Thanks for your trust in Gorman Optimal Health Solutions, Inc.!

Welcome to our office! To insure that your visit is a pleasant one, here is an outline of the procedures you can expect at our office. Please ask if you have any questions, as there is someone here to assist you.

Step 1: Please take the time to fill out the health history questionnaire in its **entirety** to help us better serve you. Because of our ability to look at you in a more holistic manner, there are very specific reasons as to why we ask **all** of the questions that we do. **Please do not leave any blanks**.

Step 2: While the doctor is reviewing your information, you will see a short video to acquaint you with our office and explain part of how we help our patients regain and optimize their health. There are many other videos to help explain everything that we do on our website as well.

Step 3: You will then meet with the doctor for a personal consultation to review your health history information. An appropriate physical, orthopedic, neurological, chiropractic, and kinesiologic examination will then be performed to determine the state of your health; and see if our methods of health care are appropriate for your condition(s). You will be advised as to the necessity of additional procedures such as laboratory work or X-rays; testing for nutrition, allergies, and/or emotional stress; or a referral to another healthcare professional.

Step 4: When you return for your second visit – the Report of Findings -- the doctor will inform you as to the results of your exam and recommendations for your care. We invite your spouse or those involved in your health care decisions to join you. If you are comfortable with the findings, treatment will begin at this time. To ensure that we are on track with your goals, a progress examination will be scheduled in advance to appropriately access your progress. We recommend bringing your schedule with you to schedule multiple appointments that will be the most convenient for you.

Step 5: Financial arrangements, insurance coverage, and office policies will be covered with you at this time by one of the staff members.

New Patient Questionnaire

Please answer the following questions:

1. Are you willing to follow a treatment program designed to help you return to health for at least three months? (Treating the root causes)
   A. Yes B. No

2. Are you willing to take nutritional supplements, if needed, for your particular case?
   A. Yes B. No

3. Are you willing to make dietary changes, if needed, for your particular case?
   A. Yes B. No

4. Are you willing to start a moderate exercise program, if needed, for your particular case?
   A. Yes B. No

5. Please rate on scale how serious you are about staying healthy after your initial intensive care.

   0 1 2 3 4 5 6 7 8 9 10
   Not Serious Very Serious

6. Are you familiar with Chiropractic?
   A. Yes B. No C. Very little (somewhat)

7. Are you familiar with Applied Kinesiology, or Muscle Response Testing?
   A. Yes B. No C. Very little (somewhat)

8. Concerning Chiropractic care, what have you experienced or heard, whether good or bad?

___

___

___

Please note the following treatments that you are interested in at this time:

- ❑ Chiropractic Care
- ❑ Diet/Nutrition and Lifestyle coaching
- ❑ Allergy Testing/Treatments
- ❑ Neuro-Emotional Technique (Stress Reduction)
- ❑ Customized Nutritional Supplement Program
- ❑ Sports Medicine/Sports Performance
- ❑ Detoxification/ Fasting/Cleansing
- ❑ Physical Therapy/Rehab
- ❑ Applied Kinesiology/Muscle Response Testing
- ❑ Saliva Hormone Testing
- ❑ Functional Medicine Blood Work and Lab Testing
- ❑ Massage Therapy
- ❑ Orthotics and Customized Footwear
- ❑ Weight loss/Ideal Protein Food Program
- ❑ Please evaluate me and recommend what I need

PATIENT INFORMATION Today's Date: ________________________

Name: ____ Date of Birth: ________________________

Address: ________________________________ City: ____________________ State: _________ Zip: ___________

Email: ____

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: _____________________

Social Security #: ___________________________ Age: _________ ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other ___________________________________

Name of Spouse or Nearest Relative: _______________________________________ Phone: ____________________

Do you have any children? __________ If so, how many and what ages? _____________________________________

Your Occupation: _________________________________ Your Employer: __________________________________

Spouse's Occupation: _______________________________ Spouse's Employer: _______________________________

Who can we thank for referring you? ____

Payment for Services will be by: ❑ Cash / Check / Credit Card ❑ Health Insurance ❑ Auto Insurance ❑ Worker's Comp

Primary care doctor: ____ Phone: _________________________

Name of Insurance Co.: ____ ID #: __________________________

Insured's Name: ____ Insured's Date of Birth: _________________

Are you the primary policy holder? ❑Yes ❑No If not, please put name of name of who is: _______________________

Insured's Address: ___________________________________ City: _______________ State: ______ Zip: ________

Insured's Employer: __________________________________ Employer's Phone #: ____________________________

Are you covered by more than one insurance company? ❑Yes ❑No Name: ___________________________________

For Medicare, please list your secondary insurance: ____

TREATMENT: What type of treatment are you looking for?

