Be Optimal
HOLISTIC HEALTH CENTER
Becoming Your Best You

847.486.8000 | info@beoptimal.com

Chinese Medicine Health Evaluation
Client Intake Form

Welcome! 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.

_____ _____
Patient Name Date of Birth

_____
Address City, State, Zip code

_____ _____ _____
Phone (cell) Phone (home/work) Who referred you to us?

_____
Email Address **Add to EMAIL List: YES / NO**

Are You Taking Medication? YES / NO **Are You Currently Pregnant? YES / NO**

Do You Have Any Heart Issues? YES / NO **Do You have Any Implants? YES / NO**

Are you currently under medical care or in rehabilitation for an acute or chronic condition? YES / NO

If so, please provide details:_____

Are you currently in pain or regularly experience pain? YES / NO

If so, please provide details:_____

Do You Have Any Skin Sensitivities? _____

List Any Allergies (Including Food)? _____

Do you have any injuries, illnesses, medical conditions or sensitivities that may affect your treatment with us?

YES / NO If so, please provide details _____

Do any of the following pertain to you?

( ) anxiety ( ) depression ( ) insomnia ( ) headaches ( ) emotional trauma

Do any of the following pertain to you? ( ) eczema ( ) psoriasis ( ) skin rash ( ) warts

( ) fungal infection ( ) acne ( ) rosacea ( ) open wounds ( ) diabetes ( ) spinal injury/surgery

Are you currently using or have ever used:

( ) Accutane ( ) Retin A ( ) Tazorac ( ) Differin ( ) Ziana

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Questions Concerning General Condition

Please circle "C" for those, which are currently a problem for you, circle "P" for those that have troubled you in the past.

Energy and Temperature Levels

Are you fatigued	C P	Tired upon waking	C P
Tired throughout the day	C P	Hands & feet cold	C P
Hands & feet hot	C P	Perspire easily upon slight exertion	C P
Do you Perspire at night	C P	Chills	C P
Low grade fever	C P	Feel overly warm	C P

Appetite, Taste and Thirst

Has your appetite altered recently? _____ How? _____

Is your Appetite poor	C P	Excessive Describe:	C P
Abdominal pain	C P	Nausea	C P
Vomiting	C P	Bloating	C P
Belching	C P	Gas	C P
Do you crave tastes Which?	C P	Do you have a bitter taste in your mouth	C P
Sweet	C P	Are you thirsty	C P

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Please circle "C" for those, which are currently a problem for you, circle "P" for those that have troubled you in the past.

Stools and Urine

Are stools generally hard	C P	Loose	C P
Do you experience constipation	C P	Diarrhea	C P
Blood or mucus in stool	C P	Rectal Bleeding	C P
Hemorrhoids	C P	Is your urine scanty	C P
Is your urine profuse	C P	Frequent	C P
Burning	C P	Do you experience dribbling urine	C P
Incomplete urination	C P	Do you wake at night to urinate	C P

Sleep

Difficulty falling asleep	C P	Staying asleep	C P
Excessive dreaming	C P	Nightmares	C P
Wake at a particular time	C P	When	
Do you work night, graveyard, or swing shift?	C P		

Emotions

Do you experience excessive anger	C P	Fear	C P
Worry	C P	Sadness	C P

Please explain and comment if you wish: _____

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Women Only

How many days to your menstrual cycle _____ How long does the flow go on?_____

Are your periods regular _____ painful _____?

Describe the location of pain _____. Do you bleed excessively _____

Very little _____ varying amounts from period to period _____?

