____

Email Address: _____ Other: _____

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

Caregiver 2: _____ Relation to Patient: _____

Occupation: _____ Cell Phone: _____

Email Address: _____ Other: _____

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

Caregiver 3: _____ Relation to Patient: _____

Occupation: _____ Cell Phone: _____

Email Address: _____ Other: _____

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

## Referral Information:

Who referred you to us?: _____ Google / Facebook/ Instagram / Other

**Have you seen a chiropractor before?** ☐ Yes ☐ No _____

# Health Questionnaire

## Patient Information

**Today's Date:** _____

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

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

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

_____

_____

_____

_____

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

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

Comments: _____

**How often do you observe symptoms?** *(Circle one)* Constantly Frequently (75-50%) Occasionally (50-25%) Intermittently

**Describe what you see:** _____

_____

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

**How do the symptoms interfere school, exercise, play, &/or development**?_____

_____

_____

**Have seen these symptoms in the past?**_____

_____

_____

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# Newborn History

**Weight at birth:** _____ **Length at birth:** _____ □Twin/Triplet/Other _____

□ Birthmarks □ Rashes □ Skin Concerns: _____

□ Required resuscitation/oxygen □ Prolonged jaundice □Anemia

□ Distorted skull □ Baby Helmet **Cries:** □ Often □ When in Need □ Infrequently □ Colicy □ Rarely

**Sleep:** □ Good □ Poor □ Excessive Naps per day: _____ Hours Slept Per Night: _____

□ Swaddle if so, until: _____ □ Sleep Sack If so, until: _____ □ Bumbo □ Disliked Tummy Time

**Eating:** □ Breastfed □ Bottle fed □ Formula fed □Difficulty latching/sucking

□ Reflux □ Vomiting □ Failure to Thrive

Food introduced (months old): _____ _____

**Infections/ Medications:** _____

**Immunization:** □ On-schedule □Delayed schedule □Modified delayed schedule □Indefinitely delayed schedule

List any *surgeries* or *hospitalizations* your child has had, complete with *the month and year for each*:

_____

_____

# Health History Has your child ever experienced the following or been diagnosed with any of the following:

□ Congential Disorders/ Birth Trauma: _____

□ Seizures/Convulsions □ Epilepsy □ Fainting □ Dizziness

□ Meningitis □ Rheumatic Fever □ COVID-19 complications □ Chronic ear infections/ earaches

□ Diabetes □ Hypoglycemia □ High blood pressure □ Heart disease

□ Serious falls or repetitive falls □ Head injury □ Motor Vehicle Collision □ Bladder control (enuresis)

□ Neck or back problems □ Joint or muscle problems □ Tongue Tie/ Lip Tie Revised? □ Yes □ No

Additional: _____

□ Constipation □ Diarrhea □ Digestive Disorder Bowel Movements Per Day: _____

Dietary interventions: □ Gluten-free □ Dairy-free □ Soy-free □ GFDFSF □ AIP □ Keto

□ Vegan □ Vegetarian □ Pescatarian □ Paleo □ No Sugar □ No additives □ Nightshade-free

_____

□ Asthma □ Food allergies □ Environmental allergies □Chemical sensitivities

**List anything your child is allergic to**: _____

Adverse reaction to any medications and/or vaccinations: _____

_____

List all *prescription,* non-prescription *medications* and other *supplements* your child takes, as well as the *associated condition*:

_____

## Developmental History Does or did your child have any difficulty with the following:

□ Rolling over □ Crawling (on all fours) □ Learning to walk □ Awkward run/walk □ Skip

What age did your child start to walk unassisted: _____

□ Using utensils □ Writing □ Button clothing □ Tying shoes

□ Riding a bicycle □ Throwing/catching a ball □ Sitting still □ Paying attention

□ Speaking □ Making eye contact □ Changing routine □ Following directions

□ Balance & coordination □ Swinging &/or climbing □ Using the toilet □ Playing with others

