PATIENT INTAKE FORM

Patient Information

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

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

Age: _____ Birth Date: _____ **Pregnant?** Y /N Due Date: _____ How many weeks? _____
I am having: ☐ **Boy** ☐ **Girl** ☐ **Unsure** ☐ **Multiples:** _____

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

Gender Identity *(circle):* Female / Male / FTM / MTF / NB/GNC / Agender / Decline to Answer

Social Security Number or Driver's License #: _____ LA / TX / MS/ Other: _____

Email Address: _____ Social Media /Other: _____

Cell Phone: _____ Work Phone: _____

I prefer to be contacted (circle): text / call / email / social media /other at Cell / Home/ Work

Employer: _____ Occupation: _____

For work I often (circle): Sit/ Stand/ Bend / Squat / Lift Heavy Things / Caretaker

I am (circle) Under Age18 / Single / Married / Partnered / Divorced / Widowed / Separated / Decline to Answer

Partner/ Spouse's Name: _____ Partner /Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Experience:

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

How did you find us?

Who referred you to us? ☐ General Practitioner (GP) ☐ Pediatrician ☐ OBGYN ☐ OT ☐ PT ☐ SLP ☐ VA

Provider Referral Name: _____

☐ First Glimpse / Mae Lah Maternity ☐ Google search ☐ ICPA directory ☐Instagram ☐ Insurance : _____

☐ Friend/Family Member: _____

Current Medical History

Current Complaints: □ General pregnancy care / prepare for the birth **Pain in:** □ Neck □ Mid back □ Low back
□ Rib pain □ Sacral pain □ Pelvic pain □ Pubic bone pain □ Round ligament pain
□ Breech baby position □ Transverse baby position □ Improve baby positioning
□ Headaches □ Sciatica □ Wrist pain □ Other: _____

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 do your symptoms interfere with your work or normal activities?_____

_____

Have you experienced these symptoms in the past? If so, when & what helped relieve it?: _____

_____

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: _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? □ Yes □ No

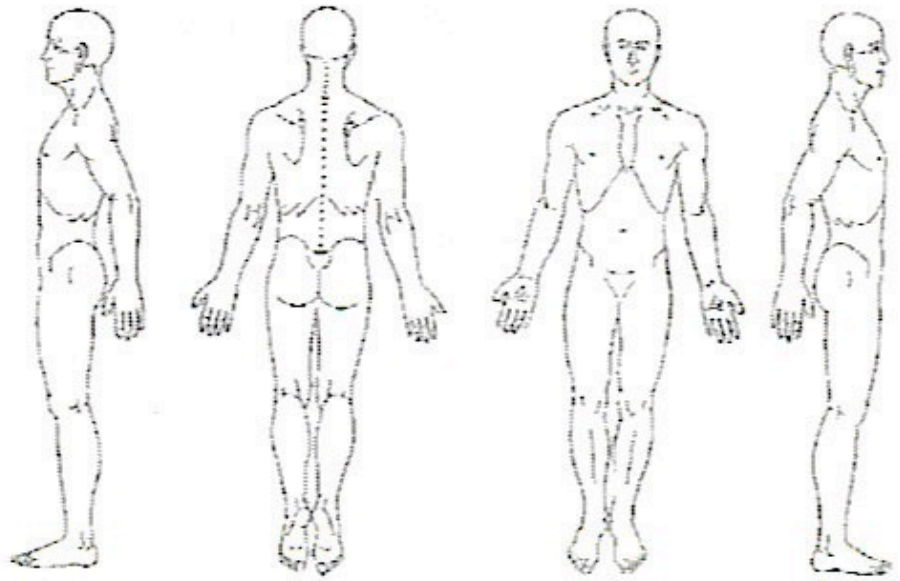
Have you seen another healthcare provider for these symptoms? If yes, who:

Healthcare Provider: _____ Phone: _____

Date last seen: _____ May we update them on your condition? □ Yes □ No

If you are currently on prescription medication, we ask you *not* to make any changes, nor go off of these medications *without* first consulting with your primary care physician or prescribing doctor. It is the responsibility of your prescribing doctor to make any medication changes. Patient's signature: _____

Description of Condition



Left Back Front Right

Mark any area(s) of discomfort with the following key:

A =Ache

N =Numbness

B = Burning

T = Tingling

S = Stiffness

O = Other

On a scale of 1-10 how intense are your 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 often do you experience your symptoms?

