PATIENT INTAKE FORM

Patient Information

Legal Name: _____ Please Call Me: _____
First MI Last

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

Age: _____ Birth Date: _____ Social Security Number: _____

Sex (circle): □ Female □ Male □ Intersex □ DSD **Pronouns:** □ He/Him □ She/Her □ Them/They

Hand Dominance: □ Right □ Left □ Ambidextrous □ Unknown

Guardian Information

Caregiver 1: _____ Relation to Patient: _____

Occupation: _____ Cell Phone: _____

Email Address: _____ Other: _____

Caregiver 2: _____ Relation to Patient: _____

Occupation: _____ Cell Phone: _____

Email Address: _____ Other: _____

Caregiver 3: _____ Relation to Patient: _____

Email Address: _____ Other: _____

Experience:

Have you seen a chiropractor before? □ Yes □ No If yes, who or technique used: _____

How did you find us? We want to thank them.

□ Lactation □ Dentist □ Pediatrician □ Speech /Feeding □ ENT / Airway □ OT □ PT

□ First Glimpse 3D/4D □ Google search □ ICPA directory □Instagram □ Facebook

Family/ Friend / Provider Referral Name: _____

Health Questionnaire

Patient Information

Today's Date: _____

Patient Name: _____ **Date of Birth**: _____

Current Medical History

Current Complaints: □ General checkup after birth **Pain in:** □ Neck □ Mid back □ Low back □ Head shape
□ Head preference / torticollis □ Clenched elbows/ hands □ Colic □ Gas □ Reflux □ Feeding Concerns
Describe the reason(s) for your doctor visit today:_____

_____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you observe symptoms? *(Circle one)* Constantly Frequently (75-50%) Occasionally (50-25%) Intermittently

Describe what you see: _____

_____

Are the symptoms? *(Circle one)* Getting better Staying the same Getting worse

How do the symptoms interfere with feeding, sleeping, mood, quality of life &/or development? _____

_____

_____

Have seen these symptoms in the past?_____

_____

_____

Pediatrician: _____ Office Name: _____

City, State: _____Date last seen: _____May we update them on your condition? □ Yes □ No

Labor & Delivery History

Weight at birth: _____ **Length at birth:** _____ **Weeks of Gestation** _____

□ Hospital □ Birthing Center □ Home birth _____

Labor was □ spontaneous □ induced **C-section:** □ scheduled □ emergent

□ average labor: (6-18 hours) □ fast / precipitous labor: (3-5hours) **Pushing:** □ 1-2hours □ 3-4hours

□ prolonged labor: □ 1st time (20hours) □ 2nd+ (14hours) □ failure to progress

Baby Position at birth: □ head down □ breech □ transverse □ sunny side-up □ hand up by face

Interventions: □ suction □ forceps □ vacuum ____□ NICU duration _____

□ Required resuscitation/oxygen □ Cord wrapped around neck _____ □ shoulder dystocia

□ Prolonged jaundice □ Birthmarks □ Rashes □ Skin Concerns: _____

Newborn History

□ Anemia □ Failure to Thrive □ Laryngomalacia

Sleep: □ Good □ Poor □ Excessive Prefers to sleep: □ on back □ being held □ upright / in a swing □ stomach

Eating: □ Breastfed □ Formula fed □ Breastmilk + formula □ Formula _____

How often? _____ How many ounces? _____ □ Bottle _____

□ Tongue Tie/ Lip Tie Revised? □ Yes □ No _____

Digestion: □ Gassy/ Bloated □ Grunt/Cry/Strain to poop □ Constipated Poops per day: _____

□ Reflux How often: □ every feed □ 1-3x/day When: □ immediately after feed □20-30min after feed

Movement: □ Arching □ Head preference □ Dislikes Tummy Time □ Dislikes laying on back

FLACC Behavioral Assessment Scale

Categories	0	1	2
Face	□ no particular expression or smile	□ occasional grimace or frown; withdrawn, disinterested	□ frequent to constant frown, clenched jaw, quivering chin
Legs	□ normal or relaxed	□ Uneasy, restless, tense	□ kicking legs or legs drawn up
Activity	□ lying quietly, normal position, moves easily	□ squirming, shifting back & forth, tense	□ arched, rigid, or jerking
Cry	□ No cry (awake or asleep)	□ moans of whimpers, occasional complaint	□ crying steadily, screams or sobs; frequent complaints
Ability to Console	□ Content, relaxed	□ reassured by occasional touching, hugging, or being talked to; distractable	□ difficult to console or comfort

