OPTIMUM CHIROPRACTIC NEUROLOGY CENTER, LLC

Outline Procedure for New Patients

Step One: All new patients are requested to fill out a personal health questionnaire prior to their appointment.
Step Two: Your consultation with a doctor to discuss your health problems.
Step Three: Diagnostic chiropractic, orthopedic and neurological examination procedures to determine if chiropractic care is appropriate for your condition.
Step Four: You will be advised if there is the need of any additional procedures such as x-rays, MRI, & CAT scan.
Step Five: If your case requires immediate attention, treatment will be administered.
Step Six: You will be advised as to a time you can return for your "Report of Findings" so that the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will be informed of specific recommendations in regards to your condition.
Step Seven: If appropriate, your treatment plan will begin following your "Report of Findings".

Confidential Patient Information

Name _____ Date _____DOB Birth _____

Age _____ Sex: ☐ Male ☐ Female ☐ Other Marital Status: How many Children? ____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

By providing us with your email you are giving us permission to email you regarding OCNC news and promotions. We will never sell or rent your email address. And you can opt-out of receiving emails from us at any time.

Referred by: ☐ Patient (name) _____ ☐ Physician (name) _____
☐ Therapist (name) _____ ☐ Ad (location) _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Full-time Student ☐ Part-time Student

Occupation _____ Employer _____

Employer Address _____City _____ Zip _____

Name of Spouse/Partner _____ Occupation _____

Employer _____ Address _____

IN CASE OF EMERGENCY: (name of relative or close friend not living in your home)

Name _____ Hm Phone _____ Wk Phone _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional wellbeing (Comprehensive Care). Chiropractic Neurology offers some of the latest advanced procedures for optimizing your nervous system function.

Optimum Chiropractic Neurology Center, LLC stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

□ Relief Care □ Corrective Care □ Comprehensive Care □ I would like to discuss options with the doctor

Patient Signature_____ Date _____

Please list your major complaints in order of severity:

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

Complaint #1: When did you first notice this condition? _____

Did it begin ☐ immediate or ☐ gradually? (Please describe briefly) _____

_____

What is the exact location of your symptoms? _____

_____

Do your symptoms spread? ☐ No ☐ Yes Where? _____

How often do you experience these symptoms?

☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)_____

Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged

What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) _____

Is your pain ☐ Deep or ☐ Superficial

Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing

Are you experiencing any of the following associated symptoms? ☐Pins & Needles ☐ Tingling ☐ Numbness

☐ Twitching of muscles If yes, please describe _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

___ Sitting ___ min	___ Lying	___ Lifting ____ lbs	___ Bowel movements	___ Hot or Cold
___ Standing	___ Pushing	___ Gripping	___ Mental activities	___ _____
___ Walking	___ Pulling	___ Coughing/sneezing	___ Bright lights	___ _____

Please indicate what helps you to relieve the pain:

☐ Lying ☐ Walking ☐ Rest ☐ Medications_____

☐ Sitting ☐ Standing ☐ Heat and Cold ☐ _____

List what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

_____

**********Do not write below this line**********

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Complaint #2: _____ When did you first notice this condition? _____
Did it begin ☐ immediate or ☐ gradually? (Please describe briefly) _____
_____
What is the exact location of your symptoms? _____
Do your symptoms spread? ☐ No ☐ Yes Where? _____
How often do you experience these symptoms?
☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)_____
Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) _____
Is your pain ☐ Deep or ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing
Are you experiencing any of the following associated symptoms? ☐Pins & Needles ☐ Tingling ☐ Numbness
☐ Twitching of muscles If yes, please describe _____
Please indicate what activities provoke (P) or aggravate (A) your condition:

___ Sitting ___ min	___ Lying	___ Lifting ____ lbs	___ Bowel movements	___ Hot or Cold	
___ Standing	___ Pushing	___ Gripping	___ Mental activities	___	_____
___ Walking	___ Pulling	___ Coughing/sneezing	___ Bright lights	___	_____

Please indicate what helps you to relieve the pain:
☐ Lying ☐ Walking ☐ Rest ☐ Medications_____
☐ Sitting ☐ Standing ☐ Heat and Cold ☐ _____
List what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

Complaint #3: _____ When did you first notice this condition? _____
Did it begin ☐ immediate or ☐ gradually? (Please describe briefly) _____
_____
What is the exact location of your symptoms? _____
Do your symptoms spread? ☐ No ☐ Yes Where? _____
How often do you experience these symptoms?
☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)_____
Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) _____
Is your pain ☐ Deep or ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing
Are you experiencing any of the following associated symptoms? ☐Pins & Needles ☐ Tingling ☐ Numbness
☐ Twitching of muscles If yes, please describe _____
Please indicate what activities provoke (P) or aggravate (A) your condition:

___ Sitting ___ min	___ Lying	___ Lifting ____ lbs	___ Bowel movements	___ Hot or Cold	
___ Standing	___ Pushing	___ Gripping	___ Mental activities	___	_____
___ Walking	___ Pulling	___ Coughing/sneezing	___ Bright lights	___	_____

Please indicate what helps you to relieve the pain:
☐ Lying ☐ Walking ☐ Rest ☐ Medications_____
☐ Sitting ☐ Standing ☐ Heat and Cold ☐ _____
List what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

Family History Have any of your family members suffered from any of the following conditions?

