



Our mission is to help restore and maintain function and balance in the bodies, minds, and lives of people of all ages, from infants to seniors. Our ultimate purpose is to help people live an optimally healthy life and reconnect with the joy of living. Our intention is to create a safe and compassionate environment for you to heal and be whole. Thank you for your visit.

All information provided is strictly confidential:

PERSONAL INFORMATION:

Name: _____ Date: ___ / ___ / ___

if child please provide parent's name _____ Gender: M / F

Address: _____ City: _____

State: _____ Zip Code: _____ Country: _____ Age: _____ Birthdate: ___ / ___ / ___

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Work Phone: _____

Whom may we thank for referring you? _____

Marital Status:

- Single
- Married How long? _____ Spouses Name _____
- Divorced How Long? _____
- Widowed How Long? _____
- Do you want/plan to marry again? _____

Children: Yes / No If yes, ages: _____ M / F
_____ M / F
_____ M / F

FAMILY HISTORY:

Mother living? Yes / No
If yes, how old is she? _____
Please list any medical problems:

Father Living? Yes / No
If yes, how old is he? _____
Please list any medical problems:

If no, what was the cause of death?

If no, what was the cause of death?

Age at death _____

Age at death _____

Are your parents married? Yes / No If no, how old were you when they divorced? _____

Do you have any siblings? Yes / No

Age _____ M / F Age _____ M / F
Age _____ M / F Age _____ M / F

Please list conditions in any family including parents, grandparents, siblings, aunts, and uncles:

- | | |
|--|---------------------------------------|
| <i>family member(s)</i> | <i>family member(s)</i> |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |



HEALTH HISTORY

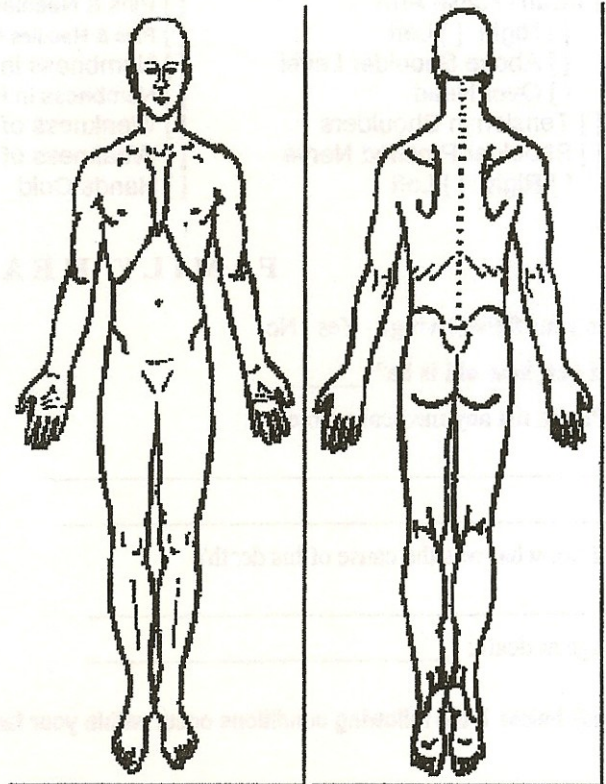
What is your **intention** for visiting Be Optimal Holistic Health Center?

Do you have any **reoccurring symptoms**?
If yes, please explain, including the approximate time of day the symptoms are most pronounced:

_____ : _____ am/pm
_____ : _____ am/pm
_____ : _____ am/pm
_____ : _____ am/pm
_____ : _____ am/pm

Please use these symbols on the diagram below to illustrate areas of physical discomfort.