❑ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
❑ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem so that it doesn't return.
❑ I am looking to take care of the cause of my problem and then go on to "achieve optimal health and wellness."

HEALTH CONCERNS/GOALS: **Please list your top health concerns/goals in order of priority**

1) ____
2) ____
3) ____
4) ____

MEDICAL / FAMILY HISTORY: S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	epilepsy	❑	❑	❑	migraines
❑	❑	❑	anemia	❑	❑	❑	German measles	❑	❑	❑	neck pain
❑	❑	❑	arthritis	❑	❑	❑	headaches	❑	❑	❑	nervousness
❑	❑	❑	asthma	❑	❑	❑	heart trouble	❑	❑	❑	numbness
❑	❑	❑	back pain	❑	❑	❑	hepatitis	❑	❑	❑	polio
❑	❑	❑	bladder trouble	❑	❑	❑	high blood pressure	❑	❑	❑	poor circulation
❑	❑	❑	bone fracture	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatic fever
❑	❑	❑	bowel control loss	❑	❑	❑	indigestion	❑	❑	❑	rheumatism
❑	❑	❑	cancer	❑	❑	❑	kidney disorder	❑	❑	❑	serious injury
❑	❑	❑	chest pain	❑	❑	❑	reproductive disorders	❑	❑	❑	sinus trouble
❑	❑	❑	concussion	❑	❑	❑	menstrual cramps	❑	❑	❑	stroke
❑	❑	❑	convulsions	❑	❑	❑	mental illness	❑	❑	❑	thyroid disease
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	dislocated joints	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Please **list** your **symptoms** below and the relative pain intensity (0 – 10) for each symptom.

No Pain	Mild			Moderate			Severe		Unbearable	
0	1	2	3	4	5	6	7	8	9	10

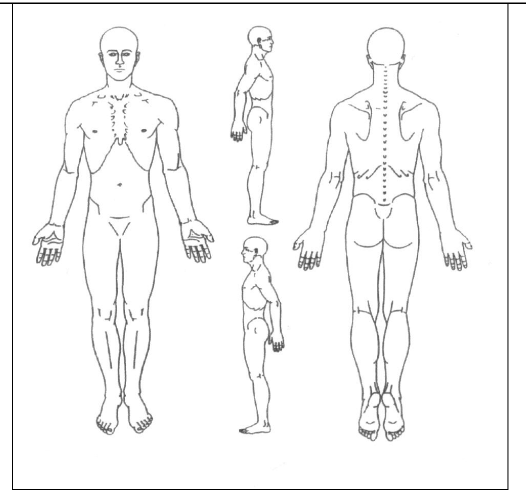
Symptoms: (*Example: Low back pain – 4*)

a) ____________________________ b) ____________________________

c) ____________________________ d) ____________________________

e) ____________________________ f) ____________________________

Please **mark** on the diagram to the right the following symbols as they relate to your symptoms:
SS= spasms ST= stiffness DP= dull pain SP= sharp pain
SH= shooting pain TI= tingling NU= numbness O= other



Have you ever had this before? ❑No ❑Yes When? ______________________________

In your opinion, what do you think is causing your complaints?______________________________

____

Name of doctors previously seen for present condition: ______________________________

Symptoms are WORSE in: ❑Morning ❑Afternoon ❑Night
When and how occurred?______________________________

Symptoms developed from: ❑Job related injury ❑Auto accident ❑Other ❑Accident ❑Illness ❑Unknown cause ❑Gradual onset **Date occurred**: ______________________________

Symptoms have persisted for # ______ Hour(s) ______ Day(s) ______ Week(s) ______ Month(s) _____ Year(s)

Symptoms/Complaints: ❑Come & go ❑Are constant

Describe the pain: ❑Sharp ❑Dull ❑Numbness ❑Tingling ❑Ache ❑Stiffness ❑Burning ❑Shooting ❑Spasm ❑Weakness ❑Stabbing ❑ Throbbing ❑Other: ______________________________

Please check the following activities that AGGRAVATE your condition:
❑Bending ❑Reaching ❑Straining while going to bathroom ❑Coughing ❑Sitting ❑Turning head ❑Lifting ❑Sneezing ❑Walking ❑Lying down ❑Standing ❑Twisting ❑Other: ______________________________