①Constantly (76-100% of the time) ②Frequently (51-75% of the time) ③ Intermittently (26-50% of the time) ④ Occasionally (0-25% of the time)

How much have your symptoms interfered with your usual daily activities? (including both work outside the home & housework)

①Not at all ②A little bit ③Moderately ④Quite a bit ⑤ Extremely

In general, would you say your overall health right now is…

①Excellent ②Very good ③Good ④Fair ⑤ Poor

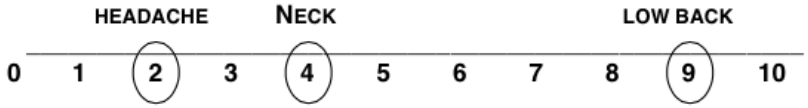
OPTIMIZED LIVING INSTITUTE

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:



1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

5. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Have these symptoms changed in the quality of pain or the duration of pain recently? If so, please explain.

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. Scandinavian Journal of Rehabilitation Medicine 27, 145-151.

Health Questionnaire

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Heart Rate: _____ Normal Blood Pressure: _____ □ **High Blood Pressure**

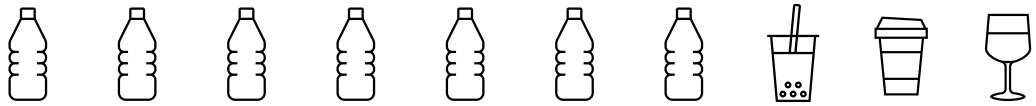
Do you smoke? □ Yes □ No _____packs per day How many years have you been smoking? _____

List anything you are allergic to: _____

Current Diet: Are you dieting? □ Yes □ No Since when? _____

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

Hydration Intake: □ Water □ Soft Drinks □ Coffee □ Energy Drinks □ Alcohol _____drinks per day



List all prescription, non-prescription medications and other supplements you take as well as the associated condition:

□ Prenatal: _____ □ DHA □ Iron □ Probiotics □ Magnesium □ Vitamin D3

_____

_____

_____Birth Control? Y/ N _____

Activities of Daily Living (ADLs): **Energy Levels:** □ High Energy □ Low Energy □ Good

Activity Level Goals: During this time/pregnancy I would like to: □ Exercise □ Provide childcare □ Work
□ Other Hobbies/Interests: _____

Do you exercise? □ Yes □ No How many days per week: _____ Minutes per week: _____

□ Walking □ Running □ Cycling □ Pilates □ Yoga Average steps per day: _____

□ CrossFit □ High Intensity Interval Training (HIIT) □ Kettlebell □ Weightlifting

□ Other: _____

Exercise Intensity: Maximal Heart Rate (MHR): 220- (*your age*) = _____

□ Light (40-54% MHR) □ Moderate (55-69% MHR) □ High (70% + MHR)

Any particular exercise goals you are trying to meet or maintain? _____

_____

Do you wear? □ Orthotics □ Compression Socks □ SI belt □ Brace / Support wear: _____

Technology: □ Computer □ iPhone / Smartphone □ iPad □ Laptop □ TV □ Smartwatch
□ Screen time per day: _____

OPTIMIZED LIVING INSTITUTE

Sleep Quality Assessment (PSQI)

During the past month,

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. What time have you usually gotten up in the morning? _____
4. A. How many hours of actual sleep did you get at night? _____
   B. How many hours were you in bed?

