

## Optimum Function Patient Checklist:

### DID YOU REMEMBER TO?


- Read all of the documents
- Obtain your medical records and/or test results from previously seen physicians and have them sent to me at:

**Optimum Function  
Dr. Tim Irving DC, LMT  
819 SE Morrison St., Suite 215  
Portland, Oregon, 97214**

### FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- Patient Acceptance Policy
- Authorization for Release of Medical Information
- Establishing Your Health Goals
- Patient Motivation Assessment
- Functional Diagnostic Medicine: Patient Intake, Health and Medical History
- Detoxification Questionnaire
- Nutritional Assessment Questionnaire
- Diet Diary

Yours in Health



DC, L.M.T

Dr. Tim Irving DC, LMT, Nutritionist

## Frequently Asked Questions:

### ***Do you think you can help me with my health problem?***

I use an innovative approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor, having blood tests, x-rays or other diagnostic tests, only for your doctor to report back that all your tests are normal yet you don't feel normal! Unfortunately this experience is all too common.

Most physicians are trained to look in very specific places for the answers, using the tests and procedures that limit their ability to put together your specific health story. The usual tests do not look for functional disturbances, potential food sensitivities, hidden infections, environmental toxins, nutritional deficiencies and metabolic imbalances. New testing and new ways of analyzing routine tests may uncover underlying metabolic and/or genetic predispositions that can be modified through diet, lifestyle, supplements in addition to or as an alternative to medications.

I use a variety of innovative testing techniques and procedures to help my patients prevent illness and recover from many chronic and difficult to treat conditions and achieve optimal function.

### ***Can all the tests I need be done at this clinic?***

Most of the testing can be performed at Optimum Function. Some testing can be done through conventional laboratories and others are only available through specialty laboratories. During your consultation, I will determine which tests are needed and then discuss with you the testing recommendations, the instructions (e.g. fasting or non-fasting, etc.) and costs. Some testing can be performed at home with test kits to collect urine, saliva or stool. Others may require you to go to a local laboratory to draw the blood. In all cases, I will assist you in coordinating initial and follow-up testing as needed.


### ***Do you take insurance?***

I do not accept Medicare but will attempt to bill your insurance company if you have "out of network" coverage that will reimburse me for the work I will do with you. Some insurance carriers may partially cover medical services and laboratory tests performed by me. Payment in full by check, cash or credit card is due at the time services are provided unless we are going to attempt to bill your insurance, then you will be responsible for anything the insurance company does not pay for.

### ***What credit cards do you accept?***

I accept the following credit cards: MasterCard, Visa and Discover. If you like, I can maintain an active credit card on file at the office so I can bill follow-up consultations, laboratory testing, and other services with your approval.

Yours in Health,



D.C., L.M.T

Dr. Tim Irving DC, LMT, Nutritionist

## Why I Use the Functional Medicine Approach

Your body and its systems (organs, muscles, bones, etc.) are masterpieces of design. Every part has its specific functions as well as an interrelationship with the whole. When you experience symptoms, it's your body's way of telling you that something isn't working at its full function. My role as your doctor is to work with you to determine what's not functioning, why, and how I might assist you in restoring you back to optimal health.

I use a holistic, supportive, patient-centered approach to healthcare that benefits patients of all ages and conditions. As a functional medicine practitioner, I consider the web of interactions that occur among the following:

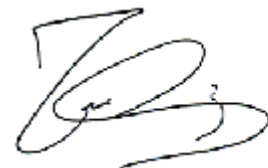
- Nutrition
- Digestive function
- Detoxification function
- Energy metabolism
- Hormonal function
- Structural function
- Immune system function/inflammation

I will clarify the extent of any dysfunction by intensive listening (taking your history), physical examination, and laboratory tests. Once I have identified the root causes of your symptoms, I'll recommend specific treatments and therapies, including chiropractic treatment, various soft-tissue techniques, nutritional counseling, nutritional supplementation, exercise and stress reduction appropriate to your lifestyle, and referrals to the proper health provider(s) when necessary. I will take on the role as a partner in helping you improve your health.

I also use functional medicine to assess your risk of developing certain health conditions with intent to prevent chronic illnesses from occurring. In this way, I move from a downstream (reactive) approach, to an upstream (proactive) approach. I can help you determine what factors are "pushing you into the river" in the first place by identifying your susceptibilities. For example, increasing a patient's consumption of whole, not processed foods, including a colorful variety of fruits and vegetables offers significant promise regarding prevention of cancer, heart disease, and osteoporosis, as well as successfully addressing a number of common maladies.