XXX = pain OOO = Numbness
SSS = tingling ΔΔΔ = Other



How would you describe your **energy level**:

(mark an X on line to indicate current energy)

low ----- high

Time of day you feel the least energy:
(check all that apply)

- 7 am – 9 am 7 pm – 9 pm
- 9 am – 11 am 9 pm – 11 pm
- 11 am – 1 pm 11 pm – 1 am
- 1 pm – 3 pm 1 am – 3 am
- 3 pm – 5 pm 3 am – 5 am
- 5 pm – 7 pm 5 am – 7 am

Circle the severity of the physical discomfort on the following scale (1) is the least amount of discomfort and (10) is the most severe discomfort.

0 1 2 3 4 5 6 7 8 9 10

Current **health concerns** or conditions:

What **treatments** have you already received for this condition?

- Medications Nutritional Support
- Physical Therapy Surgery
- Chiropractic Services Counseling
- None Other — please list:



Name of other **practitioner(s)** who have treated this condition _____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Urine Test _____

Spinal Exam _____ Chest X-Ray _____ Dental X-Ray _____

Blood Test _____ MRI, CT Scan, Bone Scan _____

Other: _____

Please list anything you are taking (prescribed or over the counter):

Medications: _____ Number per day _____

_____ Number per day _____

_____ Number per day _____

Vitamins: _____ Number per day _____

_____ Number per day _____

Nutritional Supplements: _____ Number per day _____

_____ Number per day _____

_____ Number per day _____

Have you ever been in an **accident**? _____ If yes, what type? _____

When? _____ Please describe your injuries and the treatment you received:

Have you ever been in the **hospital**? _____ If yes, please explain when and why?

Please check, explain, and date any **injuries and surgeries** you have had:

	<i>Describe</i>	<i>Month/Year</i>
⑤ Head Injuries	_____	____ / ____
⑤ Surgeries	_____	____ / ____
⑤ Broken Bones	_____	____ / ____
⑤ Gallbladder	_____	____ / ____
⑤ Tonsils	_____	____ / ____
⑤ Adenoids	_____	____ / ____
⑤ Appendix	_____	____ / ____
⑤ Plastic Surgery	_____	____ / ____
⑤ Organs	_____	____ / ____
⑤ Transplants	_____	____ / ____
⑤ Other:	_____	____ / ____



ARMS & HANDS

Please circle "Left" or "Right"

C=current P=past

- | | | |
|----------|----------|---|
| C | P | |
| ⑤ | ⑤ | Pain Upper Arms
left / right |
| ⑤ | ⑤ | Pain in Elbow
left / right |
| ⑤ | ⑤ | Pain in Forearm
left / right |
| ⑤ | ⑤ | Pain in Hand
left / right |
| ⑤ | ⑤ | Pain in Fingers
left / right |
| ⑤ | ⑤ | Pins and Needles in Arm
left / right |
| ⑤ | ⑤ | Pins and Needles in Fingers
left / right |
| ⑤ | ⑤ | Numbness in Arm
left / right |
| ⑤ | ⑤ | Numbness in Fingers
left / right |
| ⑤ | ⑤ | Weakness of Arm
left / right |
| ⑤ | ⑤ | Weakness of Hand
left / right |
| ⑤ | ⑤ | Hands Cold
left / right |

LOW BACK

- | | | |
|----------|----------|--------------------|
| C | P | |
| ⑤ | ⑤ | Feels Out of Place |
| ⑤ | ⑤ | Low Back Pain |
| ⑤ | ⑤ | Low Back Stiffness |
| ⑤ | ⑤ | Low Back Weakness |
| ⑤ | ⑤ | Muscle Spasms |
| ⑤ | ⑤ | Pinched Nerve |

HIPS, LEGS, FEET

Please circle "Left" or "Right"

- | | | |
|----------|----------|-----------------------------------|
| C | P | |
| ⑤ | ⑤ | Pain in Buttocks
left / right |
| ⑤ | ⑤ | Pain in Hip Joint
left / right |
| ⑤ | ⑤ | Pain Down Leg
left / right |
| ⑤ | ⑤ | Pain in Knee
left / right |
| ⑤ | ⑤ | Pain in Ankle
left / right |
| ⑤ | ⑤ | Pain in Foot
left / right |
| ⑤ | ⑤ | Weakness of Leg
left / right |
| ⑤ | ⑤ | Weakness of Knee
left / right |
| ⑤ | ⑤ | Leg Cramps
left / right |