Additional comments: _____

_____

_____

## Activities of Daily Living

**School:** □ Traditional □ Online □ Hybrid □ Homeschool School/Other:_____

**Technology:** Uses □ TV □ Tablet/Phone □ Computer Screen Time Per Day: _____

**Sleep:** □ Good □ Poor □ Excessive Naps per day: _____ Hours Slept Per Night: _____

**Energy Levels:** □ High Energy □ Low Energy □ Good _____

**Daily Exercise:** □ Yes □ No Preferred Exercise: _____ Hours Exercise Per Week: _____

## Family History

List all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual:

_____

_____

_____

## Pregnancy History (Mother)? If adopted or newly acquired custody, please answer to the best of your ability.

□ Miscarriage(s): _____ □ Fertility Challenges/Interventions: _____

□ Diabetes: (Uncontrolled/Gestational) □Anemia □ Autoimmune Disease(s): _____

□ Viral infection during 1st trimester □ Toxoplasmosis □ Accident or Infections: _____

□ Hypertension (high blood pressure) □ Pre-eclampsia □ Maternal depression or postpartum depression

□ Epilepsy □ Pre-term labor □ Placenta previa □ Over 35 years old

□ Alcohol consumption &/or drug use □ Smoking (Tobacco/Cannabis/Other) _____

□ Breech position during pregnancy □ Radiation exposure □ Lead exposure □ Chemical exposure

Comments: _____

_____

## Labor & Delivery History Did you &/or the child experience any of the following during labor/delivery:

**Birthing Location**: □ Hospital □ Birthing Center □ Home Birth □ Other: _____

**Labor** was □ Induced □ Long &/or difficult Lasted: _____ **Delivery** was □ Rapid □ C-section (Induced/Emergency)

**Birthing Interventions:** □ Pitocin □ Epidural □ Episiotomy _____

□ Premature (2+ weeks) □ Fetal distress □ Forceps or suction cup used □ Emergency C-section

□ Breech birth □ Cord around the neck □ "Blue Baby" □ Jaundice

Comments: _____

_____

_____

## Neurological/Other Has your child ever been diagnosed by a medical professional with any of the following:

□ Hearing loss or impairment □ Visual impairment □ Dyslexia □ Tourette Syndrome □ Tics/ Stim Behaviors

□ Neurological disorders □ Obsessive Compulsive Disorder (OCD) □ Autism /ASD □ Asperger Syndome

□ ADD/ ADHD □ Anxiety □ Depression □ Sensory Processing Disorder (SPD)

Additional comments: _____

_____

_____

Recommended Treatments: _____

_____

Special Services (including school or privately): _____

_____

## Medical Providers:

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

_____

Pediatrician: _____ Office Name: _____

City, State: _____Date last seen: _____May we update them on your condition? ☐ Yes ☐ No

Specialist: _____ Office Name: _____

City, State: _____Date last seen: _____May we update them on your condition? ☐ Yes ☐ No