Please check the following activities that RELIEVE your condition:
❑Bending ❑Sitting ❑Lifting ❑Standing ❑Lying down ❑Turning head ❑Reaching ❑Walking ❑Ice ❑Heat ❑Pain relieving medications ❑Other: ______________________________

Please check any ADDITIONAL SYMPTOMS you may be experiencing:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss / confusion ❑ TMJ ❑constipation ❑depression ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of memory ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑ low back pain ❑ neck pain ❑ skin issues ❑ poor digestion ❑pins & needles in arms ❑pins & needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Is this condition INTERFERING with your: ❑Work ❑Sleep ❑Daily routine ❑Recreation ❑Relationships

❑Hobbies ❑Other: ______________________________

<u>Allergies/Sensitivities</u>: Please check and list all allergies
❑ <u>Food</u>: ❑Dairy ❑Wheat ❑Corn ❑Soy ❑Seafood ❑Gluten ❑Peanuts ❑Fruits ❑Other: ____________________
❑ <u>Medications</u>: ❑Penicillin ❑Sulfa Drugs ❑Iodine ❑Insulin ❑Antibiotics ❑Other: ____________________
❑ <u>Seasonal</u>: ❑Pollen ❑Dust ❑Hay ❑Mold ❑Chemical(s) ❑Smoke ❑Animals ❑Insects
❑ Other: ______________________________

Are you pregnant? ❑No ❑Yes Date of last menstrual period: ______________________________

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
❑ Antacids		
❑ Antibiotics		
❑ Antidepressants		
❑ Anti-Diabetics		
❑ Anti-Inflammatory		
❑ Blood Pressure Lowering Meds.		
❑ Cholesterol Lowering Meds.		
❑ Hormone Replacements (HRT)		
❑ Oral Contraceptives		
❑ OTC (over the counter) Other		

SUPPLEMENTS: Do you take Vitamins, Supplements, Homeopathy or Herbs? ❑ Yes ❑ No

If yes, who recommended them? ______________________________

List supplements: ______________________________

PAST MEDICAL INJURIES: List all major injuries, accidents, fractures, hospitalizations, falls, ______________________________

____

Date of Last Physical: ______________ Anything abnormal? ______________________________

Date of Last Lab / Blood Work: ______________ Anything abnormal? ______________________________

Date of most recent X-ray/MRI: ______________ Anything abnormal? ______________________________

SCARS / SURGICAL PROCEDURES: Have you had any surgical procedures? ❑Yes ❑No List along with any scars:

Spine: ❑Cervical ❑Thoracic ❑Lumbar **Extremities:** ❑Shoulder / Elbow / Hand / Wrist ❑R ❑L ❑Hip / Knee / Ankle / Foot ❑R ❑L

Abdominal / Chest: ❑Appendix ❑Colon ❑Gall Bladder ❑Heart ❑Lungs ❑Breast ❑Other: ______________________________

HABITS:	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Soda / Diet Soda	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Chocolate	❑	❑	❑	❑
Stress Level:	❑	❑	❑	❑

List hobbies/activities: ______________________________

____

Exercise	5-7x/wk	3-5x/wk	1-3x/wk	None
Cardio/Aerobic	❑	❑	❑	❑
Exercise	5-7x/wk	3-5x/wk	1-3x/wk	None
Weights	❑	❑	❑	❑
Exercise	5-7x/wk	3-5x/wk	1-3x/wk	None
Stretching/Yoga	❑	❑	❑	❑

	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Sleep	❑	❑	❑	❑	❑

How do you sleep? ❑ on back ❑ on side ❑ on stomach

	5+	4	3	2
Meals / day	❑	❑	❑	❑

	64+ oz	32-64 oz	16-32 oz	<8 oz
Water / day	❑	❑	❑	❑

Number of bowel movements per day ______________ Number of times you urinate per day ______________

WORK ACTIVITY: ❑ Heavy Labor ❑ Light Labor ❑ Mostly Sitting ❑ Mostly Standing ❑ Walking / Moving ❑ Driving

How long has it been since you really felt good? ❑ Days ❑ Weeks ❑ Months ❑ Years ❑ >10 years

What was different then than now? ______________________________

List any major dental work: ______________________________

Do you currently wear heel lifts or orthotics? ❑ Yes ❑ No If yes, are they soft or hard? ______________

List any emotional / stress related issues: ______________________________

Is there anything else you are concerned about or you feel the Doctor should know? ______________

Patient's Signature: ______________________________ **Date:** ______________