MEN ONLY

- | | | |
|----------|----------|-----------------------|
| C | P | |
| ⑤ | ⑤ | Breast Lump |
| ⑤ | ⑤ | Erection Difficulties |
| ⑤ | ⑤ | Lump in Testicles |
| ⑤ | ⑤ | Low Libido |
| ⑤ | ⑤ | Penis Discharge |
| ⑤ | ⑤ | Prostate Problem |
| ⑤ | ⑤ | Sore on Penis |
| ⑤ | ⑤ | Vasectomy |

WOMEN ONLY

- | | | |
|----------|----------|--------------------------------------|
| C | P | |
| ⑤ | ⑤ | Abnormal Pap Smear |
| ⑤ | ⑤ | Birth Control Pills |
| ⑤ | ⑤ | _____ (name)
Birth Control Device |
| ⑤ | ⑤ | _____ (type)
Birth Control Device |
| ⑤ | ⑤ | Bleeding Between Periods |
| ⑤ | ⑤ | Breast Lump |
| ⑤ | ⑤ | Extreme Menstrual Pain |
| ⑤ | ⑤ | Hot Flashes |
| ⑤ | ⑤ | Infertility |
| ⑤ | ⑤ | Low Libido |
| ⑤ | ⑤ | Miscarriage |
| ⑤ | ⑤ | Nipple Discharge |
| ⑤ | ⑤ | Painful Intercourse |
| ⑤ | ⑤ | PMS |
| ⑤ | ⑤ | Uterine Cysts |
| ⑤ | ⑤ | Vaginal Discharge |
| ⑤ | ⑤ | Vaginal Infections |

Date of last menstrual cycle?

Date of last pap smear?

Date of last mammogram?

Have you ever had an abortion? Yes / no

Number of children _____

ADDICTIONS:

- | | | |
|----------|----------|---------------------------------|
| C | P | |
| ⑤ | ⑤ | Alcohol |
| ⑤ | ⑤ | Drugs |
| ⑤ | ⑤ | Food |
| ⑤ | ⑤ | Prescriptions |
| ⑤ | ⑤ | Relationships |
| ⑤ | ⑤ | Sex |
| ⑤ | ⑤ | Other (please specify)
_____ |

OTHER HEALTH CHALLENGES:

LIFE COMFORT AND CHALLENGES:

What would you rate your satisfaction level of these areas of your life

0 ----- 10
not happy very content

Circle a number:

Your Career:

0 1 2 3 4 5 6 7 8 9 10

Your Creativity:

0 1 2 3 4 5 6 7 8 9 10

Your Education/Knowledge:

0 1 2 3 4 5 6 7 8 9 10

Your Emotional Support:

0 1 2 3 4 5 6 7 8 9 10

Your Family:

0 1 2 3 4 5 6 7 8 9 10

Your Finances:

0 1 2 3 4 5 6 7 8 9 10

Your Health:

0 1 2 3 4 5 6 7 8 9 10

Your Relationships:

0 1 2 3 4 5 6 7 8 9 10

Your Travel:

0 1 2 3 4 5 6 7 8 9 10



LIFESTYLE

Please indicate all that apply:

Alcohol Use:

- Wine
- Mixed Drinks
- # of drinks per day _____
- # of times per week _____
- None
- Liquor
- Straight

Cigarettes:

Brand _____
 # per day _____
 Packs per week _____

Sweets:

- Chocolate
- Candy
- Daily
- Occasionally

Sodas:

- Caffeinated
- Decaffeinated
- Diet soda
- # per day _____
- # per week _____

Water:

- Tap
- Bottled
- Filtered
- Seltzer/Tonic
- Average amount per day _____

Sugar:

