# Welcome to Optimal Sports Therapy

Our mission at Optimal Sports Therapy is to help you achieve all of your health goals and needs. Whether your main reason for seeing us to get out of pain, increase your energy, lose weight or simply take your health to the next level, we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step in the process is to establish your current state of health and the overall function of your body. In order for us to assess this and understand the root cause of your symptoms, we will take you through a series of non-invasive examinations on your initial visit. This includes a full case history, nerve and muscle tests, postural analysis, a functional movement exam, bioimpedance analysis, and blood pressure tests.

There are a few simple steps for you to follow prior to your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

On the day of your visit, we ask that you wear comfortable clothing in which you can easily move. We will take a postural photo of you, so please avoid multiple layers or bulky clothing.

At your initial visit, please bring all completed paperwork (6 pages total) and any previous X-ray or MRI reports, or recent blood work with you so we may refer to these during our case history.

Your initial assessment will take between 45-60 minutes. Please allow sufficient time for your appointment. If you have time constraints, contact our front desk prior to your visit.

**PLEASE NOTE:**
We have a 24-hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late please contact the front desk at 203.292.9328. Late arrivals do run the risk of requiring a rescheduled appointment.

## GENERAL INFORMATION

**Please full out the forms *completely* and *accurately* to the best of your ability so we can quickly get you on the road to health.**

Today's Date: _____ Social Security Number (SSN): _____-_____-_____

Name: _____
Last First Middle Initial

Street Address: _____ City: _____ State: _____ Zip Code: _____

Email (to enable the doctors to communicate with you): _____

Cell Phone Number: _____ Home Phone Number: _____

Preferred method of communication (select one): Email _____Text _____ (Carrier's Name: _____)

Gender: Male _____ Female _____ Age: _____ Birthdate: _____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for ___ years Minor _____

Race (select one): American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Your Employer or School: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ SSN: _____-_____-_____ Phone: _____

Spouse's Birthdate: _____ Employer: _____

## EMERGENCY CONTACT

Name of Emergency Contact: _____

Relationship: _____ Phone: _____

## ACCIDENT INFORMATION

Is your condition due to an accident? Yes _____ No _____ Date of Accident: _____

Type of Accident: Auto _____ Work _____ Home _____ Other (please describe) _____

## INSURANCE INFORMATION

*Please complete this section regardless of your referral source (including non-referral external workshops). We are happy to verify your insurance coverage and provide your benefits information to you. We will NEVER bill your insurance without your permission.*

Who is responsible for this account? _____ Relationship to patient: _____

Name of Insurance Company: _____ ID#: _____

Subscriber Name: _____ Birthdate: _____

**ASSIGNMENT AND RELEASE:**

I certify that I, and / or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Andrew Yaun, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of above signature — Relationship to Patient

## CLINICAL SUMMARY (a required EMR question)

_____ I choose to decline receipt of my clinical summary after every visit. *(These summaries are often blank as a result of the nature and frequency of chiropractic care).*

## FINANCIAL RESPONSIBILITY

Patient Name: _____

Dear Patient,

The Optimal Sports Therapy provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

## YOUR VISIT

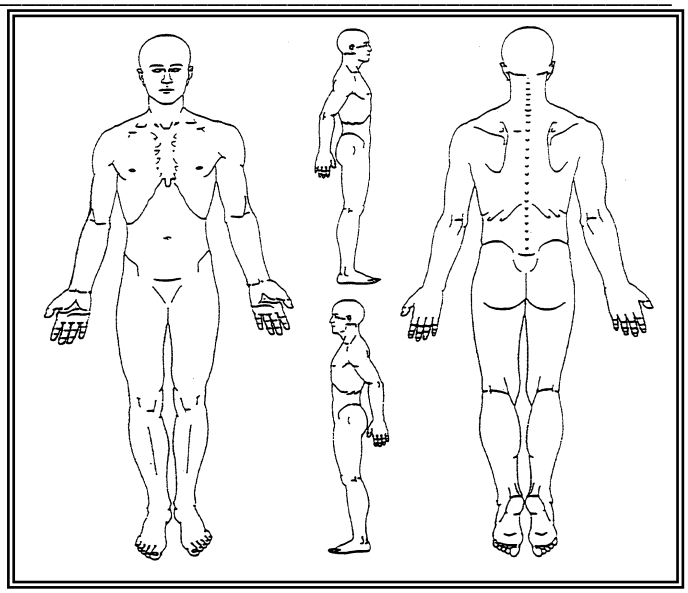
We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

_____

If you are seeing us for a pain-related issue, USE THE SYMBOLS on the image to the right to show the type of pain you feel in each location.

| | |
|---|---|
| X X X X X X X X | DULL / ACHY |
| / / / / / / / / / / | SHARP / STABBING |
| o o o o o o o o o | NUMBNESS / TINGLING |
| s s s s s s s s s s | STIFF/TIGHT |
| - - - - - - - - - - - - | BURNING |



Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

**0** = **No Pain**. No Discomfort
**1** = **Minimal Discomfort**. Minor stiffness or tightness.
**2** = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
**3** = **Minimal Pain**. More than just sore. Uncomfortable.
**4** = **Mild Pain**. Noticeable pain but tolerable.
**5** = **Moderate Pain**. Aggravating. Still allows movement.
**6** = **Strong Pain**. Quite aggravating. Movement slightly limited.
**7** = **Very Strong Pain**. Very aggravating. Movement definitely limited.
**8** = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
**9** = **Severe Pain**. Brings tears. Almost impossible to move.
**10** = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? Yes _____ No _____ Is there any numbness or tingling? Yes _____ No _____

