Name:	**Birthdate:**		**Date:**
Address:	**City:**	**State:**	**Zip:**
Phone:	**Email:**		
Marital Status:	**Gender:**		
Employer	**Employer Phone:**		
Social Security #	**Driver's License #**		
Insurance Company:	**Insured Name:**		
Emergency Contact:	**Emergency Contact Phone:**		

How did you hear about Optimum Health and Wellness?

_____

Why are you presenting to our office today?

_____

Does this complaint affect your:

Hobbies: Yes / No Explain: _____

Family Life: Yes / No Explain: _____

Social Life: Yes / No Explain: _____

Work: Yes / No Explain: _____

What are your current health goals? (Mark all that apply)

___ I am concerned with the above complaints

___ I just want to be pain free

___ I want to be as healthy as possible

___ I want to stop taking medication

___ I feel like I need to Detox my body

___ I am concerned with my future health

___ I am interested in wellness

___ I need to learn to manage stress

___ I am ready to change my lifestyle

___ Other: _____

How dedicated are you to reaching these goals?

0%---------- 25% ---------- 50% ---------- 75% ---------- 100%

On a scale of 0 (No Stress) – 10 (Extreme Stress), what is your current stress level?

0 1 2 3 4 5 6 7 8 9 10

Please list your future health goals?

_____

_____

How dedicated are you to reaching these goals?

0%---------- 25% ---------- 50% ---------- 75% ---------- 100%

How dedicated to your health do you want your doctor to be?

0%---------- 25% ---------- 50% ---------- 75% ---------- 100%

On a scale of Poor, Fair, Good, or Excellent please describe your:

Diet: _____ Exercise: _____ Sleep: _____ Overall Health: _____

What are your current medications?

_____

_____

What are you current supplements?

_____

_____

Please list past or present allergies?

_____

_____

Describe any current or past health conditions (i.e. injuries, surgeries, high cholesterol)

_____

_____

Describe any family history of illness (i.e. stroke, cancer, diabetes)

_____

_____

Do you have pain that wakes you up at night?	**Yes / No**
Have you experienced unexplainable weight loss or weight gain?	**Yes / No**
Do you have fever, chills, or night sweats?	**Yes / No**
Do you have a loss of bowel/bladder function?	**Yes / No**
Have you ever been diagnosed with cancer or an autoimmune disease?	**Yes / No**

If you answered yes to any of the questions above, please explain:

_____

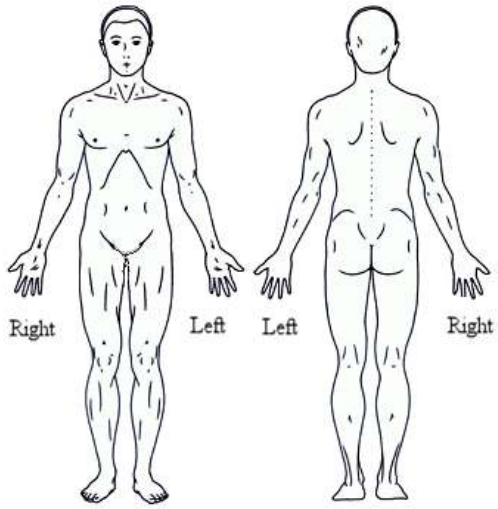
_____

Is there anything else in your medical history that you consider to be relevant?

_____

_____

Reason for seeking care:	
How did your condition start?	
How long have you had this condition?	**Is it getting better/worse/same?**
Have you had this condition before?	**If so, when?**
What activities aggravate your condition/pain?	
What activities lessen your condition/pain?	
Have you seen another provider for this condition? Y / N	
Have you been to a chiropractor in the past? Y / N	



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Is there radiation present? Yes / No
If so where? _____

What percentage of the day do you experience these symptoms? 0 ----------50----------100

This section is for the doctor only

Postural Findings:

Head: Tilt: L R Carriage: A P
Shoulder: Elevation: L R Rotation: A P
Crests: Elevation: L R Rotation: A P
Knees: Valgus Varus Recuvarum
Leg Length: Short Leg: L R

Range of Motion:

Cervical: WNL Flex_____ Ext____
RR____ LR____ RLF____ LLF____
Lumbar: WNL Flex_____ Ext____
RR____ LR____ RLF____ LLF____