Infections/ Medications: _____

Supplements: □ Vitamin D3 □ Vitamin K (oral) □ Probiotics _____

Immunization: □ On-schedule □Delayed schedule □Modified delayed schedule □Indefinitely delayed schedule

Breastfeeding Mothers:

Flow: During feeds baby appears ☐ chokes/gags ☐ coughs ☐ hiccups after ☐ spit up ☐ baby leaks from mouth corners
Latch: During feeds baby appears ☐ content ☐ tired ☐ falls asleep ☐ frustrated
☐ painful latch ☐ shallow latch ☐ chomp/bite ☐ intense suck ☐ pops on/off
Injury to Mom: ☐ blanched nipples ☐ bleeding ☐ nipple shield **Injury to baby**: ☐ blistered lip(s) ☐ clicking

Current Diet: Are you dieting? ☐ Yes ☐ No Meals per day: _____ Snacks: _____

Prenatal: _____ ☐ DHA /Fish oil ☐ Iron ☐Probiotics ☐Magnesium ☐Vitamin D3

Medications: _____

Dietary Interventions: ☐ Autoimmune Paleo (AIP) ☐ Dairy-free ☐ Gluten-free ☐ GFDFSF ☐ Keto ☐ Paleo
☐ No Sugar / No Additives ☐ Pescatarian ☐ Vegan ☐ Vegetarian ☐ Other:_____

_____

Hydration Intake: ☐ Water ☐ Electrolytes ☐ Coffee ☐ Energy Drinks ☐ Soft Drinks ☐ Alcohol

Have you had any of the following during this pregnancy:
☐ Hospitalization ☐ Infection (Viral / Bacterial /COVID) ☐ Chronic Illness ☐ Car /ATV Accident
☐ Falls ☐ Physical trauma ☐ Significant injury to tailbone ☐ Emotional stressors ☐ Career/Job Change
☐ Financial Stress ☐ Housing Change ☐ Loss of Loved One ☐ Caring for a Sick Child / Parent / Loved One
Other: _____

Previous Birth Experience

Is this your first pregnancy? ☐ Yes ☐ No ☐ Miscarriage(s): _____ ☐ Live Birth(s): _____
☐ Fertility Challenges/Interventions: _____
☐ Diabetes: (Uncontrolled/Gestational) ☐Anemia ☐ Autoimmune Disease(s): _____
☐ Viral infection during 1st trimester ☐ Toxoplasmosis ☐ Accident or Infections: _____
☐ Hypertension (high blood pressure) ☐ Pre-eclampsia ☐ Maternal depression or postpartum depression
☐ Epilepsy ☐ Pre-term labor ☐ Placenta previa ☐ Over 35 years old
☐ Alcohol consumption &/or drug use ☐ Smoking (Tobacco/Cannabis/Other) _____
☐ Radiation exposure ☐ Lead exposure ☐ Chemical exposure ☐ Mold exposure
Comments: _____

_____

_____

Health History

Has your child ever experienced the following or been diagnosed with any of the following:

□ Congenital Disorders/ Birth Trauma: _____

□ Seizures/Convulsions	□ Epilepsy	□ Fainting	□ Dizziness
□ Meningitis	□ Rheumatic Fever	□ COVID-19 complications	□ Chronic ear infections/ earaches
□ Diabetes	□ Hypoglycemia	□ High blood pressure	□ Heart disease
□ Serious falls or repetitive falls	□ Head injury	□ Motor Vehicle Collision	□ Bladder control (enuresis)
□ Neck or back problems	□ Joint or muscle problems		
□ Asthma	□ Food allergies	□ Environmental allergies	□Chemical sensitivities

List anything your child is allergic to: _____

Adverse reaction to any medications and/or vaccinations: _____

_____

List all *prescription,* non-prescription *medications* and other *supplements* your child takes, as well as the *associated condition*:

_____

_____

List any *surgeries* or *hospitalizations* your child has had, complete with *the month and year for each*:

_____

Family History

List all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual:

_____

_____

_____

Medical Providers:

Have you seen another doctor for these symptoms?

