Be Optimal
HOLISTIC HEALTH CENTER
Becoming Your Best You

Physicians Working At Be Optimal: **Dr. Cari Jacobson, DC**
Dr. Abby Kramer, DC
Dr. Naomi Smith, DC

Our mission is to help 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.

Please fill out this confidential health history form as completely as you can. All information provided is strictly confidential. The more information you provide us, the better we will be able to help you.

Today's Date: _____/_____/_____ How did you find out about our office?_____

PERSONAL HISTORY

Child's Name: _____ Parent(s)/Guardian(s)name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Age: _____ Birthdate: _____/_____/_____ Gender Identified As: _____

Cell phone: (_____) _____-_____ Work phone: (_____) _____-_____

Home phone: (_____) _____-_____Email: _____

Have you or your child ever had chiropractic care before? You: ❑Yes ❑No Your child: ❑Yes ❑No

If yes, please tell us the doctor's name: _____

Were you pleased with your care? ❑ Yes ❑ No

Is this appointment related to an auto accident? ❑ Yes ❑ No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.

Is your child receiving care from other healthcare professionals? ❑ Yes ❑ No

If yes, please name them and their specialty_____

Who is your family's primary care physician?_____

Please list any drugs or medications your child is taking _____

_____

Please list any vitamins/herbs/homeopathics/other your child is taking_____

_____

Please list any allergies your child has _____

_____

CURRENT HEALTH

What is your intention for bringing your child to Be Optimal Holistic Health Center? _____

_____

What health condition brings your child to our office? _____

_____

When did the symptoms first begin? _____

How did the problem start? ❑ Suddenly ❑ Gradually ❑ Post-Injury

Is this condition ❑ Getting worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Not Sure

What makes the problem better? _____

_____

What makes the problem worse? _____

Has your child ever had a similar condition? ❑ Yes ❑ No
Please explain _____

Has your child been treated for this problem before? ❑ Yes ❑ No
Please explain _____

_____

Is your child experiencing any pain, numbness, tingling or any other notable symptoms? ☐ Yes ☐ No
If so, where? _____

Circle the severity of the physical discomfort on the following scale:

Least 0 1 2 3 4 5 6 7 8 9 10

Describe your child's eating habits: _____

_____

What does your child commonly eat for breakfast?_____
Lunch: _____
Dinner: _____
Snacks: _____
Sweets: ☐ Chocolate ☐ Candy ☐ Desserts ☐ Daily ☐ Occasionally
Sodas: ☐ Caffeinated ☐ Decaffeinated ☐ Diet soda # per day _____ # per week _____
Water: ☐ Tap ☐ Bottled ☐ Filtered ☐ Seltzer/Tonic Average amount per day _____
Sugar**:** ☐ Regular ☐ Substitute, brand _____ ☐ Added to food ☐ Added to drinks - # of teaspoons _____
Food Substitute: ☐ Protein bars, brand _____☐ Protein shakes, brand _____☐ Whey ☐ Soy ☐ Rice ☐ Pea ☐ Other
Coffee: ☐ Caffeinated ☐ Decaffeinated Cups per day _____ Amount of sugar _____ Cream _____
Tea: ☐ Herbal ☐ Caffeinated Type of sweetener _____ Cups per day _____
Does your child have regular bowel/bladder movements? ❑ Yes ❑ No Please explain:_____

_____

Has your child ever been checked for vertebral subluxations? ❑ Yes ❑ No ❑ Unknown

Please mark if applicable:

Does your child drink Alcohol: □ Yes □ No □ Unknown

Does your child smoke Cigarettes: □ Yes □ No □ Unknown

Does your child Vape: □ Yes □ No □ Unknown

Does your child use any Drugs for recreational purposes: □ Yes □ No □ Unknown

HEALTH HISTORY

Child's birth was □ At Home □ At A Birthing Center □ At A Hospital

My obstetrician/midwife/family physician was _____

Child's Birth was: □ Natural vaginal (no medications/interventions)

□ Vaginal with interventions

□ Induction □ Pain Medication □ Epidural □ Episiotomy □ Vacuum Extraction □ Forceps

□ Other _____

□ C-section

□ Scheduled □ Emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____ Child's birth height _____ Current weight _____ Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____ Not sure/can't recall □

Was the child vaccinated or did they receive inoculations before leaving the hospital at birth? □ Yes □ No

GROWTH & DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? □ Yes □ No

If no, please explain _____

At what age did the child:

Respond to sound_____ Follow an object_____ Hold head up_____ Vocalize_____

Sit alone_____ Teethe_____ Crawl_____ Walk_____

Patient Hospitalization/Surgical history (please list all surgeries and hospitalizations with the date; from birth to present)

_____

_____

Is/was your child breastfed? □ Yes □ No If yes, how long?_____

Formula introduced at age _____ What type?_____

Introduction of cow's milk at age_____ Began solid foods at age _____

Please list any foods/juice intolerances _____

Did mother smoke during pregnancy □ Yes □ No Did mother drink alcohol during pregnancy □ Yes □ No

