Be Optimal
HOLISTIC HEALTH CENTER
Becoming Your Best You

Physicians Working At Be Optimal: **Dr. Cari Jacobson, DC**
Dr. Abby Kramer, 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.

All information provided is strictly confidential. 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: _____/_____/_____ I Identify My Gender 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

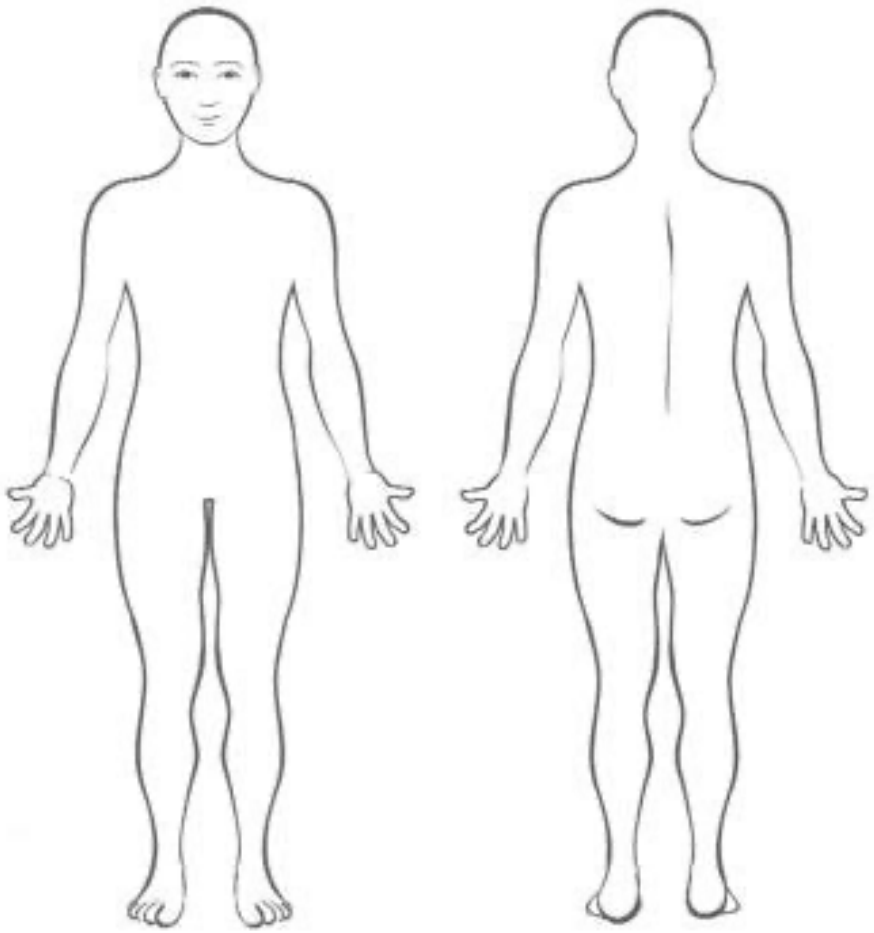
What is your intention for visiting Be Optimal Holistic Health Center?

_____

Primary health concern(s) and conditions:

_____

_____



Please use these symbols on the diagram below to illustrate areas of physical discomfort.

XXXXX = Pain OOOOO = Numbness SSSSS = Sharp TTTTT = Tingling +++++ = Other

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 reoccurring 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 Disease _____ 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:

□ Headaches

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

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:
_____
_____
_____
_____
_____
_____
_____

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 _____
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 keep a journal? □ No □ Yes – how often? _____ □ Written □ Visual

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 would you describe your ability to express emotions such as happiness, anger, fear, sadness, grief, etc.?

_____

How do you express the above emotions? (i.e. by eating, crying, drinking, talking, etc.)

_____

_____

What are your personal goals for your life?

_____

_____

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

_____

_____

What would your life be like?

_____

_____

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:

_____

_____

_____

What are your health goals?

_____

_____

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?

_____

THIS PAGE IS NOT AUTHORIZED TO BE COPIED UNDER ANY CIRCUMSTANCES

OUR OFFICE POLICIES

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

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. 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.

Payment policy

Payment is due at time of service. We accept cash, check, Visa, Mastercard, or Discover for payment. If you need to work out a payment plan, please discuss this with our office manager PRIOR to your session. Finally, should you choose to suspend or terminate care, it is your obligation to inform your health care physician. Outstanding fees are then due immediately.
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 cancelling 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 cancelling 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 _____

Email List

I consent to be added onto Be Optimal's general Mail Chimp emailing list to receive newsletters, updates & promotions.
Initials _____

Be Optimal
HOLISTIC HEALTH CENTER
Becoming Your Best You

PHONE CONSULTATION AGREEMENT & INFORMED CONSENT

Virtual Services: The services provided by the Chiropractic Physicians at Be Optimal Holistic Health Center virtually may consist of: mind-body emotional shifts, health and wellness consulting, nutrition and dietary suggestions for overall wellness, and energetic medicine. The purpose of virtual consultations is to develop and implement strategies to help you reach your personal health and wellness goals, and maintain better balance in your life.

I consent to participate voluntarily in virtual sessions with one or all of the Physicians at Be Optimal, and I recognize that this may contain inherent risks. I take full responsibility for my life and well-being and all decisions made before and after any sessions.
Initials _____

I understand that any and all lifestyle or dietary/supplement recommendations are not intended to be a substitute or replacement for medical advice provided by my prescribing doctor, or treatment that can be provided in person by a physician, therapist, licensed dietician, or nutritionist, or any other licensed health care professional.
Initials _____

I understand that the purpose of a virtual session is not designed nor is it means to attempt to diagnose, treat, or cure any medical condition, disease, mental ailment, or physical condition of the body. Rather, this session serves as a consultation to help the client maintain better balance in their life.
Initials _____

I have carefully read this document and by signing below, I consent to all of the above. I have been given the opportunity to ask and/or clarify any questions.

Participant's Name (Please Print):

Participant's Signature: Date

Signature of Parent/Guardian: Date