OptimalHealth
& Wellness Center, Ltd.

Welcome to Optimal Health & Wellness Center, Ltd.

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information

Patient Name _____
Today's Date _____ Date of Birth _____
Social Security # _____
Address _____
City _____
State _____ Zip _____

Gender _____
❑ Single ❑ Married ❑ Partnered ❑ Engaged
❑ Separated ❑ Divorced ❑ Widowed ❑ Minor
How many children do you have? _____
Please list any family members belong treated here _____

Occupation _____
Employer/School _____
Employer/School Address _____

Employer/School Phone ( ) _____

Contact Information

Home Phone ( ) _____
Cell Phone ( ) _____
Work Phone ( ) _____
Email Address _____
May we contact you via (check for all applicable)
❑ Home Phone Cell Phone ❑ Work Phone ❑ Email
The emails will be used for non-sensitive/non-urgent issues only

In case of emergency please contact:
Name _____
Relationship _____
Home Phone ( ) _____
Alternate Phone ( ) _____

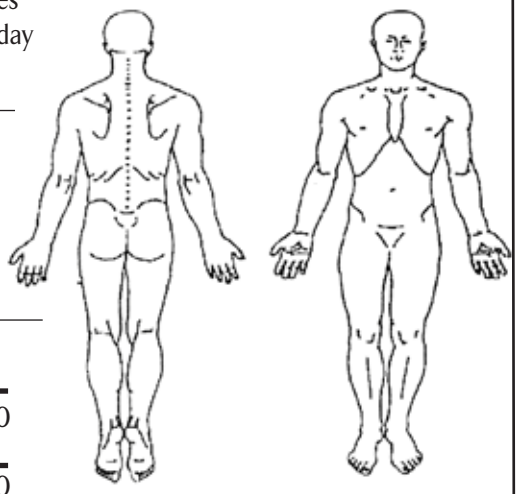
Spouse's/Partner's Name _____
Spouse's/Partner's Employer _____

Who referred you? _____

Patient Condition

What is your major complaint (be as specific as possible. Please mark all areas on the pictures where your condition,symptoms/pain occurs.)

When did your condition/symptom/pain first appear? (specific date, days ago, weeks ago, etc. _____
Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ It comes and goes
When is it worse? ❑ Morning ❑ Afternoon ❑ Evening ❑ Changes depending on time of day
Does it interfere with ❑ Work ❑ Sleep ❑ Daily Routines ❑ Recreation ❑ Other
How long has it been since you really felt good? _____
Other doctors seen for this condition ❑ MD ❑ DC ❑ DO ❑ DDS ❑ Other
Does the condition/symptom/pain radiate? ❑ Yes ❑ No
If yes, where and how frequently _____
How long/often does the radiation occur/last? _____
Do you have ❑ Numbness ❑ Tingling ❑ Weakness
Describe _____



List and mark the severity of your condition/symptoms/pain on the scale below:

Body part _____
0 (None) 5 (Severe) 10

Body part _____
0 (None) 5 (Severe) 10

Type of Pain ❑ Sharp ❑ Dull ❑ Throbbing ❑ Tingling ❑ Shooting ❑ Burning ❑ Aching ❑ Numbness ❑ Other

What activities or positions aggravate your condition? ❑ Bending ❑ Coughing ❑ Getting up/down ❑ Driving ❑ LIfting
❑ Lying down ❑ Sneezing ❑ Standing ❑ Straining at stool ❑ Turning head ❑ Twisting ❑ Walking

Patient Condition

What activities or positions relieve your condition? ❑ Heat ❑ Lying Down ❑ Sitting ❑ Stretching ❑ Other
❑ Ice ❑ Medication ❑ Massage ❑ Exercise

Have you ever had this condition before? ❑ Yes ❑ No If yes, when? _____

Were you treated for this condition or a similar one before? ❑ Yes ❑ No If yes, when/by whom? _____

Health History

Do you have any allergies? (food, contact, environmental)

List any vitamins, herbs and supplements you take ❑ Yes ❑ No If yes, when? _____

When was your last: physical examination _____; Blood/lab work _____; X-ray study _____

Injuries/Surgeries you've had and when? _____

_____

Have you had or do you have any of the following conditions or diseases? Please check any that apply to indicate yes.

