Welcome to Our Office

Your First Chiropractic Visit

Health History/Consultation: This informs the doctor and his team of your current level of health, complaints, and history of injuries or illnesses.

Clinical Examination: Your examination may include a thorough evaluation of posture, range of motion, muscle strength, reflexes, palpation, orthopedic and other tests. These tests will help determine whether subluxations (misalignments) of the spine or other joints affect your health.

X-Rays & Analysis: Your chiropractic examination may require comprehensive x-rays. The X-rays reveal the degree of spinal misalignment, the phase of spinal degeneration, significant pathologies, and other potential considerations of care. In our clinic, careful analysis leads to precision measurements. This thorough analysis, along with your clinical exam findings, enables us to provide you with our best recommendations.

Your Second Chiropractic Visit

Explanation/Report of Findings: We encourage you to bring a spouse or family member for this visit because two sets of eyes and ears are better than one. This could be the most important visit because you will be given a thorough report of findings after the doctor has studied your health history, clinical examination, and x-rays. You will be educated about your spine and nervous system. After the exam findings are explained, your x-rays are reviewed and compared to normal findings, which helps to provide you with a clear understanding of any problems present.

If the doctor finds that chiropractic can help you, he will accept your case. He will then offer his services.

First Adjustment: After you have received your reports and the doctor has answered your questions, your first chiropractic adjustment will be given (if appropriate). Because we are certified in a variety of adjusting techniques, we can choose the most effective approach to enhance your comfort and your results.

(**Please Note:** This visit is scheduled at a very special time of day, and a full 30-45 minutes have been reserved for thoroughness. We ask that you please respect this time.)

Your Follow-up Chiropractic Visit

Your Third Visit: Once the doctor has checked on how you responded to your first chiropractic adjustment, you will receive your recommendations for any corrective care. The recommendations will vary according to the severity of subluxation, phase of degeneration, age, and current condition. In addition, any other diagnostic testing needed may be ordered at this time.

Our recommendations are always based on helping you regain as healthy of a spine and nervous system as possible as well as teaching you how to maintain it throughout your life.

APPLICATION FOR CARE AT OPTIMAL HEALTH CHIROPRACTIC

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

PATIENT DEMOGRAPHICS ***(Please fill this form out completely. The doctor uses all this information to diagnose you.)***

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widow

Health Insurance: ☐ Yes ☐ No Insurance Name: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Birthdate _____ (used for insurance purpose)

Name of children and Ages: _____

"Must give an emergency person"
Name & Number of Emergency Contact: _____ Phone _____ Relationship: _____

Email Address _____

Please identify any pain you are having. ***(Example: Neck pain, back pain or headaches, etc.)*****:** Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*****:**

Primary or chief complaint is	:	0	1	2	3	4	5	6	7	8	9	10
Second complaints is	:	0	1	2	3	4	5	6	7	8	9	10
Third complaint:	:	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint:	:	0	1	2	3	4	5	6	7	8	9	10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week.

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

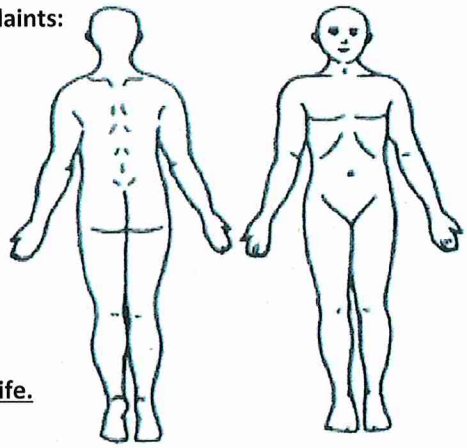
Type of treatment provided _____ How long were you under care: _____ What were the results? ☐ Favorable ☐ Unfavorable

Name of Previous Chiropractor: _____ ☐ **N/A** Last chiropractic adjustment (date) _____

Techniques-☐Manual☐Activator. **Were there any issues with cervical adjustments?** ☐No ☐Yes**. If yes,** ☐ Nausea☐ Lightheaded ☐Fainting

***PLEASE MARK** the areas on the Diagram with the following letters to describe **all of your complaints:**

R = Radiating **B = Burning** **D = Dull** **A = Aching**
N = Numbness **S = Sharp/ Stabbing** **T= Tingling**



What relieves your symptoms? _____

What makes them feel worse? _____

To fill out the information below, you may want to refer to your answers from the **Activities of Life.** The form included in this packet shows restricted daily activities.

Activities that are painful: (For example, Walking, Sitting)	**How long could you do an activity? Before the problem occured (Example 1 hr.)**	**How long can you do an activity *After* the problem occurred (Example 10 min)**

Identify any other injury(s) to your spine, minor or significant, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered from this issue or any similar problem in the past? ❑ No ❑ Yes **If yes,** how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____,
and who provided it: _____ **How long ago?** _____What were the results. ☐ Favorable ☐ Unfavorable→
please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a (**P**) for in the ***Past,***
(**C**) for ***Currently*** have and (**N**) for ***Never*** *have had* (***There must be an answer next to each one of these conditions***):

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability
___ Cancer ___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Stroke ___ Bladder/Bowel Incontinence
*** Other conditions:** _____

PLEASE identify ALL PAST and any **CURRENT** conditions.

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

List any **Medications** you are **currently taking** (*Prescription and over the counter*); _____

_____

_____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

FAMILY HISTORY:

1. Does anyone in your family suffer the same condition(s)? ❑ No ❑ Yes
If yes, whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know.
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

Pregnancy Release (Female patients)**:**
This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle _____ Signature_____ Date_____

I hereby authorize payment to be made directly to OPTIMAL HEALTH CHIROPRACTIC for all benefits that may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies faxes thereof for the purpose of processing claims and effecting payments and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to OPTIMAL HEALTH CHIROPRACTIC for any and all services I receive at this office. The fee paid for X-rays is for the doctor's analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. (There may be a fee for copies.)

