

# Adult Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:     /     /
SS#:     -     -	DOB:     /     /	Sex: <input type="radio"/> M <input type="radio"/> F
Marital Status:	# of Children:	Occupation:
Street Address:	Height:     ft.     in.	
City:	State:     Zip:	Weight:     lbs.
Email:	Cell Phone:     -     -	Other Phone:     -     -
Emergency Contact:	Emergency Relation:	Emergency Phone:     -     -
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit:		
Are you also receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No		
- If yes, please name them and their specialty:		
Please note any significant family medical history:		

## CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Have you received care for this problem before? ☐ Yes ☐ No

- If yes, please explain:

When did the condition(s) first begin?

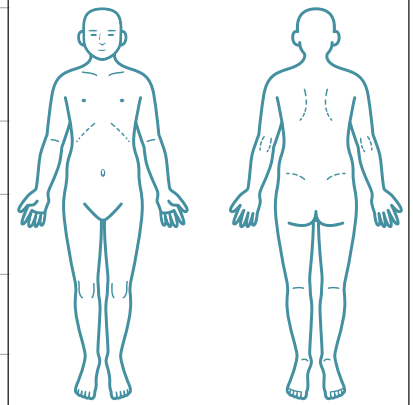
How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.



## YOUR HEALTH GOALS

Your top three health goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ☐ Resolve existing condition(s) ☐ Overall wellness ☐ Both

Have you ever visited a chiropractor? ☐ Yes ☐ No If yes, what is their name?

What is their specialty? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutritional ☐ Subluxation-based ☐ Other:

Do you have any health concerns for other family members today?

## TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ☐ Yes ☐ No

- If yes, please explain:

Notable childhood injuries? ☐ Yes ☐ No If yes, please explain:

Youth or college sports? ☐ Yes ☐ No If yes, list major injuries:

Any auto accidents? ☐ Yes ☐ No If yes, please explain:

Exercise Frequency? ☐ None ☐ 1-2x per week ☐ 3-5x per week ☐ Daily

What types of exercise?

How do you normally sleep? ☐ Back ☐ Side ☐ Stomach Do you wake up: ☐ Refreshed and ready ☐ Stiff and tired

Do you commute to work? ☐ Yes ☐ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

## TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None						None				
	Moderate						Moderate				
	High						High				
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

## THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None						None				
	Moderate						Moderate				
	High						High				
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

## ACKNOWLEDGEMENT & CONSENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Dr. Rick Baldenegro** | Optimum Wellness Chiropractic  
24W500 Maple Ave, Suite 116, Naperville | 630.364.2034  
team@owcnaperville.com | OWCNaperville.com

# Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS			
		PAST PRESENT	PAST PRESENT		
<b>Cervical</b>	• Autonomic Nervous System	<input type="checkbox"/> <input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/> <input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/> <input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/> <input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/> <input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/> <input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/> <input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/> <input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/> <input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/> <input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/> <input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/> <input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/> <input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/> <input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/> <input type="checkbox"/>	Stiff Neck & Shoulders
		<input type="checkbox"/> <input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Depression
		<input type="checkbox"/> <input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/> <input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/> <input type="checkbox"/>	Poor Metabolism & Weight Control
<b>Upper Thoracic</b>	• Upper G.I.	<input type="checkbox"/> <input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/> <input type="checkbox"/>	Bronchitis & Pneumonia
	• Respiratory System	<input type="checkbox"/> <input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/> <input type="checkbox"/>	Functional Heart Conditions
	• Cardiac Function	<input type="checkbox"/> <input type="checkbox"/>	Asthma		
<b>Mid Thoracic</b>	• Major Digestive Center	<input type="checkbox"/> <input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/> <input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/> <input type="checkbox"/>	Fever	<input type="checkbox"/> <input type="checkbox"/>	Blood Sugar Problems
<b>Lower Thoracic</b>	• Stress Response	<input type="checkbox"/> <input type="checkbox"/>	Behavior Issues	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/> <input type="checkbox"/>	Hyperactivity	<input type="checkbox"/> <input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/> <input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Chronic Stress	<input type="checkbox"/> <input type="checkbox"/>	Gas Pain & Bloating
<b>Lumbar, Sacrum &amp; Pelvis</b>	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/>	Sciatica & Radiating Pain
		<input type="checkbox"/> <input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/> <input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Gut-Immune System	<input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Hamstring Tightness
	• Major Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Bed-wetting	<input type="checkbox"/> <input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/> <input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/> <input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/> <input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/> <input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/> <input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/> <input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/> <input type="checkbox"/>	Infertility	<input type="checkbox"/> <input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/> <input type="checkbox"/>	Impotency	<input type="checkbox"/> <input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Activities of Daily Living/Symptoms/Medications

**Patient Name:** \_\_\_\_\_

**Acct #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:


Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

## Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **OPTIMUM WELLNESS CHIROPRACTIC** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  *Witness Initials*

Patient or Authorized person's Signature Date


### REGARDING: X-rays/Imaging Studies

**FEMALES ONLY** → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on \_\_\_\_-\_\_\_\_-\_\_\_\_ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  *Witness Initials*

Patient or Authorized person's Signature Date

## Optimum Wellness Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call [Dr. Richard Baldenegro](#) at (630) 364-2034. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to your local state chiropractic board.

Patient initials: \_\_\_\_\_-retaining page 1 of 2

**Optimum Wellness Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....**

I have received a copy of Optimum Wellness Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# OUR OFFICE POLICIES

## Welcome to OPTIMUM WELLNESS CHIROPRACTIC!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read “Our Office Policies”, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care***, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone’s best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY** - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **OPTIMUM WELLNESS CHIROPRACTIC** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body’s innate wisdom. The doctors **use a myriad** of techniques to accomplish this goal, including but not limited to **{Spinal Manipulation}**. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitative and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through **two** distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT’S REPORT OF FINDINGS** - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a ‘Doctors Report of Findings’. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors’ recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient’s family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

*Note: Patient retains the above Notice of Office Policies and OPTIMUM WELLNESS CHIROPRACTIC retains the signature sheet.*

**Patient initials: \_\_\_\_\_-retaining pages 1 of 2**

*I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.*

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date