We Welcome You To Optimize Health Center.

APPLICATION FOR CARE: Our goal is to help individuals achieve their highest level of health through our Wellness Programs. Our Metabolic and Brain-Based Therapies are very unique. We expect our patients to achieve profound results. Please fill out this form to the best of your ability. This information will be reviewed by one of our Doctors to determine if you will be accepted for care in our office. Please feel free to ask any questions. We look forward to serving you.

Full Name ______________________________________ Age ____ DOB ____/____/____

Home Phone (__) _________Cell (__) ____________E-mail_________________________

Home Address ____________________ City _______________ State ___ Zip __________

Marital Status S M D W Name of Spouse/significant other______________________

Occupation ____________________ Business Phone _______________________________

Whom may we thank for referring you to our office? ________________________________

Names and ages of children ____

What hobbies or activities do you enjoy? ____

Please list (in order of importance) the 3 main areas in your health that you would like to improve or change.

1 ____

2 ____

3 ____

ABOUT YOUR HEALTH HISTORY

Throughout life, stress and traumatic events can damage every system of your body. This stress may be PHYSICAL, CHEMICAL and/or EMOTIONAL. The information below will help us better understand the stress that you have experienced. We will compare this information with your examination findings.

Current Medications (Insulin further down page)

Medicines Dose /How Often How do/did you feel on it?

1.____
2.____
3.____
4.____
5.____
6.____

Insulin

Time	**Amount/Type**	**Amount/Type**
Example	**50 units NPH**	**10 units Reg**
Breakfast:		
Lunch:		
Dinner:		
Bedtime:		
Other:		

Do you use an insulin Pump? □ Yes □ No Make and Model:____________

Allergies to Medication?

Name	**Reaction**
1.______________________	______________________________________
2.______________________	______________________________________
3.______________________	______________________________________
4.______________________	______________________________________

Medical History (check all that apply and indicate year of diagnosis if one exists)

□ Headache □ Lactose intolerance □ Depression
□ Shortness of breath □ Gallbladder disease □ Gout
□ Heart palpitations □ Prostate disease □ Scarlet fever
□ Heart murmur □ Bowel irregularity □ Chronic rashes
□ Chest pain □ Incontinence □ Rheumatic fever
□ Dizziness/Fainting □ Sexual/menstrual dysfunction □ Mumps
□ Peripheral vascular disease □ Venereal disease □ Measles

□ Allergies/Hay fever
□ Asthma
□ Bronchitis
□ Pneumonia
□ Ulcer
□ GI disorder
□ High cholesterol
□ Hypertension
□ Bowel disorders
□ Diabetes
□ Frequent infections
□ Hepatitis
□ Anemia
□ Arthritis
□ Osteoporosis
□ Liver disease
□ Kidney disease
□ Anorexia/Bulimia
□ Glaucoma
□ Insomnia
□ Rubella
□ Polio
□ Diphtheria
□ Tetanus
□ Nervousness
□ Heart disease
□ Thyroid Disorder
□ Seizures
□ Other ________
□ Other________

Women Only

Pregnant? Yes__ No__ Due Date:
Planning pregnancy? Yes__ No__
Cervical Cancer Screening (PAP smear) Date of last exam: Result:
Mammogram Yes__ No__ Date of last exam: Result:

Men Only

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? Yes__ No__
How often does this occur? □ Frequently □ Sometimes □ Rarely

Surgical History (please list)

Year Type of Surgery Attending Physician and Hospital

1.____
2.____
3.____
4.____

Recent Hospitalizations

Date Diagnosis

1.____
2.____

Social History & Habits

Do you smoke? □ Yes □ No How many packs per day__ week__
Do you drink alcohol? □ Yes □ No
How much? per: day______ week______ month_______
Type of alcohol________________
Do you drink coffee? □ Yes □ No How many cups per day _______
Do you use recreational drugs? □ Yes □ No How much?
Type of drug(s)____

Exercise

Do you exercise? □ Yes □ No Type of exercise_______________

How often do you exercise? minutes _____ /hours___ Daily / weekly

Sleep

Difficulty falling asleep □ Yes □ No Continuity disturbances □ Yes □ No

Snoring □ Yes □ No Early morning awakening □ Yes □ No

Daytime drowsiness □ Yes □ No Hours per night _____ Dreams Y/N

Family History

Are you adopted? □ Yes □ No

Indicate: Father, Mother, Father's Parents, Mother's Parents, Siblings, Children

Heart Disease ____

High Blood Pressure ____

Stroke ____

Cancer ____

Glaucoma ____

Diabetes ____

Epilepsy / Convulsions ____

Bleeding Disorder ____

Kidney Disease ____

Thyroid Disease ____

Mental Illness ____

Osteoporosis ____

Arthritis ____

Multiple Sclerosis ____

Lupus ____

Other ____

HISTORY OF CHEMICAL STRESS

There are over 82,000 different man-made chemicals in our air, water and food. Chemical stress occurs due to these toxic substances that are inhaled, injected, taken orally, or absorbed into the skin.