MSR's

Upper Extremity:

C5	**M**	**S**	**R**
C6	**M**	**S**	**R**
C7	**M**	**S**	**R**
C8	**M**	**S**	**R**
T1	**M**	**S**	**R**

Lower Extremity:

L4	**M**	**S**	**R**
L5	**M**	**S**	**R**
S1	**M**	**S**	**R**

Subluxation Findings

Seg	P	A	R	T	S

Special Tests:

Vitals: Height: _____ **Weight:** _____ **Blood Pressure:** _____/_____ **Pulse:** _____ **MetaOxy** ____

Optimum Health & Wellness, PLLC

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

Column #1		Column #2	
	Anxiety		Sensitivity to light
	Mood swings		Fatigue after exercising (feeling worse)
	Enraged behavior or anger for no reason		Bad night vision or seeing halos around lights
	Excessive shyness, timidity, social phobia (not typical to your personality)		Shortness of breath, with very little effort
	Irritability (not typical to your personality)		Excessive thirst and/or frequent urination
	Low body temperature (below 97.5º)		Red eyes or tearing
	Insomnia (can't get to sleep or return to sleep		Blurred vision at times
	Dizziness		Morning stiffness
	Sound in ears (ringing or hearing your heart beat)		Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Psychological symptoms, even thoughts of suicide		Chronic fatigue or weakness
	Sensitivity to sound		Non-restful sleep
	Indecisiveness		Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Feeling of being overwhelmed or fearful		Trouble processing new information
	Metallic taste in your mouth		Word reversal or trouble finding words
	Bad breath		Sensitivity to touch
	Bleeding gums		Short-term memory loss
	Sensitive teeth		Chronic sinus congestion
	Canker sores or other sores in the mouth		Dry non-productive cough
	Floaters, shadows or swimmers when you read or look into the sky		Muscle twitching
	Dyslexia or loss of place while reading, even as a child		Excessive sweating, especially at night
	Swelling eyelids		Joint pain-not necessarily true arthritis-can move from joint to joint
	Peeling on top layer of skin (hands, feet)		Difficulty losing weight regardless of diet or exercise
	Dry skin		Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Heart pain (angina) and you are under 45 years old		Frequent illness, prolonged illness or sick days
	Depression		Numbness or weakness in arms and legs
	Gout (arthritic pain, especially in big toes)		Headaches
	Pain in shoulders or upper back		Trouble adding or dividing numbers in your head
	Twitching eyelids		Fluctuating constipation and diarrhea
	Anemia (low iron/hemoglobin on blood test)		Stomach pain for no apparent reason
	Wrist/ankle drop or weak extensor muscles		Appetite swings
	Hair falls out (not normal male pattern baldness)		Frequent muscle aches, cramps, unusual sharp sudden pains
			Rashes or rosacea
			Cold extremities (hands and feet)

	Total Columns 1 & 2

Patient Policies

Revised March 2014

Below you will find information regarding your rights and responsibilities and established policies of Optimum Health and Wellness, PLLC. Please read this carefully and sign at the bottom. This Patient Policy form is to be completed by the patient, or the patient's legally authorized representative/parent:

Appointments:
Appointments can be made by calling (406) 317-1014. Arrive to your appointment 15 minutes early if possible. We will make every effort to see you on time, or inform you if there is a delay. Likewise a call to our office is appreciated if a late arrival is expected. If you are a chiropractic patient of ours, please do not discuss nutrition related questions with Dr. Engel during adjusting hours. A follow-up appointment outside of chiropractic hours is required if you would like to review or update your supplement regimen or discuss nutritional matters.

Cancellation Policy:
You must call to cancel an appointment in order to avoid being charged the full fee. Chiropractic appointments: 24 business hours. Nutrition appointments: 48 business hours. For example, if your nutrition appointment is on Monday, you must call the week before on Thursday to cancel your appointment. Missed appointments without the appropriate cancellation notification will result in the full fee being charged to the patient. If treatment is terminated prior to contract completion financial responsibility to the patient is assessed at a per visit fee based on the type of consultation.

