

Optimum Wellness & Rehab Center
 Office of Dr. Jason B. Jones
 706 W. Ehringhaus St. Elizabeth City, NC 27909
 252-335-2225 www.optimumwellnessandrehab.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Date:	
Address:			
Street	City	State	Zip
Home phone:		Work phone:	
Cell phone:		Email address:	
Best time/place to contact you:			
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Height:		Weight:	
Driver's license number:		Social Sec. #:	
Marital status: M S W D		Spouse/guardian name:	
Your Occupation:			
Employer's name & address:			
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Do you have insurance that covers Chiropractic care?		Do you have Medicare coverage?	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Insurance Company:			
Insurance Policy number:		Insurance Company phone number:	
Insurance Company address:			

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury? Or something else?	% of the time pain is present
1.					
2.					
3.					
4.					

What does it feel like (Circle all that apply)? Sharp * Dull * Achy * Throbbing * Tingling * Numb * Cramping * Burning * Stiffness * Tightness * Stabbing * Shooting * Electric * Other _____

Does the problem move/radiate to other body parts? If so, where? Arm * Hands * Buttocks * Thigh * Calf * Feet * Ribs * Abdomen * Chest * Head * Neck * Groin * Other _____

Since the problem started is it: About the same? Getting better? Getting worse?

Which activities aggravate your condition (Circle all that apply)? Sitting * Standing * Walking * Lifting * Working * Exercising * Lying Down * Other _____

Is this condition interfering with any of the following (**CIRCLE ALL THAT APPLY**): *Work *Sleep *Sports/Exercise *Daily Routine *Playing w/Children *Bathing *Running *Housework *Yardwork *Hobbies *Lifting *Eating *Dressing *Grooming *Standing *Sitting *Lying down *Sex *Walking *Other (please explain) _____

What have you done for this condition? Tylenol * Advil * Aleve * Prescription Drugs * Muscle Rubs * Heat * Ice * Stretching * Exercise * Home Remedies * Physical Therapy * Surgery *Other _____

How helpful were the above? (Circle One) Not helpful * Somewhat helpful * Moderately helpful * Very helpful

Have you ever had x-rays taken for this condition?

Area of body:	When?	Where?
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Anyone in your family with a history of this or similar symptoms (Please explain):

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details (from above doctors seen):

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Often times lifestyle factors over a long period of time effect our health in ways that we may not even be aware of. Please take special care to answer the following questions carefully. Thank you.

Diet ----- Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables	Fast Food	Candy	Bread

The type of diet I usually follow is classified as: _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

- Physical stress (falls, accidents, work postures, work injuries, sports injuries, repetitive work postures, etc.)
 - _____
 - _____
 - _____
- Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, medications, drugs/alcohol, etc.)
 - _____
 - _____
 - _____
- Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - _____
 - _____
 - _____

----Have you ever had psychotherapy or counseling? Yes No **If Yes, Diagnosis?** _____
Currently being seen Previously If Previously, from _____ to _____
 What kind of counseling? _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

In the blank provided (when appropriate) please fill in how often the symptom occurs: (Example: ✓Heartburn 3x/week)