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): _____ Frequent (50-75% of the time): _____
Occasional (25-50% of the time): _____ Intermittent (0-25% of the time): _____

List any MDs or Chiropractors you've already seen for this problem: _____

_____

What tests have you already had for this problem? X-rays _____ MRI _____ Myelogram _____ EMG / NCV _____ None _____
Other (please describe) _____

What makes your problem worse? Sitting _____ Standing _____ Changing Position _____ Walking _____ Bending _____
Lifting _____ Twisting _____ Reaching _____ Driving _____ Sleeping _____ Sneeze / Cough _____ Computer Work _____
Telephone _____ Going from Sit to Stand _____ Other (please describe) _____

## MEDICAL HISTORY

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: _____

_____

_____

Please list any surgeries/hospitalizations you have had over the course of your life: _____

_____

_____

Are you allergic to any medications? Yes _____ No _____ If yes, please list: _____

List any medications, herbs or supplements you are taking and the reason for their use: _____

_____

_____

## FAMILY HISTORY

Mother: Living _____ Deceased _____ List any medical problems: _____

Father: Living _____ Deceased _____ List any medical problems: _____

List any problems common to your family: Cancer _____ Diabetes _____ Heart disease _____ High blood pressure _____ Stroke

Arthritis Scoliosis Thyroid disease Osteoporsosis Other (describe)

## SOCIAL HISTORY

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for _____ years

Do you have any children? Yes _____ No _____ If yes, how many? _____

Do you drink alcohol? Yes _____ No _____ If yes, how much and how often? _____

Do you smoke? Yes _____ No _____ If yes, how much, how often and how long? _____

Are you currently employed? Yes _____ No _____

Who is your current employer? _____ How long have you been at this job? _____

What do you do most of the day in your job postures, positions and repetitive movements? _____

_____

On a scale of 0-10 (0 = Worst and 10 = Best) rate how well you think you are doing with the following:

Exercise _____ Sleep_____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____

## REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

| | | |
|---|---|---|
| **Head:**<br>_____ Headaches<br>_____ Faintness<br>_____ Dizziness<br>_____ Insomnia | **Energy / Activity:**<br>_____ Fatigue / Sluggishness<br>_____ Apathy / Lethargy<br>_____ Hyperactivity<br>_____ Restlessness | **Lungs:**<br>_____ Chest Congestion<br>_____ Asthma, Bronchitis<br>_____ Shortness of Breath<br>_____ Difficulty Breathing |
| **Eyes:**<br>_____ Watery or Itchy Eyes<br>_____ Swollen, Red or Sticky Eyelids<br>_____ Bags or Dark Circles Under Eyes<br>_____ Blurred or Tunnel Vision (not including near or far sightedness) | **Weight:**<br>_____ Binge Eating / Drinking<br>_____ Craving Certain Foods<br>_____ Excessive Weight<br>_____ Compulsive Eating<br>_____ Water Retention<br>_____ Underweight | **Heart:**<br>_____ Irregular or Skipped Heartbeat<br>_____ Rapid or Pounding Heartbeat<br>_____ Chest Pain |
| **Ears:**<br>_____ Itchy Ears<br>_____ Earaches, Ear Infections<br>_____ Drainage from Ear<br>_____ Ringing in Ears, Hearing Loss | **Emotions:**<br>_____ Mood Swings<br>_____ Anxiety / Fear / Nervousness<br>_____ Anger / Irritability / Aggressiveness<br>_____ Depression | **Digestive Tract:**<br>_____ Nausea, Vomiting<br>_____ Diarrhea<br>_____ Constipation<br>_____ Bloated Feeling<br>_____ Belching, Passing Gas<br>_____ Heartburn<br>_____ Intestinal / Stomach Pain |
| **Nose:**<br>_____ Stuffy Nose<br>_____ Sinus Problems<br>_____ Hay Fever<br>_____ Sneezing Attacks<br>_____ Excessive Mucus Formation | **Mind:**<br>_____ Poor Memory<br>_____ Confusion, Poor Comprehension<br>_____ Poor Concentration<br>_____ Poor Physical Condition<br>_____ Difficulty Making Decisions<br>_____ Stuttering or Stammering<br>_____ Slurred Speech | **Mouth and Throat:**<br>_____ Chronic Coughing<br>_____ Frequent Need to Clear Throat<br>_____ Sore Throat, Hoarseness<br>_____ Swollen or Discolored Tongue<br>_____ Canker Sores |
| **Skin:**<br>_____ Acne<br>_____ Hives, Rashes, Dry Skin<br>_____ Hair Loss<br>_____ Flushing, Hot Flashes<br>_____ Excessive Sweating | **Joints / Muscles:**<br>_____ Pain or Aches in Joints<br>_____ Arthritis<br>_____ Stiffness or Limited Movement<br>_____ Pain or Aches in Muscles<br>_____ Weakness or Fatigued Muscles | **Other:**<br>_____ Frequent Illness<br>_____ Frequent or Urgent Urination<br>_____ Genital Itch or Discharge |
| **GRAND TOTAL:** | | |