For more information, you may visit [www.functionalmedicine.org](http://www.functionalmedicine.org), the website for the Institute for Functional Medicine, [www.jeffereybland.com](http://www.jeffereybland.com), or [www.functionalmedicineuniversity.com](http://www.functionalmedicineuniversity.com), where I have completed some of my studies.

Yours in Health,



Dr. C., L.M.T

Dr. Tim Irving DC, LMT, Nutritionist

**Remember: Optimum Function = Optimum Health**

## Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is my opinion that you should be well informed on our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, I need you read the steps below and provide your signature. This would simply imply that you have read the *Patient Acceptance Policy* and understand what is expected of you.

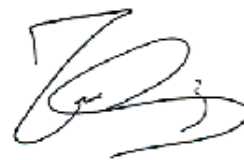
**1. Completion of the required forms:**

- It is **VERY** important for you to carefully and thoroughly complete all of these forms and questionnaires prior to our first appointment. In many cases, I will wait to schedule your first appointment until I received all of the necessary paperwork/medical records so I can have a clear picture of your health up until you came to Optimum Function.

**2. Medical Records, if necessary, MUST be obtained prior ASAP.**

- 3.** The cost of your initial appointment is included in the price of the program you have enrolled in. When medically necessary, I may require that you participate in tests not included in the program you have chosen. This is for your own health and well-being, there is no way to predict when this is necessary and if this situation occurs, I will disclose all of the reasons and all of your options to you so you can make an educated decision.
- 4.** After your initial appointment, I will schedule any blood work, perform a functional urinalysis, and/or order any advanced functional tests depending on the program you are enrolled in.
- 5.** The results of your lab tests may take approximately **2-3 weeks**, at which point, I will call to schedule a follow-up appointment with you. This appointment usually takes approximately one to 45-60 minutes and, for a limited time will not cost extra. You will be presented with a written report **detailing the results of your tests, the possible causes of your health problem and the recommended treatment protocol including any support materials like a diet plan, supplement plan, etc.**
- 6.** Your treatment will consist of dietary and lifestyle changes as well as prescribed **Natural Pharmaceuticals**, which will be custom ordered for you and must be paid for during this follow-up appointment.
- 7.** It is strongly recommended that you have access to a computer with Internet Connection. **Support forms, questionnaires and information will be sent to you via email.** Other forms will be periodically sent to you to monitor your progress. Correspondence by e-mail is strongly encouraged and is **Free of Charge**. If you would prefer to schedule an in office appointment to discuss any questions, you may do so for a \$59 fee during special 20-30 minute support appointments. **Note: The online scheduler is not to be used to schedule these appointments, please call 503-866-9739 to schedule.**
- 8.** Follow-up consultations will be scheduled as needed and as I feel your specific health goals warrant, this will allow you the opportunity to discuss your progress and any concerns with me. Your cooperation in taking “**personal responsibility**” in your health care will help me to help you achieve optimal health.
- 9. Abnormal laboratory tests** will need to be re-evaluated. The success of your treatment will not only be measured on the reduction of elimination of your physical symptoms, but on abnormal laboratory tests returning to a normal status.

I, \_\_\_\_\_ (print your name) have read and fully understand the **Patient Acceptance Policy**



D.C., L.M.T

\_\_\_\_\_  
**Your Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Dr. Tim Irving DC, LMT**

**REQUEST FOR MEDICAL RECORDS**

**PURPOSE OF REQUEST:** For diagnostic assessment and to complete medical records **DATE:** \_\_\_\_\_

Patient Name (Print):			
Patient Identification:	<b>Address:</b>		
	<b>Phone Number:</b>		
	<b>Social Security No:</b>	<b>Date of Birth:</b>	

**Name and address of Doctor/Facility where patient’s medical records are located:**

Name:	
Address:	
Phone/Fax	

**WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE AND MAIL:**

<input type="checkbox"/> All Medical Records: _____ <input type="checkbox"/> X-Ray/MRI/CT reports/films (circle): _____ <input type="checkbox"/> Lab work (CBC, chem. screen): _____ <input type="checkbox"/> IME or consulting reports dated: _____ <input type="checkbox"/> Other _____ Dated: _____
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**SEND THE SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:**

**Optimum Function  
 Dr. Tim Irving DC, LMT  
 819 SE Morrison St. Suite 215  
 Portland, OR, 97214  
 Ph.503.866.9739  
 Fax.503.716.4575**

I, (Patient Print Your Name) \_\_\_\_\_, hereby request and authorize disclosure of information in the above medical records to be photocopied, released and mailed to above doctor at the indicated address for the specified dates. The information obtained with this form will be used to assist the named chiropractor in determining the nature of the specified patient’s prior medical condition(s) and/or injuries and what testing, diagnosis, or treatment was provided as well as other relevant information. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor’s office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

**EXPIRES:** This authorization is good for 12 months from the date signed for the disclosure of the information described above.

