Welcome to Core Health Chiropractic!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask!

Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

General Information

First Name
-

Last Name
-

Email
-

Phone
-

DOB
-

Referred By
-

Street Address
-

City
-

State/Province
-

Zip Code
-

Occupation
-

Emergency Contact Relationship
-

Emergency Contact Name
-

Emergency Contact Phone Number
-

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had acupuncture previously?

☐ yes ☐ no

Please list current medications & conditions they are treating
-

Please list any major accidents and/or surgeries (include dates)
-

Please tell us about any allergies or hypersensitivities
-

Health History Information

Please select any symptoms you are currently experiencing or have experienced in the past. If experiencing none of the following, please select 'none'.

Head & Neck

☐ Headaches ☐ Migraines ☐ Vertigo ☐ Dizziness ☐ Ringing in ears

☐ Hearing loss ☐ Vision problems ☐ Vision Loss ☐ None

Respiratory

- ☐ Asthma
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Frequent colds
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Sinusitis
- ☐ Smoker
- ☐ Family History of respiratory difficulties
- ☐ None

Nervous System

- ☐ Sensory loss / change
- ☐ Numbness / tingling
- ☐ Sciatica
- ☐ Seizures
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ None

Musculoskeletal System

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Jaw pain (TMJ)
- ☐ Pins / plates / wires / artificial joints
- ☐ Family history of arthritis
- ☐ None

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Heart disease
- ☐ Stroke / CVA
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Phlebitis / Varicose Veins
- ☐ Hemophilia
- ☐ Cardiovascular aneurysm
- ☐ Embolism
- ☐ Chronic congestive heart failure
- ☐ Family history of cardiovascular problems
- ☐ None

Skin & Infections

- ☐ Hepatitis
- ☐ Herpes
- ☐ Lyme Disease
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ None

Other Conditions

- ☐ Cancer
- ☐ Diabetes
- ☐ Unexplained weight loss
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Anxiety
- ☐ Chronic fatigue syndrome
- ☐ Psychiatric disorder
- ☐ None
- ☐ Other

Other (Please explain)

-

For Women Only

- ☐ Pregnant (currently)
- ☐ Given birth (past)
- ☐ Menstrual disorders
- ☐ Pelvic pain
- ☐ PCOS
- ☐ None
- ☐ Other

Other (Please explain)

-

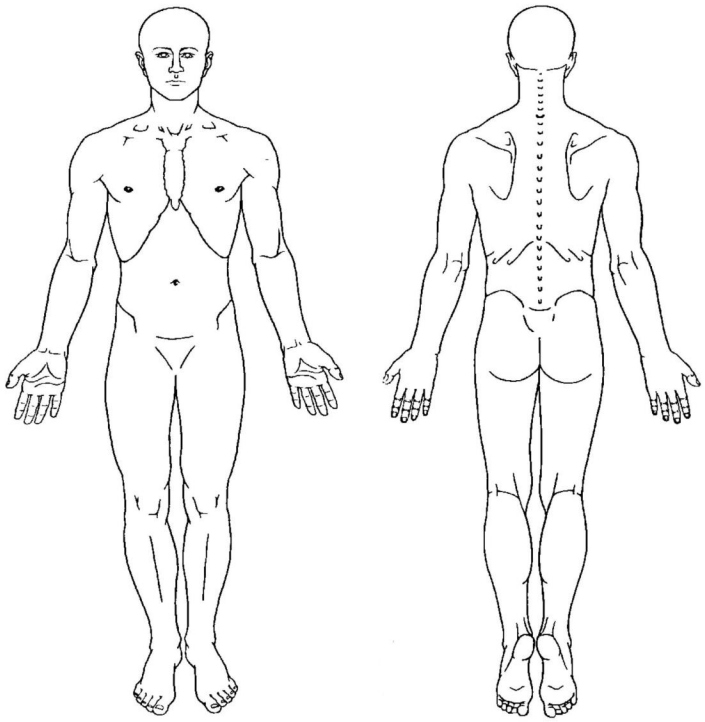
If currently pregnant, please list how far along you are and your due date

-

Please explain anything else you would like the practitioner to know: (if nothing, write none)

-

Mark your Pain Point



Agreements and Consents

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), gua sha, bleeding techniques, and nutritional counseling. I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Petechiae is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic exclusively uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue supplements until I have consulted and received advice from my obstetrician or primary care physician. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history,

medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion andto secure other options about my circumstances and healthcare as I see fit.
By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.
We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- With the exception of emergencies, it is vital that you keep all your appointments. Reminder texts are provided to help you save the date. If you need to re-schedule an appointment, please call/text our office and arrange for a make-up appointment. Any appointments cancelled/rescheduled same day may be subject to a fee as missed appointments result in lost time that could have been used to provide care to other patients.
- In the instance of a no show without notice or less than 24 hours notice we reserve the right to charge you a $50.00 fee using a credit card we have on file.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Signature	Date Signed
	-
Printed Name	**Email**
-	-