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.

About this Patient

First Name	Last Name
-	-

Street Address
-

City	State/Province	Zip Code
-	-	-

Cell Phone	Email
-	-

Date of Birth	Age	Gender
-	-	○ **Female** ○ **Male**

Marital Status	Number of Children
☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Married**	-

Occupation	Employer
-	-

Social Security #
-

About Your Spouse (if applicable)

First Name	Last Name
-	-

Employer
-

Spouse Phone Number	Type of Work
-	-

Medical History

Do you have any information with regard to your birth history or infant health status? For example, were you hospitalized, or had any serious health issues?

–

Childhood Conditions had, please check:

☐ Measles ☐ Mumps ☐ Chicken Pox ☐ Whooping Cough ☐ Scarlet Fever
☐ Diphtheria ☐ Rheumatic Fever ☐ Typhoid Fever ☐ Ear Infections ☐ Tubes in Ears
☐ Chronic Illness

Are you regularly checked by the following?

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath ☐ Naturopath ☐ Dentist

Do you have braces on your teeth, or have you had them in the past?

☐ yes ☐ no

Do you have any amalgam fillings?

☐ yes ☐ no

Please list all of your medical and/or psychological diagnoses, past and present:

–

Please list all current prescription medications:

–

Please list any serious falls, physical traumas, or physical injuries:

–

Have you ever been involved in a motor vehicle accident?

☐ yes ☐ no

If yes, details of accident:

–

Have you ever been hospitalized?

☐ yes ☐ no

If yes, details:

–

Have you had any surgeries?

☐ yes ☐ no

If yes, details:

–

Have you had any surgeries recommended to you that have NOT been performed?

☐ yes ☐ no

If yes, details:

–

Has your hearing ever been tested?

☐ yes ☐ no

If yes, when

–

Has your vision ever been tested?

☐ yes ☐ no

If yes, when

–

Do you wear glasses and/or contact lenses?

☐ glasses ☐ contact lenses ☐ both ☐ neither

Describe your PERSONAL stress level:

☐ no stress ☐ very little stress
☐ moderate stress ☐ extremely stressed

Describe your OCCUPATIONAL stress level:

☐ no stress ☐ very little stress
☐ moderate stress ☐ extremely stressed

Reason for this Visit

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall

☐ Chronic Discomfort ☐ Home Injury ☐ Other

Primary Complaint (s):

-

Is this problem affecting any other area of your body? If yes, please explain:

-

When did this condition begin?

-

Has this condition

☐ Gotten worse ☐ Stayed Constant

☐ Comes and goes

Does this condition interfere with

☐ Work ☐ Sleep

☐ Daily Routine ☐ Other activities

Has this condition occurred before?

☐ Yes ☐ No

Have you seen other doctors for this condition?

☐ No ☐ Yes

Doctor's Name (s)

-

Type of Treatment

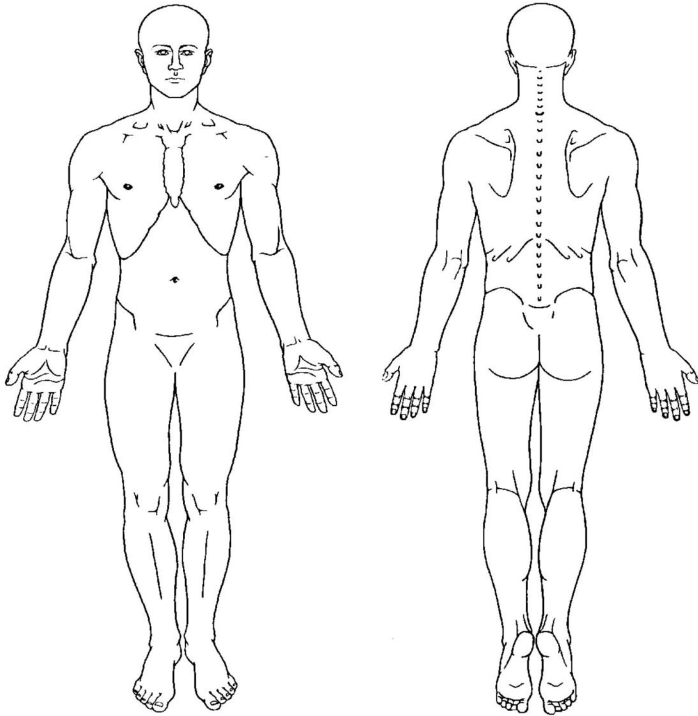
-

Results

-

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Experience with Chiropractic

Have you been adjusted by a chiropractor before?	Reason for those visits?
☐ **Yes** ☐ **No**	-
Doctor's Name	**Approximate date of last visit?**
-	-

Health Conditions

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and treatment of care.