Did mother drink (or eat) diet sodas or artificial sweeteners during pregnancy? □ Yes □ No

Any illness of mother during pregnancy? □ Yes □ No

If yes, please explain including treatment/medications/supplements _____

_____

List any drugs/medications (including over the counter) taken during pregnancy_____

_____

List any supplements taken during pregnancy_____

Any exposures to ultrasound? ☐ Yes ☐ No If so, how many and what was the medical reason? _____

_____

Any pets at home? ☐ Yes ☐ No Any smokers at home? ☐ Yes ☐ No

Has child received any vaccinations? ☐ Yes ☐ No If yes, which ones, at what age, and list any reactions_____

_____

Has child received any antibiotics? ☐ Yes ☐ No If yes, how many times and list reason_____

_____

Any difficulty breastfeeding? ☐ Yes ☐ No If yes, please explain _____

_____

Any difficulty with bonding? ☐ Yes ☐ No If yes, please explain _____

_____

Any behavioral problems? ☐ Yes ☐ No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? ☐ Yes ☐ No If yes, please explain _____

_____

Age child began daycare _____

Average number of hours of TV/Digital media (iPod, computer, video games, etc.) per week _____

Was there any point at which you said, "that doesn't seem normal/right" since your child was born? ☐ Yes ☐ No

If yes, please explain_____

Does your child seem normal for his/her age? ☐ Yes ☐ No If no, please explain _____

_____

FAMILY HISTORY REVIEW

Are child's parents married? ☐ Yes ☐ No If no, when were they divorced? _____

Any siblings? ☐ Yes ☐ No If yes, ages: _____ M/F _____ M/F _____ M/F _____ M/F

Mother living? ☐ Yes ☐ No If yes, how old is she? ____

Please list any medical problems:

_____

_____

_____

_____

If no, what was the cause of death?

_____

Age at death _____

Father living? ☐ Yes ☐ No If yes, how old is he? _____

Please list any medical problems:

_____

_____

_____

_____

If no, what was the cause of death?

_____

Age at death _____

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

☐ Heart Disease _____ ☐ High Blood Pressure _____

☐ Diabetes _____ ☐ Stroke _____

☐ Cancer _____ ☐ Seizures _____

☐ Other _____

DO YOU KNOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? ☐ Yes ☐ No

Do any of your friends or relatives see a chiropractor? ☐ Yes ☐ No

If yes, do they use chiropractic for ☐ Health maintenance/optimization ☐ Health Problems ☐ Both

What would you like to gain from chiropractic care?_____

_____

Are there other health concerns or anything else you'd like us to know about your child?_____

_____

GOALS FOR YOUR CARE

We would like to thank you for choosing our office for your chiropractic and healthcare needs. It is our primary goal to provide the highest level of health care available. At Be Optimal Holistic Health Center, we know that people see chiropractors for a variety of reasons. Some go just for pain relief; some go to correct the CAUSE of their pain/symptoms as well; and others go even further by choosing complete health and wellness by correcting all areas of dysfunction going on in their bodies even before any symptoms are present.

Please check the type of care desired so that we can best serve your health needs.

☐ **Relief Care:** Pain/Symptom relief only

☐ **Corrective Care:** Correction of the CAUSE of the pain/symptoms as well as relief of the pain/symptoms.

☐ **Comprehensive Care:** Bring all areas of the body that are malfunctioning to the highest state of health possible, while correcting the cause and providing pain/symptom relief to the areas of complaint.

☐ **Other:** I want the doctor to select the type of care appropriate for my health and condition.

What are your health goals for your child?

_____

_____

Why did you choose Be Optimal Holistic Health Center?

_____

_____

For our time together to be successful, what do you want to take place over the course of your child's care here?

_____

_____

How long do you feel this will take?

_____

_____

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.

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 _____

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.

Initials _____

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.

Initials _____

Nutritional Supplements & Products

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

Initials _____

Returned Checks

The fee for returned checks is $30.

Initials _____

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.**

Initials _____

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.

Initials _____

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

Initials _____

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.

Initials _____

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.

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.

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.

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: _____

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CHIROPRACTIC INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

Our goal at Be Optimal is to evaluate each complaint and concern as thoroughly and accurately as possible. The physicians at Be Optimal will use as many different tools and objective manners as necessary to help with every individual case. If the physicians are unable to meet the needs of the individual complaint(s) to the best of their ability or if in their professional judgment determine another physician or treatment would be more beneficial, they will refer you to the most appropriate health care provider.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to 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, homeopathic remedies, various modes of physical therapy, and any other supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by working or associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor(s) of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctors feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I have weighed the risks involved in receiving treatment and agree that it is in my best interest (or the patient's best interest for whom I am legally responsible) to be treated. This consent form covers the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Date: _____

Patient Name: _____

Signature of Parent/Guardian: _____