- | | |
|--|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Dental Problems _____ |
| <input type="checkbox"/> Arm Pain _____ | <input type="checkbox"/> Colitis/Crohn's/IBS/Diverticulitis _____ |
| <input type="checkbox"/> Cold/Tingling Extremities _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Confusion/Depression _____ | <input type="checkbox"/> Lung Problems/Congestion _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Mood Swings _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Swollen Ankles/Hands _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Prostate/Sexual Dysfunction _____ |
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Irregular Heartbeat _____ |
| <input type="checkbox"/> Excessive Thirst _____ | <input type="checkbox"/> Menstrual Cramps _____ |
| <input type="checkbox"/> Fainting _____ | <input type="checkbox"/> Varicose Veins _____ |
| <input type="checkbox"/> Fatigue/ Low Energy _____ | <input type="checkbox"/> Vision Problems _____ |
| <input type="checkbox"/> Fever _____ | <input type="checkbox"/> Ear Aches/Infections _____ |
| <input type="checkbox"/> Issues with Memory _____ | <input type="checkbox"/> Heart Problems _____ |
| <input type="checkbox"/> Frequent Nausea _____ | <input type="checkbox"/> Vaginal Pain/Infection _____ |
| <input type="checkbox"/> General Stiffness _____ | <input type="checkbox"/> Painful/Excessive Urination _____ |
| <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Hearing Difficulty _____ |
| <input type="checkbox"/> Hemorrhoids _____ | <input type="checkbox"/> Sinus Problems _____ |
| <input type="checkbox"/> Joint Pain/Stiffness _____ | <input type="checkbox"/> Abdominal cramps _____ |
| <input type="checkbox"/> Kidney Problems _____ | <input type="checkbox"/> Asthma/Breathing Problems _____ |
| <input type="checkbox"/> Liver Problems _____ | <input type="checkbox"/> Weight Trouble _____ |
| <input type="checkbox"/> Loss of Sleep _____ | <input type="checkbox"/> Recurring Infections _____ |
| <input type="checkbox"/> Low Back Pain _____ | <input type="checkbox"/> Gas/Bloating After Meals _____ |
| <input type="checkbox"/> Neck Pain _____ | <input type="checkbox"/> Black/Bloody Stool _____ |
| <input type="checkbox"/> Nervous _____ | <input type="checkbox"/> Irregular Periods _____ |
| <input type="checkbox"/> Numbness _____ | <input type="checkbox"/> Shortness of Breath _____ |
| <input type="checkbox"/> Pain Between Shoulders _____ | <input type="checkbox"/> Heartburn/Acid Reflux _____ |
| <input type="checkbox"/> Paralysis _____ | <input type="checkbox"/> Blood Pressure Problems _____ |
| <input type="checkbox"/> Poor/Excessive Appetite _____ | <input type="checkbox"/> Menstrual Irregularity _____ |
| <input type="checkbox"/> Stress _____ | <input type="checkbox"/> Gall Bladder Problems _____ |
| <input type="checkbox"/> TMJ/Clicking Jaw _____ | <input type="checkbox"/> Bladder Trouble _____ |
| <input type="checkbox"/> Vomiting _____ | <input type="checkbox"/> Breast Pain/Lumps _____ |
| <input type="checkbox"/> Walking Problems _____ | <input type="checkbox"/> Discolored Urine _____ |
| <input type="checkbox"/> Hot Flashes/Night Sweats _____ | <input type="checkbox"/> Eczema/Acne/Psoriasis _____ |
| <input type="checkbox"/> Urinary Tract Infections _____ | <input type="checkbox"/> Fibromyalgia _____ |
| <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Carpal Tunnel _____ |
| <input type="checkbox"/> Kidney Stones _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Irritability _____ | <input type="checkbox"/> Frequent Antibiotic Use _____ |
| <input type="checkbox"/> Always Hungry _____ | <input type="checkbox"/> Anxiety/Depression _____ |
| <input type="checkbox"/> Decreased Sex Drive _____ | <input type="checkbox"/> Tired after meals _____ |

Please list other problems you have or had (please explain) _____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Why are you here at this point in time? _____

Is there anything else which may help to better understand your condition which has not been discussed?

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION (required by NC Law)

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Appointment Reminders

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your informed consent, insurance and financial statements and privacy pledge and agree to its terms.

Signature

Date

This must be signed by legal guardian for anyone being seen under 18 years of age

CONSENT TO EVALUATE and TREAT A MINOR CHILD

I, _____ being the parent or legal guardian of
_____ grant permission for my child to receive treatment in this office.

If you agree, sign below:

Signature

Date

ALL PATIENTS: Before your visit today, just a few quick things...



- Payment is due at the time of the service.
- If you are not 100% sure of your financial responsibility, please ask immediately.
- **Medicare patients must pay for** any exams, x-rays, re-exams, modalities, extremity adjustments, products or supplements. it is your responsibility to pay the complete cost at the time received. If you are unsure of what your responsibility is, please ask immediately. **MEDICARE COVERS ADJUSTMENTS ONLY.**
- **Medicare patients are not eligible** by law for **any special discounts or free services.**

By signing below, I am stating that I understand fully the information as it is written.

Patient's Name (Print) : _____

Patient's Signature: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE (required by NC Law)

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. This doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic.

I understand that the doctor will perform an examination in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

Be advised that at Jones Family Chiropractic, PC no cures are ever implied or promised.

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 agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

I also state that I am here for evaluation, examination, recommendations and treatment only and am here for no other purposes.

Signature

Date