Do you discharge clots? _____What color is the blood? _____Do you have headaches associated with your period? _____ At what time during the period? _____

Where? _____ Do you have bothersome vaginal discharge? _____

Have you given birth? _____ How many times _____ any miscarriages _____

Terminations _____any trouble associated with or after birth, miscarriage (i.e., fatigue, menstrual change, weight gain, etc.) _____

Please explain _____

Is it possible that you are currently pregnant? _____ Have you ever had fertility problems? _____

Do you experience sexual dysfunction? _____

Men Only

Do you experience any sort of sexual dysfunction (i.e., lack of sexual interest, impotence, premature ejaculation, seminal emission etc.)? _____

_____

Do you suffer from any urogenital discharge or pain? _____

Testicular pain or swelling? _____

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Systems Check "P" for past, "C" for current

Cardiovascular:

Blood clots _____ chest pain _____ heart attack _____ heart murmur _____

High Blood pressure ____ Irregular heart beat _____ palpitations _____ shortness of breath____

Vertigo _____ edema _____ Other _____

Eyes:

Blurred vision ____ cataracts _____ double vision _____ dry eyes _____ glaucoma _____

Red eyes _____ Other _____

Ears:

Discharge from ears _____ earaches ____ ear infections _____ hearing difficulty _____

Loss of balance _____ ringing or buzzing _____ Other _____

Musculoskeletal:

Joint pain ____ Where _____ Neck pain _____ Back pain – upper _____

Middle _____ lower _____ Muscular pain _____ Where _____

Other _____

Neurological:

Tremors _____ paralysis _____ headaches _____ lack of concentration _____

Numbness _____ tingling _____

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Respiratory

Shortness of breath _____ wheezing _____ frequent colds _____ bronchitis _____

Asthma _____ cough _____ nasal allergies _____ congestions _____

sinus infections _____ Other _____

Skin

Acne _____ pimples _____ bruise easily _____ eczema _____ hives _____

Itching _____ rashes _____ moles _____ lumps _____

Other _____

Miscellaneous

Alcoholism _____ drug addiction _____ smoking _____ gall bladder _____

Headaches _____ diabetes _____ thyroid _____ Other _____

Is there anything else you think I need to know in order to best help you?

What would you most like to get out of your treatments?

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Acupuncture Information and Informed Consent

I hereby voluntarily request and consent to be treated, or give permission for my child to be treated with acupuncture and other techniques based on Traditional Asian Medicine. I understand I may be given diet/lifestyle recommendations and/or nutritional or herbal supplements and that it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. Although rare, certain sides effects may result from Acupuncture, I understand that each procedure or treatment has specific risks and benefits. I understand that student interns, or designees under supervision of licensed acupuncturists perform these treatments. I understand that Be Optimal Holistic Health Center may record medical and other information concerning my treatment in electronic and in other physical form. Such information may be released by the clinic for the purposes authorized on this form. I understand that portions of my medical records may be disclosed to qualified non-clinic personnel. I have not been guaranteed any success concerning the uses and effects of these treatments by Be Optimal Holistic Health Center. I understand I am free to discontinue treatment at any time.

Possible Side Effects /Healing Reactions I understand that these treatments may result in certain side effects, including local bruising, slight bleeding, broken needles, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

_____ _____

First Name Last Name

_____ _____

Patient Signature (Parent if under 18) Date

BE OPTIMAL OFFICE POLICIES

Communication is vital for good doctor patient relations. If you have any questions, comments, complaints or concerns, 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 the 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.

Any questions you have regarding our policies are welcome at any time.

Payment Policy

Our office is not affiliated with HMO's, PPO's, or health insurance companies. Patients are charged directly for all services rendered by this office. Payment is due in full at time of service. We accept cash, check, Visa, MasterCard, American Express or Discover for payment. This office does not carry balances.

Health Insurance

It is not our policy, under any circumstances, to submit bills to your insurance company. If your insurance company covers chiropractic benefits, and you intend to submit bills, please let us know and we will be happy to provide you with a statement/claim at the time of checkout. A minimum charge of $10.00 per month will be applied for statements/claims that need to be reissued to you. If your insurance covers our services, you will be reimbursed directly. Should a check be mistakenly issued to Be Optimal or any of our practitioners from your insurance company, the check will be voided and sent to you (the patient). It will be your responsibility to contact your insurance company for reissuance. Additionally, you authorize our office to furnish any necessary information requested by your insurance company to process the claims you have submitted.