5. During the past month, how often have you had trouble sleeping because you	Not during the past month (0)	Less than once a week (1)	1-2x/ week (2)	3 or more times/ week (3)
A. Cannot get to sleep within 30 minutes	○	○	○	○
B. Wake up in the middle of the night or early morning	○	○	○	○
C. Have to get up to use the bathroom	○	○	○	○
D. Cannot breathe comfortably	○	○	○	○
E. Cough or snore loudly	○	○	○	○
F. Feel too cold	○	○	○	○
G. Feel too hot	○	○	○	○
H. Have bad dreams	○	○	○	○
I. Have pain	○	○	○	○
J. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason(s):				

6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?	○	○	○	○
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	○	○	○	○
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	○	○	○	○
9. During the past month, how would you rate your sleep quality overall?	Very good (0) ○	Fairly good (1) ○	Fairly bad (2) ○	Very bad (3) ○

Scoring:

Component 1	#9 Score	C1 _____
Component 2	#2 Score (<15min (0), 16-30min (1), 31-60min (2), >60min (3)) + #5a Score (if sum is equal 0=0, 1-2=1; 3-4=2;5-6=3)	C2 _____
Component 3	#4 Score (>7(0), 6-7 (1), 5-6 (2), <5 (3)	C3 _____
Component 4	(total # of hours asleep) / (total# of hours in bed) x 100 >85%=0, 75-84%=1, 65-74%=2, <54%=3	C4 _____
Component 5	# sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3)	C5 _____
Component 6	#6 Score	C6 _____
Component 7	#7 Score + #8 score (0=0; 1-2=1, 3-4=2; 5-6=3)	C7 _____

Add the seven component scores together: _____ Global PSQI: _____

A total score of "5" or greater is indicative of poor sleep quality.
If you scored "5" or more it is suggested that you discuss your sleep habits with a healthcare provider.

8775 Jefferson Hwy, Suite E, Baton Rouge, LA 70809 || Text Us: 225.339.9911

Pregnant People Preparations

Birth Team Members:

Birth Team Members: □ OBGYN □ Midwife □ Doula □ Pelvic Floor Therapist/PT □ Lactation Consultant

OBYGN : _____ Phone: _____

Date last seen: _____ May we update them on your condition? □ Yes □ No

Other Birth Team Member : _____ Phone: _____

Date last seen: _____ May we update them on your condition? □ Yes □ No

What are your goals for pregnancy, labor/birth, and postpartum?: _____

_____

_____

_____

Do you have a current birth plan? □ Yes □ No

Preference: □ Hospital □ Birthing Center □ Home Birth □ Other: _____

□ Induction, Pitocin □ Natural, Unmedicated □ VBAC □ Other: _____

If so, please explain: _____

_____

Are you taking any prenatal or birthing classes? □ Yes □ No

If so, please explain: _____

After 32nd week of pregnancy: Position of Baby: □ Head down □ Breech □ Posterior □ Transverse □ Unsure

Confirmed by: □ Palpation □ Ultrasound

If you have been tested for GBS during your *current* pregnancy, were you: □ GBS+ □ GBS -

If you were GBS+ in past pregnancies, did you receive antibiotics? □ Yes □ No

Your Post-Birth Plan:

What are your hesitations or concerns do you have about pregnancy, birth, or postpartum? _____

_____

_____

Do you plan to breastfeed? □ Yes □ No

What is your plan for support postpartum? How long do you intend to rest postpartum? _____

_____

_____

What activities and exercise/fitness would you like to return to postpartum? _____

_____

_____

Have you considered postpartum rehab? Y / N _____

Previous Medical History

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

Comments: _____

_____

_____

Labor & Delivery History Did you &/or the child experience any of the following during labor/delivery:

Birthing Location: □ Hospital □ Birthing Center □ Home Birth □ Other: _____

Labor was □ Induced □ Long &/or difficult Lasted: _____ **Delivery** was □ Rapid □ C-section (Induced/Emergency)