Confidentiality: HIPPA Privacy Policy
To ensure quality record maintenance and patient confidentiality, Optimum Health and Wellness, PLLC will conduct routine patient record audits. To comply with state and federal laws regarding patient confidentiality, I understand that no information about my treatment will be released to anyone unless I provide written authorization. The only exception to this would be if I have not paid for services and are sent to collections for payment; then necessary information will be released in order for Dr. Engel or the assistant of his choice to be paid for service. I also understand that there are limits to my confidentiality, including the following:
- Where there is the risk of imminent harm to myself or another person, we at Optimum Health and Wellness, PLLC have the legal and/or ethical duty to take the appropriate steps to protect life.
- When a court orders a release of information, we at Optimum Health and Wellness, PLLC are bound by law to comply.
- When there is reason to believe that child or an elderly person is in danger or is being abused (physically, emotionally, or sexually), we at Optimum Health and Wellness, PLLC are obligated by law to report the abuse.
- In response to a subpoena from a court of law.

Fees and Financial Agreement:
Fees for service are due at the time the service is provided including telephone consultations. Cancellation policy is outlined above. Forms of payment accepted include: cash, check and credit card. *There is a $25.00 service charge for personal checks returned for any reason.* Nutritional consultations are a non-billable service. The patient is responsible for any non-covered service as determined by your insurance carrier. Insurance company quoted benefits is not a guarantee of payment. I understand that it is my responsibility, prior to any consultation, to determine insurance coverage. Due to the additional time and costs incurred, there is a charge for extended or complex phone calls, and for extensive letters needed on an immediate basis, reports, or extended calls done on your behalf to other clinicians or insurance companies/agencies etc. At our discretion, simple letters that are not time sensitive can be provided within 5 – 10 business days at no expense. Phone conversations are not covered by any insurance plan. Payment for these phone consults will be an out-of-pocket expense.

Emergency Contact/Crises:
I understand that Dr. Engel is not on-call 24 hours a day. We do not give out personal phone numbers of any employed personnel of Optimum Health and Wellness, PLLC. I understand that I am free to call Dr. Engel at his office phone number during off hours and leave a phone message. I understand that non-emergent concerns will be addressed within 2 – 3 business days. In cases of emergency when immediate help and counsel is needed I understand the local resources available are: Emergencies: 911

Treatment Process and Your Rights Regarding Treatment:
I understand that Dr. Engel and I will work together to define my goals for chiropractic and nutrition. Since nutrition is not an exact science, I understand that the results of treatment can be variable. I understand that the attainment of a positive outcome is dependent upon the effort I am willing to put into this experience. I understand that I have the right to ask questions about my treatment. I also have the right to end chiropractic treatment or nutritional counseling at any time and understand that I should notify Optimum Health and Wellness, PLLC when I am finished. If I decide that I would like to continue my treatment or counseling with another professional, we at Optimum Health and Wellness, PLLC will facilitate that process. I understand that Dr. Engel also reserves the right to refer me to another professional if the level of care provided at Optimum Health and Wellness, PLLC is assessed to not be the appropriate level of care. I have been informed that Dr. Engel has the right to terminate services offered with a 30 day written notification given to the client with a listing of referrals for continuity of care. By signing this document I acknowledge that I have voluntarily chosen to participate in a program of chiropractic and/or nutrition planning. In signing this document, I acknowledge that I have informed Optimum Health and Wellness, PLLC and its representatives of all possible allergies. I also understand that all supplements that Optimum Health and Wellness, PLLC recommends are suggestions and I should not take them without reading all labels and warning information. Furthermore, I will do my own research before taking these products. By signing this document, I assume all risk for my health and well-being and hold harmless of any responsibility, the facility, Dr. Engel or any staff members of Optimum Health and Wellness, PLLC. I understand that questions about chiropractic, nutrition, toxicity protocols and supplementation procedures and recommendations are encouraged and welcomed. I also understand that this Patient Policy is subject to change at our discretion.

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including Paraspinal EMG scanning and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed. My questions have been answered to my satisfaction.

BEFORE TREATMENT CAN BE PROVIDED, please sign below showing that you read and understand the above information. A copy of this consent can be requested for your records. Your consent can be revoked with written notice at any time for future treatment. I consent to treatment for myself or for the patient for whom I am the parent or legally authorized representative.

Signature of Patient_____ Date_____

Signature of Parent/Guardian_____ Date_____
(If patient is a minor)

Witness Signature_____ Date_____