❑ AD/HD
❑ Adrenal disorder
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Autoimmune disorder: _____
❑ Bleeding disorder
❑ Blurred vision
❑ Bowel/Bladder problems
❑ Buzzing in ear
❑ Cancer - type? _____
❑ Carpel tunnel syndrome
❑ Celiac disease (gluten)
❑ Chest pains
❑ Chronic fatigue
❑ Cold hands and feet
❑ Colitis/diverticulitis
❑ Compression fractures
❑ Connective tissue issues
❑ COPD
❑ Depression
❑ Diabetes
❑ Digestive/bowel problems
❑ Dizziness or vertigo
❑ Ear infections
❑ Fibromyalgia
❑ Food sensitivity
❑ Fusions (spinal, joint)
❑ Gout
❑ Gall bladder issue
❑ Immune compromise
❑ Heart disease
❑ Hepatitis (A, B, C, etc.)
❑ Herpes
❑ High blood pressure
❑ Hip replacement
❑ HIV/AIDS
❑ Kidney disease
❑ Knee surgery
❑ Liver disease
❑ Marfan's syndrome
❑ Multiple sclerosis
❑ Osteoporosis/penia
❑ Parkinson's disease
❑ Rotator cuff problems
❑ STI/STD
❑ Shoulder surgery
❑ Spinal surgery
❑ Stroke/TIA
❑ Thyroid problems
❑ Tuberculosis
❑ Other _____

Are there any conditions that run in your family? ❑ Yes ❑ No If yes, what condition(s) and which family member(s)?

_____

Patient Condition

Are you currently pregnant, or do you think you may be pregnant? ❑ Yes ❑ No If yes, how many weeks? _____
How many hours per week do you typically work/attend school? ❑ <20 hrs ❑ 30 hrs ❑ 40 hrs ❑ >40 hours
What are your typical duties and postures (sitting, standing, lifting, etc.)? _____
Do you exercise? ❑ Yes ❑ No If yes, how often and what type? _____
How would you rate your eating habits? ❑ Excellent ❑ Pretty Good ❑ Could be better ❑ Needs Improvement
How well do you sleep? ❑ Excellent ❑ Pretty Good ❑ Restless ❑ Can't sleep ❑ Wake up often
How many hours of sleep do you get daily? _____ hours, and do you feel rested in the morning ❑ Yes ❑ No
How is your energy overall? ❑ Full Power ❑ OK ❑ Low ❑ Sporadic/Generally fatigued ❑ I depend on caffeine for energy
How often do you get "sick"? ❑ Almost never ❑ I tend to catch what is going around ❑ I am constantly sick
What do you hope to receive from our program? _____

My Current Diet

Name _____ Date _____

List your diet on an average day below. Don't' worry about trying to impress us by telling the doctor what you think he wants to hear. Just think about how you eat on an average day. ***Be realistic.***

Check all meals that you eat each day (check all that apply):
❑ Breakfast ❑ Snack ❑ Lunch ❑ Snack ❑ Dinner ❑ Snack

A typical breakfast consists of _____

A typical lunch consists of _____

A typical dinner consists of _____

A typical snack between meals consists of _____

How much water do you drink per day? _____

Do you drink green/black tea? _____

How much coffee do you drink per day? _____

How much soda pop do you drink per day _____

List any know food sensitivities or allergies _____

List foods you crave _____

_____

_____

My Surgical History

List the type of surgery, reason for the surgery and year performed. (I.e.: 'Left breast surgery for cancer in 2004')

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

—Thank you for completing our Health Care questionnaire.

My Medications

Name _____ Date _____

List the name of each current prescribed and over the counter medications, it's prescribed use and any side effects/reactions/positive responses — (example of use: BCP - birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.) — (example of side effect could be 'Tylenol caused liver enzymes to increase.').

	Medications	Prescribed Use	Side Effects
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			