Specialist: _____ Office Name: _____

City, State: _____Date last seen: _____May we update them on your condition? □ Yes □ No

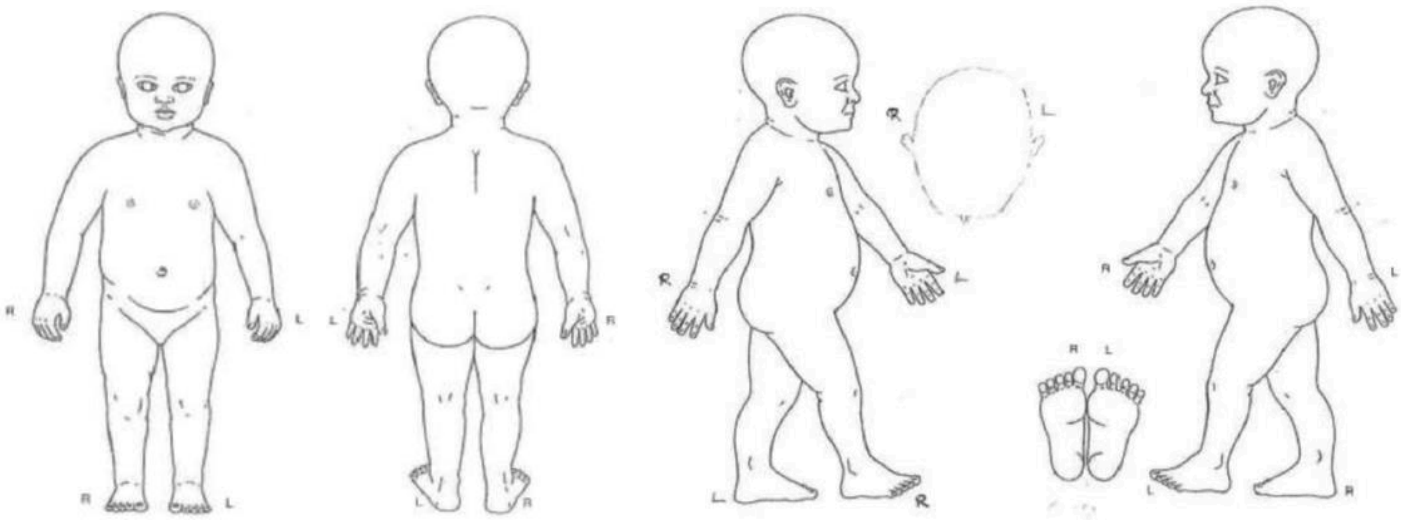
Specialist: _____ Office Name: _____

City, State: _____Date last seen: _____May we update them on your condition? □ Yes □ No

OPTIMIZED LIVING INSTITUTE

Visual Description of Condition

Mark/circle any & all spots of perceived pain or discomfort, or areas that you suspect are a problem.



Parent Perception: On a scale of 1-10 how intense are the symptoms?

Last 24 hours: NO PAIN ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE / WORST PAIN

Past week: NO PAIN ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ UNBEARABLE / WORST PAIN

How frequent are the symptoms?

☐ **Constantly** (76-100% of the time) ☐ **Frequently** (51-75% of the time) ☐ **Occasionally** (26-50% of the time) ☐ **Intermittently** (0-25% of the time)

What percentage of awake hours is baby at his/her **best?** _____**%** **worst?** _____**%**

How much have baby's symptoms interfered with his/her usual daily activities? Ability to eat, sleep, meet developmental milestones

☐ **Not at all** ☐ **A little bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely**

Additional comments:

_____

_____

_____

Patient's signature: _____ **Date:** _____

9522 Brookline Ave, Suite 111A, Baton Rouge, LA 70809 || Text Us: 225.339.9911

Identification:

In an effort to maintain compliance with various state and federal regulations, we require a photocopy of the following information:

The patient's driver's license La Wallet App

Photo of FRONT of driver's license

La Wallet App

Financial Policy

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

Payments

Private Pay: (please initial)

_____ I prefer pay self-pay. I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

Would you like a Superbill (itemized receipt) emailed to you? □ Yes □ No

Recurrent / Auto Payments:

_____ I wish to keep my credit card/ Health Savings Account (HSA) / Flexible Spending Account (FSA) on file.

Credit Card/ Account #: _____ **Exp Date:** _____ **CVV:** _____ **Billing Zip:** _____

Missed Appointments

It is the policy of Optimized Living Institute to assess a $30.00 missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ Signature

_____ Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" & involves your understanding & agreement regarding the care we recommend, the benefits & risks associated with the care, alternatives, & the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.
The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper & lower) GI tract was 1219 events/ 1,000,000 persons/year and risk of death has been estimated as 104/ 1,000,000 users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature:_____ Date: _____

Witness Name: _____ Signature:_____ Date: _____