- Substitute _____ (brand)
How many times per week _____
- regular
- added to food
- added to drinks

Food Substitute:

- Protein bars _____ (brand)
- Protein shakes _____ (brand)
- whey soy rice
- Other _____

Coffee:

- Caffeinated
- Decaffeinated
- Cups per day _____
- Amount of:
sugar _____ cream _____

Tea:

- Herbal
- Caffeinated
- Type of sweetener _____
- Cups per day _____

Eating Habits — what do you usually eat for:

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

Sleep Habits:

How many hours per night? _____

Do you wake up in the middle of the night

no yes if yes, what time? ____:____

Exercise:

Do you exercise? yes No

How often? _____ # per week

Type _____

How much do you want to change?

0 1 2 3 4 5 6 7 8 9 10

How willing are you to change?

0 1 2 3 4 5 6 7 8 9 10



Do you keep a **journal**? _____ ☺ Written ☺ Visual How often? _____

Do you have a specific **spiritual practice**? _____ If yes, please explain:

Do you **feel passionate** about life? Yes / No What's your **passion**? _____

How would describe your ability to **express emotions** such as happiness, anger, fear, sadness, grief, etc.? _____

What are your **personal goals** for your life?

If you knew you could not fail, what would you be doing differently?

What would your life be like? _____

Other challenges or life goals not covered:

Infinite Love & Gratitude for sharing all of your thoughts. The power of healing is ultimately about being whole. Being whole is a process of accepting, forgiving, and loving all parts of one self.



PATIENT POLICIES

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

Communication is vital for good doctor patient relations. If you have any questions, comments, complaints, or compliments, do not hesitate to bring them to our attention. To maintain a peaceful atmosphere we ask that cell phones are silenced and all calls are taken outside.

Please check in with receptionist upon entering the office. Prior to your appointment please remove the contents of your pockets; jewelry, watches and other objects so they won't interfere with chiropractic adjustments.

If you've had a change in symptoms, become (or potentially become) pregnant or been involved in an accident (work, auto or otherwise) since your last visit, it is your obligation to report this to your doctor prior to your session.

PAYMENT POLICY

Payment is due at time of service. We accept cash, check, Visa, Mastercard, or Discover for payment. The fee for returned checks is \$25.

If your insurance company covers chiropractic care, we will be happy to provide you with a form detailing your visit that you can submit. If your insurance covers our services, you will be reimbursed directly. It is not our policy, under any circumstances, to submit bills to your insurance company. By signing this, you authorize our office to furnish any necessary information requested by your insurance company to process the claims you have submitted.

THANK YOU

If you need to work out a payment plan, please discuss this with the doctor PRIOR to your session.

Any unpaid balance is charged 1.5% interest per month.

A 24 hour notice is required if you need to reschedule an appointment, otherwise you will be charged for the cancelled visit. Occasionally, patients are turned away for an appointment because the schedule is full. Because of this, missed appointments are assessed the full visit fee.

Any product returns must be done within 30 days of purchase, and in original condition. Finally, should you choose to suspend or terminate care, it is your obligation to inform your health care physician. Outstanding fees are then due immediately.

I understand and agree to the above.

Signed _____ Dated _____



Be Optimal

HOLISTIC HEALTH CENTER

Becoming Your Best You

Dear Patient,

Please read the 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.

Chiropractic Informed Consent For Diagnosis and Treatment

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 may have 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: spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, hot/cold therapy, vital signs, basic neurological testing, nutritional supplements and homeopathic remedies.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there is 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 sprains and separations. 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. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million and one in five million cervical adjustments. The other complications are also generally described as rare.

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 DOCUMENT.
PLEASE CHECK THE APPROPRIATE AND BOX AND SIGN BELOW.**

I have read

Have had read to me

the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Cari Jacobson, D.C. 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 (or the patient's best interest, for whom I am legally responsible) 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/Guardian: _____

Doctor's Name: Dr. Cari Jacobson, D.C.

Doctor's Signature: _____