OptimumHealth
An Integrative Approach To Healing

Date ________________

PATIENT INFORMATION

____
Last Name First Name Middle Initial

Address____

City____

State________ Zip__________--__________ (9 digit zip required)

Email Address______________________ ☐Home ☐Work

Cell(______)____________ Cell Carrier ____________

Home(______)__________Work(_____)____________

SS#____________________

Date of Birth___________ Age______ Gender ☐ M ☐ F

Height____ Weight____ ☐ Married ☐ Widowed ☐ Single

Occupation/Employer:______________________________

Who is responsible for account?____________________

In case of emergency please contact:________________

Relationship______________ Phone(_____)__________

How did you hear about us?______________________

☐Google ☐Facebook ☐Website ☐Referral ☐BodyPlex

INSURANCE INFORMATION

Primary Insurance Company____________________

Subscriber's Name____________________________

Relationship to Patient________________________

Subscriber's Employer_________________________

Member #___________________________________

Group #____________________________________

Subscriber's DOB___/____/____ SS#______________

Secondary Insurance Company__________________

Subscriber's Name____________________________

Relationship to Patient________________________

Subscriber's Employer_________________________

Member #___________________________________

Group #____________________________________

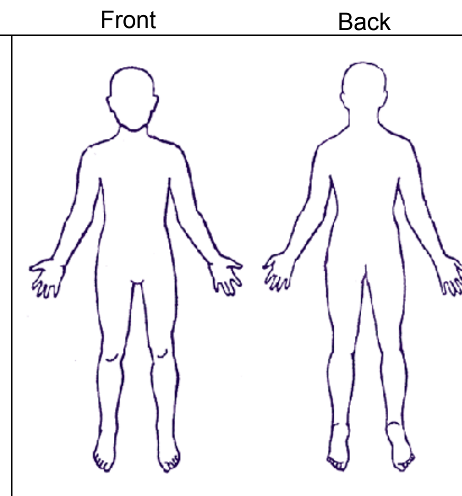
Subscriber's DOB___/____/____ SS#______________

(1) Primary health complaint?____

(2) When did your symptoms appear?___________________________________

(3) Are these symptoms progressively worse? ☐ Yes ☐ No

(4) Mark an **X** on the picture where you are having symptoms.



Type of Symptoms: ☐ Sharp Pain ☐ Dull Pain ☐ Throbbing Pain

☐ Burning ☐ Numbness ☐ Tingling ☐ Aching

☐ Cramping ☐ Stiffness ☐ Swelling

(5) Rate the severity of your pain on a scale from 1 (least) to 10 (severe) ________

(6) How often do you have this pain?___________________________________

(7) Is the pain constant or does it come and go?__________________________

(9) Does the pain interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

(10) Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending

ACCIDENT INFORMATION

Are any of the above conditions due to an accident? ☐ Yes ☐ No (If so) Date_____/_____/_____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Signature____ Date________________________________