Have you previously been exposed to or are you currently exposed to? (please circle)

Tap water Mold Flu shots Chemicals Fumes Hair dye Smoke/Ash Cigarettes

How often do you consume? N=Never/Rarely D=Daily W=Weekly M=Monthly

Diet Soda ___ Fast Food ___Candy ___Dairy___ Wheat___ Corn___ Potatoes___ Soy___

Any food sensitivities? ____

Do you follow ant special diet?____

What is your blood type? _________

How much water do you drink daily? ________________

HISTORY OF EMOTIONAL STRESS

Emotional stress creates damage in your systems and causes the release of stress hormones in your body. Although it is common to be under stress, it can affect your overall health. Please circle the emotional stresses you have encountered.

Childhood trauma Yes No **Relationships** Yes No **Illness** Yes No

Loss of Loved One Yes No **Work/School** Yes No **Family** Yes No

Divorce/Separation Yes No **Financial** Yes No **Abuse** Yes No

QUALITY OF LIFE

How do you grade your physical health? Excellent Good Fair Poor

How do you grade your emotional health? Excellent Good Fair Poor

How do you grade your nutritional health? Excellent Good Fair Poor

How do you rate your **overall** "quality of life"? Excellent Good Fair Poor

What is the **main reason** for your visit today? ____

What are your goals of treatment?

____

____

____

What Type of Care are You Seeking?(Please circle)

Temporary relief only Relief and optimum correction

<u>Terms of Acceptance</u>

Optimize Health specializes in the detection, correction and prevention of stress-related disorders and imbalances of your brain-body connection. We do not treat or diagnose medical conditions nor dispense drugs. If you have questions about medications you will be referred to another practitioner who can help you possibly within this office. Today you will have a consultation and examination to evaluate the health of your systems with one of our team. The information gathered today will be analyzed. You will then be scheduled for a special visit with one of the Doctors to discuss the results of your exam. If we accept your case, you will receive written recommendations outlining the steps needed to improve your health. Our methods include spinal adjustments, brain-based therapy, nutrition, detoxification, rehabilitative exercises, education, and stress reduction. As with any treatment a risk of adverse reaction from the body exists. By signing below, you understand and agree to these terms.

Signature ____ Date ______/______/______

Signature of Parent (for minor): ______________________ Date ______ /______/______

Optimize Health Center

11110 Ohio Ave. Suite.108 West Los Angeles, CA. 90025 (310).614.2024

New Patient Questionnaire

Name:____Date____________________

How has your health condition affected your job, relationships, finances, family, or other activities?

____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)

____

What are you most concerned with regarding your problem?

____

Where do you picture yourself being in the next 5 years if this problem is not taken care of?

____

What would be different/better without this problem? Please be specific.

____

What do you desire most to get from working with Dr. Beckingham?

____

What one thing would you like to be able to do that your current health is preventing you from doing?

____

Anything you would like to add?

____

Optimize Health   11110 Ohio Ave. Suite.108   Los Angeles, CA. 90025   (310).614.2024

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Optimize Health, we are committed to treating and using your protected health information responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective January 05, 2012, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Optimize Health a record of your visit is made. This record may contain information regarding your symptoms, examination and test results, diagnoses, subluxation listings, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

Basis for planning your care and treatment,
Means of communication among the health professionals who contribute to your care,
Legal document describing the care you received,
Means by which you or a third-party payer can verify that services billed were actually provided,
A tool in educating health professionals,
A source of information for public health officials charged with improving the health of this state and the nation,
A source of data for our planning and marketing,
A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Specific Authorizations

Patient Demographics: I give permission to Optimize Health to use my address, phone number and clinical records to contact me with welcome, thank you, birthday cards, holiday related cards, and newsletters and information about treatment alternatives or other health related information.

Open Room Adjustments: I give permission to Optimize Health to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with my doctor at any time in private, the doctor will provide a room for these conversations.

Patient Health Information: By signing this form you are giving Optimize Health permission to use and disclose your protected health information in accordance with the directives listed above.

Your Health Information Rights

Although your health record is the physical property of Optimize Health, the information belongs to you. You have the right to:

Obtain a paper copy of this notice of information practices upon request,

Inspect and copy your health record as provided for 45 CFR 164.524,
Amend your health record as provided in 45 CFR 164.528
Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.522, and
Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Optimize Health is required to:

Maintain the privacy of your health information,
Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, Abide by the terms of this notice, Notify you if we are unable to agree to a requested restriction, and Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices changes, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have any questions and would like additional information, you may contact the practice's Privacy Officer, Ian Beckingham DC (310) 614-2024.

Expiration: The Authorization shall expire on the following date: January 1, 2014

______________________________ ______________________________

Patient/Guarantor **Date of Birth**

______________________________ ______________________________

Patient/Guarantor's Signature **Date**