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. The more information you provide us, the better we will be able to help you.

Today's Date: _____/_____/_____ Whom may we thank for referring you to our office?_____

PERSONAL HISTORY

Name: _____ If Child, please list parent's name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Age: _____ Birthdate: _____/_____/_____ Gender Identified As: _____
Cell phone: (_____) _____-_____ Work phone: (_____) _____-_____
Home phone: (_____) _____-_____ Email: _____
Occupation: _____
Marital Status: ☐ Single ☐ Married, How long? _____Spouse's Name: _____
☐ Divorced, How long? _____☐ Widowed, How long? _____
Children: ☐ Yes ☐ No If yes, ages: _____ M/F _____ M/F _____ M/F _____ M/F
In an emergency, whom do we contact? (Name/Relationship): _____
Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

FAMILY HISTORY

Are your parents married? ☐ Yes ☐ No If no, when were they divorced? _____
Do you have 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 _____ ☐ Other _____

CURRENT HEALTH CONCERNS

What is your intention for visiting Be Optimal Holistic Health Center?

_____

Primary health concern(s) and conditions:

_____

_____

Are you 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 Most

Do you have any recurring symptoms? If yes, please explain, including the approximate time of day the symptoms are most pronounced:

_____ _____ : _____ am/pm

_____ _____ : _____ am/pm

Other Health Challenges:

_____

_____

How would you describe your energy level? For example, is there a time of day where you feel you have more energy? Less energy?

_____

_____

What treatments have you already received for this condition?

☐ Medications ☐ Nutritional Support ☐ Other – please list:

☐ Physical Therapy ☐ Surgery _____

☐ Chiropractic Services ☐ Counseling _____

Have you had any intolerance or reaction to treatments? ☐ Yes ☐ No

If yes, describe: _____

Has it become worse recently? ☐ Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

Frequency of symptoms? ☐ Constant ☐ Daily ☐ Intermittent

How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Intermittent

Does anything relieve the symptom(s)? ☐ No ☐ Yes

☐ Rest ☐ Medication (Prescription or OTC) ☐ Exercise/Stretch ☐ Other: _____

What makes the symptoms worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Lifting ☐ Twisting

What do you believe is the cause of the symptoms? _____

Are you presently under the care of any other healthcare practitioners who have treated this condition?

☐ Acupuncture ☐ Massage Therapist ☐ Nutritionist ☐ Other: _____

PLEASE LIST ANYTHING YOU ARE CURRENTLY TAKING (PRESCRIBED OR OVER THE COUNTER)

Medications:

_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____

Vitamins:

_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____

Nutritional Supplements:

_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____
_____ **Number per day** _____ **Date Started** _____

PAST HEALTH HISTORY

Date of Last:

Health Exam _____ Spinal X-Ray _____ Urine Test _____ Spinal Exam _____ Chest X-Ray _____
Dental X-Ray _____ Blood Test _____ MRI _____ CT Scan _____ Bone Scan _____
Other: _____

Surgeries/Operations: (If yes, list the date)

Appendix _____ Tonsils _____ Hernia _____ Spinal _____ Plastic Surgery _____ Organs _____
Broken Bones _____ Dislocations _____ Gallbladder _____ Adenoids _____ Transplants _____
Scars _____ Other _____

Major accidents, falls, or head injuries since birth _____
Have you ever been in an accident? ☐ Yes ☐ No If yes, what type? _____
When? _____ Please describe your injuries and the treatment you received: _____
_____

Hospitalizations (other than above):

_____
_____

Please check any of the following conditions that you have had in the past:

☐ Pneumonia
☐ Mumps
☐ Tuberculosis
☐ Thyroid Disorder
☐ Influenza
☐ Polio
☐ Arthritis
☐ Heart Disease
☐ Cancer
☐ Anemia
☐ Rheumatic Fever
☐ Small Pox
☐ Measles
☐ Pleurisy
☐ Eczema/Psoriasis
☐ Whooping Cough

In the past six months have you experienced any of the following:

Musculoskeletal
☐ Low Back Pain
☐ Pain b/w the shoulders
☐ Neck pain
☐ Shoulder/arm/wrist pain
☐ Joint pain or stiffness
☐ Difficulty walking
☐ Jaw/head pain

Nervous System
☐ Cold/tingling extremities
☐ Numbness/loss of sensation
☐ Dizziness
☐ Fainting
☐ Forgetfulness
☐ Depression
☐ Seizures
☐ Paralysis
☐ Nervousness/Stress

General
☐ Allergies
☐ Fatigue
☐ Loss of sleep
☐ Unexplained fevers
☐ Headaches

Gastrointestinal
☐ Poor Appetite/Underweight
☐ Excessive thirst
☐ Frequent nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver problems
☐ Colitis/Crohn's/IBS
☐ Gall bladder problems
☐ Abdominal cramps
☐ Gas/bloating after meals
☐ Heartburn
☐ Blood in stool

Genitourinary
☐ Painful/excessive urination
☐ Discolored urine
☐ Bladder infections
☐ Urinary leakage

EENT
☐ Vision problems
☐ Dental problems
☐ Earache/infection
☐ Difficult hearing
☐ Ringing in ears
☐ Cold/Flu
☐ Sinus problems
☐ Sore throat