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

Optimal Health Chiropractic

Patient's Name: _____

ACTIVITIES OF LIFE

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

ACTIVITIES:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Constant Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Constant Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Steps	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient signature: _____ Today's Date: ___/___/___

Optimal Health 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 **P**ersonal **H**ealth **I**nformation. 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 summary of these circumstances. If you would like a more detailed explanation, one will be provided to you and can be found on our website (www.optimalhealthchiropracticsc.com). In addition, you will find we have placed a copy in a report folder labeled **'HIPAA'** in the reception area. Once you have read this notice, please sign the **ACKNOWLEGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE** and return it with paperwork to our front desk receptionist. Keep these 2 page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures—An open treatment area means 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 worker's 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 imminent 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 benefit purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls, text, emails and appointment reminders—We may contact you and leave messages regarding a missed appointment or inform 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 the 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 request amendments to information. However, like restrictions, we are not required to agree to them.
6. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours)
7. **X-rays** are original records and you are therefore not entitled to them. Our office can make copies of your x-rays with required notice of 72 hours. There may be an additional fee that you would be responsible for.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

1. Confidentiality of Reproductive Health Information:

Our practice is committed to protecting the privacy and confidentiality of your reproductive health information. This includes information related to fertility treatments, prenatal care, contraception counseling, and abortion services. We have implemented strict safeguards to ensure that your reproductive health data is always kept secure and confidential.

2. Access to Reproductive Health Records:

You have the right to access and obtain copies of your reproductive health records maintained by our practice. These records will only be released after obtaining a specific and separate release of reproductive rights protected information signed by the patent, except where required by law. If you wish to review or receive a copy of your fertility treatment history, prenatal care notes, contraception counseling records, or abortion services documentation, please contact our privacy officer to initiate the special request and authorization for such.

3. Non-Discrimination and Respect for Reproductive Choices:
Our practice upholds a policy of non-discrimination. We respect and support your reproductive choices, regardless of factors such as age, gender identity, sexual orientation, marital status, or individual preferences. Your reproductive health records will be honored and respected by our healthcare team.

4. Disclosure of Reproductive Health Information:
We will only disclose your reproductive health information to authorized individuals or entities as permitted by law and with your explicit consent. Your reproductive health data will not be shared with third parties without your permission. We require a special authorization, above and beyond a simple standard release form, to release any reproductive care documentation, except in cases where disclosure is required by law or for purposes of treatment, payment, or healthcare operations.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Appointment Reminders: This office uses texting, email, and phone to send appointment reminders to patients in advance of their appointments. We use the information you supply to us to contact you. The contact information will be limited and contain no highly sensitive information. There may be a risk that someone else other than the patient may hear or receive the message. If, at any time, you wish to opt out, please contact our office in writing.

Recognition- We like to recognize our patient's accomplishments in our office (internal only), such as Patient of the Week or Month. This is internal in our office only. We also recognize your birthday with a birthday text. Happy Birthday greetings during your office visit. We also send thank you letters to our patients. If a patient chooses to provide us with their testimonial, we will add it to "Our Patients" book. If you decide not to be recognized, you can opt out by writing.

COMPLAINTS:
If you wish to make a formal complaint about how we handle your health information, please call
Renae McKelvey at (843) 524-4325 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with how this office handles your complaint, you can submit a formal complaint to: DHHS, Office for Civil Rights. 200 Independence Ave. SW, Room 509F HHH Bldg., Washington, DC 20201

Optimal Health Chiropractic
1264 Ribaut Rd Ste 102
Beaufort, Sc 29902

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I have received a copy of ***Optimal Health*** **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 any time in the future and will make the new provisions effective for all information that maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and is kept in the reception area and on their website. At this time, I do not have any questions regarding my rights or any of the information I have received. By signing this page, I am acknowledging that I have read and kept the Privacy Practices Notice.

Patient

Signature

Date

r Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

Staff signature **Date**

Revised 01-01-2025

Optimal Health Chiropractic
1264 Ribaut Road Ste 102
Beaufort, SC 29902

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Optimal Health Chiropractic to use and/or disclose certain protected health information (PHI) about me for treatment, payment (insurance) or healthcare operations (TPO) as listed in our extended Notice of Privacy Practices.

This authorization permits Optimal Health Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.) for TPO as listed in our extended Notice of Privacy Practices.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Optimal Health Chiropractic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: Optimal Health Chiropractic 1264 Ribaut Road Ste. 102 Beaufort, SC 29902

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Note: *This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (e.g., your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.*

Marketing Authorization

From time to time our practice displays the achievements of our patients and to do so we must obtain your authorization. We have many different ways of displaying these achievements and listed below are descriptions of items that we would like your permission to share.

Internal Office- Some specific achievements we want to display are: Patient of the week/month/year awards, Optimal Health board, Patient Testimonials that the patient gives us to enter into "Our Patients" book.

Text/Mailings/Emails- Appointment reminders, Newsletters, health updates, birthday cards, promotional events for our office (Health workshops).

You may restrict the individuals or organizations to which your healthcare information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy any of the information that we use to contact you for marketing purposes at any time. (164.524).

I authorize you to use or disclose my health information in the manner described above.

This notice is effective as of the date written below. This authorization will expire seven years after the date on which you last received services from us.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Personal Representative Printed	Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.