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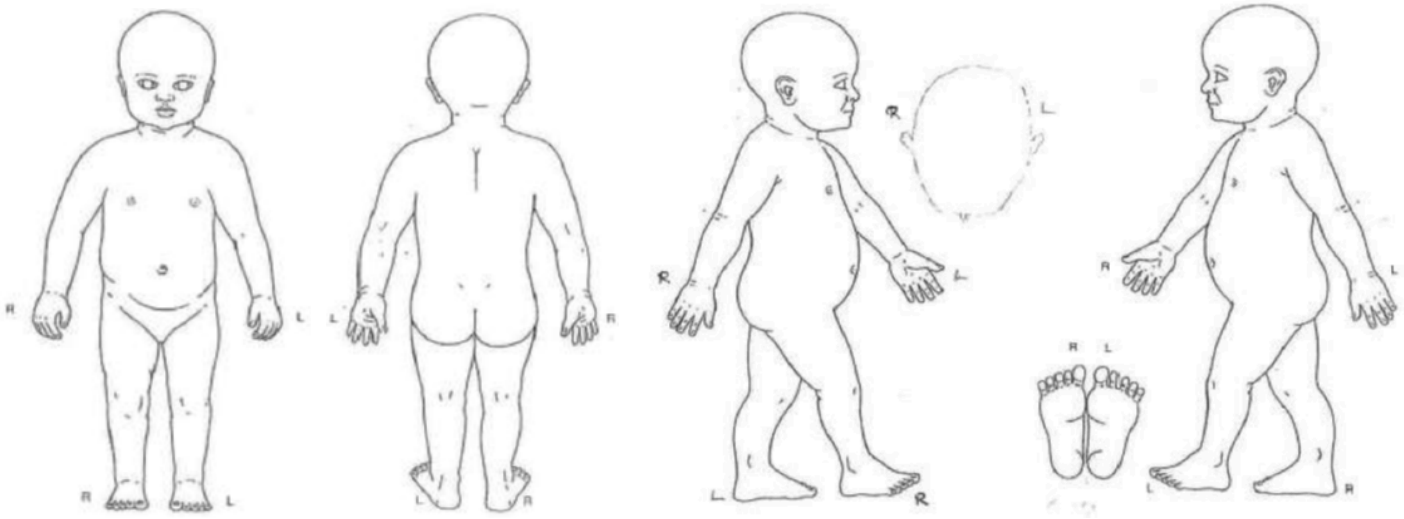
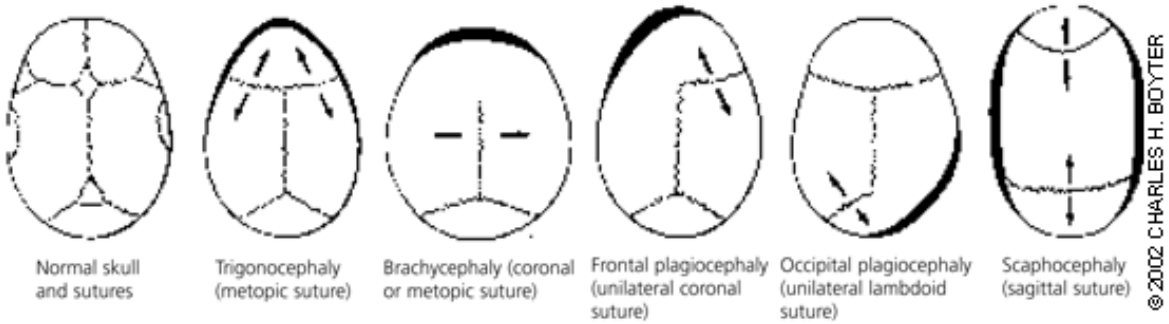
# Visual Description of Condition

Mark/circle any & all spots of perceived pain or discomfort, or areas that you suspect are a problem.






**On a scale of 1-10 how intense are the 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 frequent are the 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**

Additional comments: _____

_____

_____

**Patient's signature:** _____ **Date:** _____

# 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 us for more information.
- If you are eligible & choose a payment plan that allows for *"prompt payment" discounts.*

## Payments

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

**A**_____ I prefer pay self-pay, thus receiving a time-of-service discount. 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*. 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)***
*At this time, OLI is in-network with: ☐ UnitedHealthCare ☐ VA CCN ☐ Medicare

**C**_____I am veteran with a VA referral. Authorization #: _____

**D**_____I have Medicare. Please bill Medicare first. I understand that Medicare only covers the chiropractic adjustment. I am responsible for any non-covered services.

**E**_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

## 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

**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 driver's license | Photo of BACK of driver's license |
|---|---|

## Veteran's Card or Health Insurance Card / PCD card / ChiroHealth USA card

OLI is in-network with: □ UnitedHealthCare □ VA CCN □ Medicare

| Photo of FRONT of Veteran's ID card<br>Medicare/ health insurance card | Photo of BACK of Veteran's ID card<br>Medicare / health insurance card |
|---|---|

Group #: _____ Identification #: _____

_____

**Online Payments:**

I wish to keep my credit card/ Health Savings Account (HSA) / Flexible Spending Account (FSA) on file. _____

Credit Card/ Account #: _____ Exp Date: _____ Billing Zip Code: _____

## 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:** _____