



Office of Dr. Seth Pearl, DC, CCN, CNS

ADULT INTAKE FORM

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____

City / State / Zip: _____

Cell Phone: () _____ Alternate Phone: () _____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day

Email: _____ *(For updates on office hours, events, etc.)*

Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

of Children: _____

Children's Names & Ages: _____

Who can we thank for referring you or how did you hear about us? _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Optimal Health Chiropractic? _____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

What is this affecting that is MOST important in your life? (List all that apply)

Have you seen any other providers for this condition? (List all that apply)

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

HEALTH CONCERNS

- | | |
|---|---|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Digestive Troubles | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Loss of Concentration |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Neck/Back Pain | <input type="checkbox"/> Stiffness/Flexibility |
| <input type="checkbox"/> Pain in Arms/Legs | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above or add additional concerns:

Is there anything else regarding your current condition you feel the doctor should know? _____

MEDICATIONS

- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above: _____

EMERGENCY CONTACT

First Name: _____ M.I.: _____

Last Name: _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Phone: () _____ Relation: _____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions



Headaches
Migraines
Dizziness
Sinus Problems
Fatigue / Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

VITAMINS / SUPPLEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Explain any boxes checked above: _____

STRESS QUESTIONNAIRE

Most life stresses can be grouped into 3 main categories: Physical, Chemical, and Emotional Stress.

Please check any of the following stresses you experience on a regular basis.

Physical Stress

- Physical Pain Low Energy/Fatigue Job/Hobbies Cause Discomfort Tightness/Stiffness
 History of Accidents/Injuries Inability to Exercise/Perform Physical Activities Other _____

Explain: _____

Chemical Stress

- Fast Food/Highly Processed Food Medications (Prescription or OTC) Consume Alcohol Tobacco
 Amalgam Fillings Makeup/Lotion/Other Skin Products Other _____

Explain: _____

Emotional Stress

- Work/Job School Health Finances Family Daily Schedule/Time Other _____

Explain: _____

What else about your health or your life do you feel is important for the doctor to know?

For Office Use Only

ID#: _____ V: _____

Films: _____ P: _____

ROF: _____ A: _____

Other _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Optimal Health Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will therefore may be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care may not be reimbursed by a third party carrier. This does not apply to PI, WSI, or Medicare. HSA and FLEX spending accounts may be utilized.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN)*. Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance may not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Date: _____ Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Optimal Health Chiropractic to treat my condition as deemed appropriate. At Optimal Health Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Optimal Health Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____