☐ Diabetes ☐ Neurological Disorders _____ ☐ Depression/Mental Illness
☐ Heart Disease ☐ Autoimmune Diseases _____ ☐ _____
☐ Stroke ☐ Cancer _____ ☐ _____

Medications Please list your current medications and what taken for _____

_____

_____

Vitamins and Minerals

Do you take vitamins or minerals ☐Yes ☐ No Do you think you need vitamins or minerals ☐ Yes ☐ No

Are you wearing: ☐ Inner Soles ☐ Heel Lifts ☐ Sole Lifts ☐ Arch Supports

Habits

Tobacco	☐ Heavy	☐ Moderate	☐ Light	☐ None
Alcohol	☐ Heavy	☐ Moderate	☐ Light	☐ None
Coffee	☐ Heavy	☐ Moderate	☐ Light	☐ None
Drugs	☐ Heavy	☐ Moderate	☐ Light	☐ None
Exercise	☐ Heavy	☐ Moderate	☐ Light	☐ None
Water	☐ Heavy	☐ Moderate	☐ Light	☐ None
Appetite	☐ Heavy	☐ Moderate	☐ Light	☐ None
Sleep	☐ Heavy	☐ Moderate	☐ Light	☐ None

CHECK any of the following conditions you have HAD and CIRCLE any condition you HAVE currently.

☐ Mental Disorders ☐ Diabetes ☐ Pneumonia ☐ Infective Diseases _____
☐ Venereal Infection ☐ Anemia ☐ Tuberculosis ☐ Fungal Infection _____
☐ Scarlet Fever ☐ Glaucoma ☐ Hepatitis _____ ☐ Herpes _____
☐ Heart Disease ☐ Alcoholism ☐ Thyroid Disease ☐ Drug Addiction _____
☐ Rheumatic Fever ☐ Arthritis ☐ Parasites ☐ Cancer _____
☐ Autoimmune Disease ☐ Tumors ☐ Epilepsy ☐ _____

Nervous System
☐ Depression
☐ Memory Loss/Confusion
☐ Dizziness
☐ Numbness
☐ Weakness
☐ Poor Balance/Coordination
☐ Twitches/Tremor
☐ Cold/Tingling Extremities
☐ Sleeping Difficulties
☐ Headaches

EENT
☐ Vision Problems
☐ Flashing Lights
☐ Black Spots
☐ Blurriness
☐ Hearing Loss
☐ Ringing in Ears
☐ Swallowing Difficulty

Cardio Vascular
☐ Chest Pain
☐ Irregular Heartbeat
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling

GI
☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Frequent Diarrhea
☐ Frequent Constipation
☐ Hemorrhoids
☐ Black/Bloody Stool
☐ Digestive Problems
☐ Abdominal Cramping
☐ Gas/Bloating After Meals
☐ Heartburn
☐ Weight Issues
☐ Gall Bladder Problems
☐ Liver Problems

GU
☐ Bladder Trouble
☐ Painful Urination
☐ Discolored Urination

Musculoskeletal
☐ Jaw Pain
☐ Difficulty Chewing
☐ Face Pain
☐ Neck Pain
☐ Arm/Elbow Pain
☐ Wrist/ Hand Pain
☐ Mid Back Pain
☐ Lower Back Pain
☐ Thigh/Knee Pain
☐ Ankle/Foot Pain
☐ Difficulty Walking
☐ Leg/Arm Fatigue

Reproductive
☐ Erectile Difficulties
☐ Sexual Dysfunction
☐ Menstrual Irregularity
☐ Menstrual Cramping

How often do you have a bowel movement? _____ Are your movements consistent? ☐ Yes ☐ No
Do your stools ☐ float or ☐ sink?

How many times a day do you urinate? _____ Is this consistent? ☐ Yes ☐ No _____
Do you experience any urgency, dribbling, incontinence? _____

How long has it been since you really felt good? _____
What do you believe is wrong with you? _____
Have you been treated for any health conditions by a physician in the last year? _____

Family Doctor _____ Address _____
Send a report ☐Yes ☐ No

Payment is expected at time of visit.
Name of person responsible for payment _____
Are you insured? ☐Yes ☐ No Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Optimum Chiropractic Neurology Center, LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Optimum Chiropractic Neurology Center, LLC will be credited to my account on receipt . However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card
Card name # _____ Exp. Date _____
Patient's Signature _____ Date _____
Guardian or Spouse's Signature Authoring Care _____ Date _____
Information Taken By _____ Date _____

**********Do Not Write Below Line **********