



Optimal Health & Wellness Center, Ltd.

800 Roosevelt Rd., Bld. D, Ste. 104 • Glen Ellyn, IL 60137 • 630-858-9900

Patient Application Form

WELCOME TO OUR OFFICE. We specialize in assisting people to achieve their highest level of health through our Chiropractic Neurology, Brain-Based therapy, Metabolic corrective programs and Laser techniques. Our approach may be considered unique and advanced from other rehabilitative programs so we have very strict requirements in accepting new patients. This allows our patients to achieve far superior results compared to most other systems.

In order to be seen, I agree to:

1. Fill out the following information as thoroughly as possible so we can let you know if we can accept your case.
2. Put my name and date on every page, of every form.

I agree to the above terms and understand that should I NOT have the paperwork completed to the best of my ability, I may NOT be seen. I also agree and understand that should I receive a consultation on my case as outlined in this paperwork, that Dr. Kelenyi is assessing my case on the basis of her chiropractic license alone and does not diagnose or treat any disease including cancer. I agree and understand that it is my responsibility to seek appropriate medical care in such cases.

Signature

Today's Date

**PLEASE BRING THIS PAPERWORK WITH YOU TO YOUR SCHEDULED APPOINTMENT
OR FAX/SCAN/RETURN PRIOR TO YOUR PHONE CONSULTATION.**

BE SURE TO BRING ALL CURRENT BLOOD WORK.

You may also have it faxed to our office ahead of time from your doctor's office.

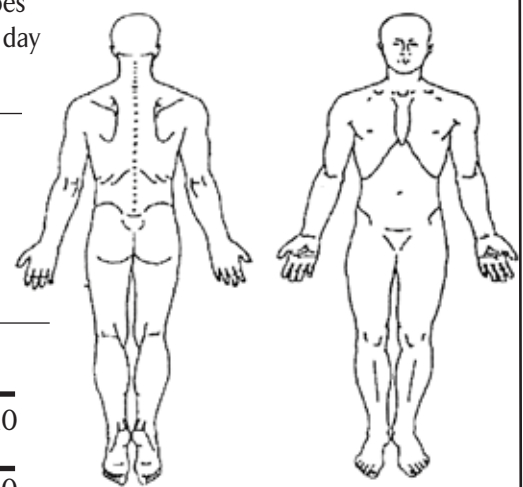
Welcome to Optimal Health & Wellness Center, Ltd.

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information
Patient Name _____
Today's Date _____ Date of Birth _____
Social Security # _____
Address _____
City _____
State _____ Zip _____
Gender _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Engaged
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor
How many children do you have? _____
Please list any family members belong treated here _____
Occupation _____
Employer/School _____
Employer/School Address _____
Employer/School Phone () _____

Contact Information
Home Phone () _____
Cell Phone () _____
Work Phone () _____
Email Address _____
May we contact you via (check for all applicable)
<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email
<small>The emails will be used for non-sensitive/non-urgent issues only</small>
In case of emergency please contact:
Name _____
Relationship _____
Home Phone () _____
Alternate Phone () _____
Spouse's/Partner's Name _____
Spouse's/Partner's Employer _____
Who referred you? _____

Patient Condition				
What is your major complaint (be as specific as possible. Please mark all areas on the pictures where your condition, symptoms/pain occurs.) _____				
When did your condition/symptom/pain first appear? (specific date, days ago, weeks ago, etc. _____				
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant <input type="checkbox"/> It comes and goes				
When is it worse? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Changes depending on time of day				
Does it interfere with <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routines <input type="checkbox"/> Recreation <input type="checkbox"/> Other				
How long has it been since you really felt good? _____				
Other doctors seen for this condition <input type="checkbox"/> MD <input type="checkbox"/> DC <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> Other				
Does the condition/symptom/pain radiate? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, where and how frequently _____				
How long/often does the radiation occur/last? _____				
Do you have <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness				
Describe _____				
List and mark the severity of your condition/symptoms/pain on the scale below:				
Body part _____				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border-top: 1px solid black;"></td> <td style="width: 25%; text-align: center;">0 (None)</td> <td style="width: 25%; text-align: center;">5</td> <td style="width: 25%; text-align: right;">(Severe) 10</td> </tr> </table>		0 (None)	5	(Severe) 10
	0 (None)	5	(Severe) 10	
Body part _____				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border-top: 1px solid black;"></td> <td style="width: 25%; text-align: center;">0 (None)</td> <td style="width: 25%; text-align: center;">5</td> <td style="width: 25%; text-align: right;">(Severe) 10</td> </tr> </table>		0 (None)	5	(Severe) 10
	0 (None)	5	(Severe) 10	
Type of Pain <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Numbness <input type="checkbox"/> Other				
What activities or positions aggravate your condition? <input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Getting up/down <input type="checkbox"/> Driving <input type="checkbox"/> Lifting				
<input type="checkbox"/> Lying down <input type="checkbox"/> Sneezing <input type="checkbox"/> Standing <input type="checkbox"/> Straining at stool <input type="checkbox"/> Turning head <input type="checkbox"/> Twisting <input type="checkbox"/> Walking				