**Individual Authorizing Disclosure:** \_\_\_\_\_ / \_\_\_\_\_  
*Signature* **Date**

If not signed by subject of disclosure, specify basis for authority to sign:  Parent of minor,  Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR parts 160 and 164, 42 CFR part 2, 38 CFR, 34 CFR parts 99 and 300, and State law.

## Establishing Your Health Goals

Name \_\_\_\_\_ Date \_\_\_\_\_

### Personal Message Before You Begin

Before you begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

### What do you hope to achieve in your visits with me?

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### If you had a magic wand and could erase three problems, what would they be?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Have you made the decision to change? To do what it takes to get well?

Yes \_\_\_\_\_ No \_\_\_\_\_

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and expecting different results"***. If you keep following the same course of treatment, your results may never really change. Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they're made the decision to change. Very few people have truly decided to change. Why? Because there is a big difference between deciding something and having "reasons" to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

### 2. List up to 5 things that you have been unable to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

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**3. List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)**

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**4. Please check off the following that you would like to achieve with my help:**

<ul style="list-style-type: none"><li><input type="checkbox"/> Have more energy</li><li><input type="checkbox"/> Sleep better</li><li><input type="checkbox"/> Have better digestion</li><li><input type="checkbox"/> Be able to eat more foods</li><li><input type="checkbox"/> Get rid of my allergies</li><li><input type="checkbox"/> Have a better immune system i.e. less colds and coughs</li><li><input type="checkbox"/> Not be dependent on laxatives or stool softeners</li><li><input type="checkbox"/> Be able to work out again</li><li><input type="checkbox"/> Have better muscle tone</li><li><input type="checkbox"/> Be in less pain</li><li><input type="checkbox"/> No longer use pain medication</li><li><input type="checkbox"/> No longer use allergy medication</li><li><input type="checkbox"/> No longer use sleep medication</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> To feel less sleepy in the afternoon</li><li><input type="checkbox"/> Lose weight</li><li><input type="checkbox"/> Increase my sex drive</li><li><input type="checkbox"/> Increase my metabolism to burn more fat</li><li><input type="checkbox"/> Increase my flexibility I want to reduce my stress</li><li><input type="checkbox"/> I want to improve my memory</li><li><input type="checkbox"/> I want to be able to be more focused</li><li><input type="checkbox"/> I want a better mood</li><li><input type="checkbox"/> I want to reduce my risk of developing a chronic disease</li><li><input type="checkbox"/> I want to work on anti-aging program</li><li><input type="checkbox"/> I want to detoxify my body</li><li><input type="checkbox"/> I want to improve my diet</li><li><input type="checkbox"/> I want to clear up my skin</li></ul>
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**5. Are there any other health goals you want to achieve?**

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**Patient Motivation Assessment:** Name: \_\_\_\_\_ Date: \_\_\_\_\_

**In order to improve your health, how willing are you to:**

*Rate on a scale of: 5 (very willing) to 1 (not willing).*

1. Significantly modify your diet: 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_
2. Take several nutritional supplements each day: 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_
3. Keep a record of everything you eat each day: 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_
4. Modify your lifestyle (e.g. work demands, sleep habits): 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_
5. Practice relaxation techniques: 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_
6. Engage in regular exercise: 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_
7. Have periodic lab tests to assess progress: 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How confident are you of your ability to both organize and follow through to improve your health and wellness?** *Rate on a scale of: 5 (very confident) to 1 (not confident at all).*

5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**At the present time, how supportive do you think the people in your household/family will with regards to implementing the above changes?** *Rate on a scale of: 5 (very supportive) to 1 (not supportive at all).*

5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How much ongoing support and contact (e.g. telephone consults, e-mail correspondence) from me do you feel like you will need to implement a personalized health and wellness program?**

*Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact).*

5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_