Cardiovascular
☐ Chest pain
☐ Shortness of breath
☐ High blood pressure
☐ Irregular heart beat
☐ Stroke
☐ Lung congestion
☐ Varicose veins
☐ Ankle swelling
☐ Lung symptoms

Male Only
☐ Prostate dysfunction
☐ Loss of libido
☐ Sexual dysfunction

Women Only
☐ Menstrual cramps
☐ Irregular/absent periods
☐ Vaginal pain/infection
☐ PMS
☐ Loss of libido
☐ Menopausal symptoms
☐ Breast pain
☐ Uterine/ovarian fibroids

Date of last period?
_____/_____/_____

Have you ever had an abortion? ____

Are you pregnant? ☐ Yes ☐ No
☐ Not sure

Other Health Issues:

_____

_____

ALLERGIES

Do you have any allergies (seasonal, medicine, food, etc.)?: ☐ Yes ☐ No If yes, what is the reaction for each?

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Do you have any intolerances/sensitivities?: ☐ Yes ☐ No If yes, what is the reaction for each?

Intolerance/Sensitivity: _____ Reaction: _____
Intolerance/Sensitivity: _____ Reaction: _____
Intolerance/Sensitivity: _____ Reaction: _____
Intolerance/Sensitivity: _____ Reaction: _____
Intolerance/Sensitivity: _____ Reaction: _____

DIET/NUTRITIONAL HEALTH HISTORY

What you eat and what you supplement your diet with has a direct effect on your health. Please help us help you by providing us with the following information:

How many meals do you eat per day? _____

What do you commonly eat for:
Breakfast:_____
Lunch:_____
Dinner:_____
Number of Snacks? _____ Kinds of snacks: _____

Describe your eating habits:

_____

_____

Please mark if applicable:

Alcohol use: ☐ Wine ☐ Liquor ☐ Beer ☐ Mixed drinks ☐ # of drinks per day _____ ☐ # of times per week _____

Cigarettes: ☐ Yes ☐ No If yes, what brand: _____ # per day _____ Packs per week _____

Vaping: ☐ Yes ☐ No If yes, how often: _____

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 _____

ERGONOMIC HEALTH HISTORY

Sleep Habits:

How many hours per night? _____ What position do you sleep in at night? ☐ Back ☐ Side ☐ Stomach

Do you wake up in the middle of the night? ☐ No ☐ Yes

If yes, what time? _____ : _____ am/pm

Do you have difficulty sleeping? ☐ No ☐ Yes – describe:

_____

_____

Exercise Habits:

Do you exercise? ☐ No ☐ Yes – describe type and frequency: _____

What is your activity level at work? ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor ☐ Working at a computer

How many hours/day are you doing the above:_____

What is the best type of learning for you? ☐ Visual ☐ Auditory ☐ Kinesthetic

MENTAL/EMOTIONAL HEALTH HISTORY

Do you have a specific spiritual practice? ☐ No ☐ Yes If yes, please explain:

_____

_____

Do you feel passionate about life? ? ☐ No ☐ Yes What is your passion?

_____

_____

How do you tend to express your emotions? (i.e. by eating, crying, drinking, talking, etc.)

_____

_____

If you knew you could not fail, what would you be doing differently?

_____

_____

Please rate the following areas of potential stress:

Financial/Money matters	Low	0	1	2	3	4	5	6	7	8	9	10	High
Relationship/Family	Low	0	1	2	3	4	5	6	7	8	9	10	High
Job/Career/Education	Low	0	1	2	3	4	5	6	7	8	9	10	High
Current level of Health	Low	0	1	2	3	4	5	6	7	8	9	10	High
Spiritual/Religious/Ethical	Low	0	1	2	3	4	5	6	7	8	9	10	High
Overall level of life stress	Low	0	1	2	3	4	5	6	7	8	9	10	High

Please check all of the following life events that you currently experience stress with:

☐ Birth of siblings
☐ Toilet training
☐ Babysitters
☐ Death of a pet
☐ First year of school
☐ Teachers
☐ Peer relationships
☐ Onset of puberty
☐ Fights
☐ Romance/dating
☐ Illness/operations
☐ Parental conflict/separation
☐ Divorce
☐ Prom
☐ College
☐ Abortion/Miscarriages
☐ Any betrayal
☐ Marriage
☐ Moving
☐ Accidents
☐ Loss of job/layoff
☐ Financial disruptions
☐ Illness of a loved one
☐ Diagnosis of a fatal condition
☐ Death of a loved one
☐ Other:
_____
_____
_____
_____

Other challenges or life goals not covered:

_____

_____

SENSITIVE HEALTH INFORMATION

The following items have been listed as sensitive health information and, therefore, will never be copied or released. Even though they are sensitive, they are still vital to the effective management of your health. Please complete as accurately as possible.

History of alcohol use/abuse: ☐ No ☐ Yes – describe: _____

History of recreational drug use/abuse: ☐ No ☐ Yes – describe: _____

Have you been diagnosed with a mental illness? ☐ No ☐ Yes – diagnosis? _____ When? _____

Treatment? _____

Have you been tested for the HIV virus? ☐ No ☐ Yes Results? _____

Have you ever been diagnosed with HIV or an HIV related illness? ☐ No ☐ Yes What type of treatment are you under?

_____

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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?

_____

_____

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 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: _____

Patient Signature: _____

(Signature of Parent/Guardian): _____