Nutritional Supplements & Products

Nutritional supplements, health supplies and any other products must be paid for at time of service.

Returned Checks

The fee for returned checks is $30.

Late Cancellation Fee

Patients are required to give **24 business hours advanced notice** when canceling any appointments. Please note, this is during regular business hours. For appointments scheduled on a Monday, Saturday or New Patient Initial Appointments, we do require **48 business hours advanced notice (5 days preferred)**. This allows the opportunity for someone else to schedule an appointment. Due to the doctor's full schedules and patients being turned away for appointments, if you are unable to give us the full advance notice you will be charged a late cancellation fee for **half of the visit price.**

Missed Appointments

You are fully responsible for canceling and/or rescheduling your appointment(s). An automatic reminder system is used as a courtesy to aid you in keeping track of appointments. Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "No-Show" and will be **charged the full amount** for their missed appointment.

Late Arrivals

If you happen to arrive late for an appointment, your visit will likely be shortened and end at the originally scheduled time in order to accommodate other patients whose appointments follow yours. Depending upon how late you arrive, your doctor will have to determine if there is enough time remaining to start your treatment. Regardless of the length of the treatment provided, you will be responsible for the **full amount** of your scheduled appointment

Opened Products & Product Returns

Any and all products sold at Be Optimal are considered purchased and are non-returnable if opened by the patient. Any product returns must be done within 30 days of purchase, in original condition and unopened, for store credit. Any special/custom orders (products not typically stocked at Be Optimal) are non-returnable.

Notice of Medical Procedures

I will notify a member of the front office staff or my practitioner of any recent medical procedures/hospitalizations (e.g. plastic surgery, botox, vaccines, implants, etc.) within 48 hours of any upcoming appointments.

I agree with the above Be Optimal Office Policies.
Initials _____

ADDITIONAL POLICIES/CONSENTS

Consent To Treat

I hereby consent to treatment as provided by the Physicians working at Be Optimal as determined by the Physician's diagnosis and professional judgment. If I do not agree to a course of treatment, I will raise concern and discuss it with the Physicians of Be Optimal prior to administration of the treatment. I also understand that other exams and tests such as x-rays, lab tests, etc. may be necessary to gain more information regarding my health.
Initials _____

Correspondence

We communicate with our patients through mail, e-mail, by text and over the phone. These communications include, but are not limited to birthday greetings, appointment reminders, missed appointment rescheduling and holiday cards. All appointment reminders are done as a courtesy through a text service. I hereby consent to receive communications on my home and/or cell phone, including leaving voice or text messages as well as through mail and email. We always do our best to honor your requests when communicating with you. Indicate any way we may **NOT** communicate with you: ☐ Cell/Home Voicemail ☐ Text ☐ Mail ☐ Email
Initials _____ Preferred Phone Number: _____

Email List

I consent to receive emails related to marketing activities. These emails include our newsletters, updates, last minute openings & promotions. You have the ability to unsubscribe at any time.
☐ Yes ☐ No Initials _____

Sharing Information For Recommended Services

You agree to allow practitioners, including but not limited to Chiropractors, Nurses and Chinese Medicine Doctors to communicate with Be Optimal non-clinician based practitioners as to how they can best support your care. This is for services in which you are aware of the recommendation and have shown interest.
☐ Yes ☐ No Initials _____

Disclosure Of Information

Is there anyone you would like us to share your health information with during your course of treatment? ☐ Yes ☐ No
If yes, please provide, Name: _____Relationship: _____
Phone Number: _____

Privacy Notice

By signing, you acknowledge that you have had an opportunity to review our Notice of Privacy Practices and you understand and agree to the terms.
Signature: _____ Date: _____