Patient Condition

What activities or positions relieve your condition? Heat Lying Down Sitting Stretching Other
 Ice Medication Massage Exercise
Have you ever had this condition before? Yes No If yes, when? _____
Were you treated for this condition or a similar one before? Yes No If yes, when/by whom? _____

Health History

Do you have any allergies? (food, contact, environmental)
List any vitamins, herbs and supplements you take Yes No If yes, when? _____
When was your last: physical examination _____; Blood/lab work _____; X-ray study _____
Injuries/Surgeries you've had and when? _____

Have you had or do you have any of the following conditions or diseases? Please check any that apply to indicate yes.

- AD/HD Connective tissue issues HIV/AIDS
 Adrenal disorder COPD Kidney disease
 Anxiety Depression Knee surgery
 Arthritis Diabetes Liver disease
 Asthma Digestive/bowel problems Marfan's syndrome
 Autoimmune disorder: _____ Dizziness or vertigo Multiple sclerosis
 Bleeding disorder Ear infections Osteoporosis/penia
 Blurred vision Fibromyalgia Parkinson's disease
 Bowel/Bladder problems Food sensitivity Rotator cuff problems
 Buzzing in ear Fusions (spinal, joint) STI/STD
 Cancer - type? _____ Gout Shoulder surgery
 Carpel tunnel syndrome Gall bladder issue Spinal surgery
 Celiac disease (gluten) Immune compromise Stroke/TIA
 Chest pains Heart disease Thyroid problems
 Chronic fatigue Hepatitis (A, B, C, etc.) Tuberculosis
 Cold hands and feet Herpes Other _____
 Colitis/diverticulitis High blood pressure _____
 Compression fractures Hip replacement _____

Are there any conditions that run in your family? Yes No If yes, what condition(s) and which family member(s)? _____

Patient Condition

Are you currently pregnant, or do you think you may be pregnant? Yes No If yes, how many weeks? _____
How many hours per week do you typically work/attend school? <20 hrs 30 hrs 40 hrs >40 hours
What are your typical duties and postures (sitting, standing, lifting, etc.)? _____
Do you exercise? Yes No If yes, how often and what type? _____
How would you rate your eating habits? Excellent Pretty Good Could be better Needs Improvement
How well do you sleep? Excellent Pretty Good Restless Can't sleep Wake up often
How many hours of sleep do you get daily? _____ hours, and do you feel rested in the morning Yes No
How is your energy overall? Full Power OK Low Sporadic/Generally fatigued I depend on caffeine for energy
How often do you get "sick"? Almost never I tend to catch what is going around I am constantly sick
What do you hope to receive from our program? _____

My Current Diet

Name _____ Date _____

List your diet on an average day below. Don't worry about trying to impress us by telling the doctor what you think he wants to hear. Just think about how you eat on an average day. **Be realistic.**

Check all meals that you eat each day (check all that apply):

Breakfast Snack Lunch Snack Dinner Snack

A typical breakfast consists of _____

A typical lunch consists of _____

A typical dinner consists of _____

A typical snack between meals consists of _____

How much water do you drink per day? _____

Do you drink green/black tea? _____

How much coffee do you drink per day? _____

How much soda pop do you drink per day _____

List any know food sensitivities or allergies _____

List foods you crave _____

My Surgical History

List the type of surgery, reason for the surgery and year performed. (I.e.: 'Left breast surgery for cancer in 2004')

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

— Thank you for completing our Health Care questionnaire.

My Medications

Name _____ Date _____

List the name of each current prescribed and over the counter medications, it's prescribed use and any side effects/reactions/positive responses — (example of use: BCP - birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.) — (example of side effect could be 'Tylenol caused liver enzymes to increase.').

	Medications	Prescribed Use	Side Effects
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			