www.optimalperformclinic.com

Confidential Patient Information

Today's Date: ____/____/____

Name_____ **D.O.B** _____/_____/_____

Address_____
Street **City** **State** **Zip**

Phone: (Home) _____**(Work)**_____ **(Cell)**_____

E-mail address: _____

Name of Spouse/ Parent / Guardian / or Emergency Contact: (circle one)
_____Phone number: _____

How did you hear about our clinic? Referred by_____
Internet/Website_____ Other_____

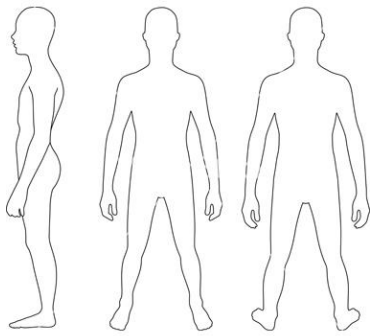
What is your present complaint? _____

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

Lt/Rt **Front** **Back**



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)

____Anemia	____CVA/Stroke	____High Blood Pressure
____Arthritis/joint disease	____Dementia	____HIV or AIDS
____Asthma	____Depression	____Infection
____Bleeding Disorder	____Diabetes	____Kidney / Liver Disease
____Backaches / Neck pain	____Dizziness	____Muscular Dystrophy
____COPD/Lung disease	____DVT/Blood Clot	____Multiple Sclerosis
____Concussion(s)	____Headache	____Numbness or Tingling
____Cancer	____Heart Disease	____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 or Guardian's 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 if necessary) and care (including laser therapy or soft tissue mobilization).

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

INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have been experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures: (PLEASE INITIAL each procedure you are consenting to)

___ spinal manipulative therapy	___ palpation	___ deep tissue laser therapy
___ range of motion testing	___ orthopedic testing	___ vibration therapy
___ muscle strength testing	___ postural analysis	___ traction therapy
___ ultrasound	___ hot/cold therapy	___ EMS
___ radiographic studies	___ basic neurology testing	___soft tissue mobilization
___ _____	___ _____	___ _____
___ _____	___ _____	___ _____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray (if available). Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between 1 in 1,000,000 and 1 in 5,000,000 cervical adjustments. The other complications are also generally described as rare.

Availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Eric Legault and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____/_____/_____

_____
Patient's name

_____
Signature

_____
Signature of parent or guardian (if a minor)

Dated: _____/_____/_____

_____
Doctor's name

_____
Signature