Birthing Interventions: □ Pitocin □ Epidural □ Anesthesia □ Episiotomy □ Degree of tearing/ stitches: _____

□ Other: _____ _____

□ Breech position during pregnancy □ Premature (2+ weeks) □ Cord around the neck □ Fetal distress

□ Forceps or suction cup used □ "Blue Baby" □ Jaundice

□ Any continued bleeding? How heavy (related to days on period): _____

□ Stress or Urge Incontinence □ Any areas of numbness or restriction: _____

Comments: _____

_____

_____

List any surgeries /hospitalizations you have 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):

_____

_____

_____

Previous History Concerns

Please carefully read the following. If you are unsure, check the "?" box.

☐ Yes ☐ No ☐ ? A past history of cancer?

☐ Yes ☐ No ☐ ? Unexplained weight loss?

☐ Yes ☐ No ☐ ? Does your pain fail to improve with rest?

☐ Yes ☐ No ☐ ? Are you over 50 years old?

☐ Yes ☐ No ☐ ? Failure to respond to a course of conservative care? (lasting 4-6 weeks)

☐ Yes ☐ No ☐ ? Have you had spinal pain greater than 4 weeks?

☐ Yes ☐ No ☐ ? Prolonged use of corticosteroids (such as an organ transplant Rx)?

☐ Yes ☐ No ☐ ? Intravenous drug use?

☐ Yes ☐ No ☐ ? Current of recent urinary tract, respiratory tract or other infections?

☐ Yes ☐ No ☐ ? Immunosuppressive medication and/or condition?

☐ Yes ☐ No ☐ ? History of significant trauma?

☐ Yes ☐ No ☐ ? If over 50 years old, history of minor trauma?

☐ Yes ☐ No ☐ ? History of osteoporosis (soft bones)?

☐ Yes ☐ No ☐ ? Are you over 70 years old?

☐ Yes ☐ No ☐ ? Acute onset urinary infection or overflow incontinence (wet underwear)?

☐ Yes ☐ No ☐ ? Loss of anal sphincter tone or fecal incontinence (bowel accidents)?

☐ Yes ☐ No ☐ ? Saddle paresthesia (numbness in the groin region)?

☐ Yes ☐ No ☐ ? Global or progressive muscle weakness in the legs (legs give out)?

OPTIMIZED LIVING INSTITUTE

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Headache	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

_____

Date: _____ Date: _____

Patient's signature: _____ Doctor's signature: _____

Dr. Derek or Rebekah Bruner

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. You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a state or federal program with a mandated fee schedule.
- If you are a member of Preferred Chiropractic Doctor (PCD), ChiroHealthUSA or any other Discount Medical Plan Organization we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join in our office and will be entitled to network discounts similar to our insured patients. Ask us for more information.
- If you are eligible & choose a payment plan that allows for "prompt payment" discounts.

Payments

Private Pay: (please initial)

A_____ I prefer pay self-pay, thus receiving a time-of-service discount. I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally. I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)
*At this time, OLI is in-network with: □ VA CCN □ Medicare

C_____I am veteran with a VA referral. Authorization #: _____

D_____I have Medicare. Please bill Medicare first. I understand that Medicare only covers the chiropractic adjustment. I am responsible for any non-covered services.

E_____I would like this clinic to bill my insurance*. I understand I am responsible for the costs of treatment.

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

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
- Insurance card (front & back) if you would like for us to bill your health insurance provider if we are in-network with the insurance.

Driver's License Photo

Photo of FRONT of driver's license	Photo of BACK of driver's license

Veteran's Card or Health Insurance Card / PCD card / ChiroHealth USA card

OLI is in-network with: □ VA CCN □ Medicare

Photo of FRONT of Veteran's ID card Medicare / health insurance card	Photo of BACK of Veteran's ID card Medicare / health insurance card

Group #: _____ Identification #: _____

_____

Online Payments:

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

Credit Card/ Account #: _____ Exp Date: _____ Billing Zip Code: _____

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: _____