General:

- ☐ **Allergies**
- ☐ **Dizziness**
- ☐ **Fevers**
- ☐ **Loss of Sleep**
- ☐ **Depression**
- ☐ **Numbness**
- ☐ **Loss/Gain of weight**
- ☐ **Chills**
- ☐ **Fainting**
- ☐ **Headaches/Migraines**
- ☐ **Nervousness**
- ☐ **Neuralgia**
- ☐ **Sweats**
- ☐ **Tremors**

Muscle & Joint:

- ☐ **Arthritis**
- ☐ **Bursitis**
- ☐ **Foot trouble**
- ☐ **Hernia**
- ☐ **Low back pain**
- ☐ **Neck pain**
- ☐ **Neck stiffness**
- ☐ **Pain between shoulders**

Eyes, Ears, Nose, & Throat:

- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental decay
- ☐ Asthma
- ☐ Ear aches
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Tonsillitis
- ☐ Sinus infections
- ☐ Eye pain
- ☐ Nosebleeds
- ☐ Concussion

Respiratory:

- ☐ Chest pain
- ☐ Chronic Cough
- ☐ Difficulty breathing
- ☐ Spitting blood
- ☐ Throat phlegm
- ☐ Wheezing

Cardiovascular:

- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Poor circulation
- ☐ Heart attack/Stroke
- ☐ Heart Surgery/Pacemaker

Gastrointestinal:

- ☐ Gas
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Distension of abdomen
- ☐ Stomach pain
- ☐ Hemorroids
- ☐ Jaundice
- ☐ Nausea/Vomiting

Genitourinary:

- ☐ Bed wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Urinary Incontinence
- ☐ Painful urination

FOR WOMEN ONLY:

Are you currently pregnant?

☐ Yes ☐ No

When is your due date?

-

Are you nursing?

☐ Yes ☐ No

Are you taking birth control?

☐ Yes ☐ No

Do you experience painful periods?

☐ Yes ☐ No

Do you have irregular cycles?

☐ Yes ☐ No

Do you have breast implants?

☐ Yes ☐ No

Authorization for Care & X-Ray

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and my insurance and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.
AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST

MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES. DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR OF INSPIRE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE. BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

Signature	Date Signed -
Printed Name -	Email -

Who should receive bills for payment on your account?

- ☐ **Patient**
- ☐ **Spouse**
- ☐ **Parent**
- ☐ **Workers Comp**
- ☐ **Medicare**
- ☐ **Personal Health Insurance**
- ☐ **Auto Insurance**

Nutrition and self-care are just two of the components in obtaining optimal wellness.

Please let us know what you are currently doing for your health.

Please list any vitamin supplements you are currently taking

-

Things I do currently to support my health include:

- ☐ **Drink plenty of water**
- ☐ **Exercise regularly**
- ☐ **Get plenty of rest**
- ☐ **Acupuncture**
- ☐ **Homeopathic remedies**
- ☐ **Maintain positive attitude**
- ☐ **Eat organically grown foods**
- ☐ **Maintain the proper weight**
- ☐ **Receive regular massages**
- ☐ **Use a cervical pillow**

Missed Appointments

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.

Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.

- 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. We would prefer the make up appointment to be within the same week. 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 $25.00 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.

Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I hearby authorize payment to be made directly to Core Health Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Core Health Chiropractic for any and all services I receive at this office.

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time the claim is received. We will verify your benefits and outline them to you to the best of our knowledge. It is your responsibility to fully understand your insurance benefits. Payment is due at the time of treatment. I agree to pay Core Health Chiropractic all amounts that are due for services rendered, which includes deductible amounts, copays, and cash charges. We require a credit card to be kept on file to pay for these services.

Any applicable co-pay/deductible amount/cash rate is due at the time of service. Co-insurance, deductibles, and payments for non-covered services are the patient's responsibility. An itemized statement will be sent to you after your insurance company has processed your claim. We do require that a credit card be kept on file for balances that are not covered by insurance. Your credit card will be billed automatically for any unpaid balances. We do ask that you call us when you receive a statement if you would like to set up a payment plan. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, contact us immediately. We will try our best to set up a reasonable payment plan, if necessary. Payment on your account will be expected by the last day of each month. In the event that your account is not kept current, we reserve the right to send your account to collections. It is of utmost importance that you provide our office with complete responsible party information. It is our policy that we will collect payment at the time of service from any parent/guardian who may be bringing minor children to an appointment unless we are notified of other arrangements. In the event that there are legal or custody issues, please provide copies of legal documents to be kept as part of the patient's medical/financial record. Any patients with outstanding balances may be refused services in our offices until arrangements can be made with our billing department. We reserve the right to charge credit cards for any balances. We reserve the right to apply interest charges to accounts in which any portion is unpaid 45 days from the date of service and to charge for returned checks. Should the account be sent to collections, you will be responsible for additional collection fees ($75) as well as court costs and reasonable legal fees, if necessary.

Patients seeking services that require a referral are solely responsible for obtaining proper referrals from their Primary Care Provider. If you do not have a referral for your visit, you will have the option of paying for the visit IN FULL at the time of service or you will need to reschedule your appointment until the referral has been secured. Our office makes every effort to remind you when referrals are needed, but at no time does securing the referral become the responsibility of our office.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Insurance Company	Policy/ID #
-	-

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