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 care.

First Name
-

Last Name
-

Street Address
-

City
-

State/Province
-

Zip Code
-

Phone
-

Email
-

Date of Birth
-

Age
-

Referring Physician
-

Primary Care Physician
-

Have you had Surgery for this injury?
☐ yes ☐ no

Type of Surgery:
-

Surgery Date:
-

Please check any medical or physical therapy care you have had for this injury:

☐ Chiropractic
☐ Emergency Room
☐ General Practitioner
☐ Occupational Therapy
☐ Physical Therapy
☐ Massage Therapy
☐ Orthopedist
☐ CT Scan
☐ EMG/NCV
☐ MRI
☐ Myelogram
☐ X-Rays
☐ Neurologist
☐ Podiatrist

Social History:

Who do you live with?
-

Number of Members in Household:
-

How many stairs/steps do you have to navigate?
-

How many levels are in your home?
-

Handedness:
☐ left ☐ right ☐ both

I am a (check all that apply):

☐ Student
☐ Employed
☐ Stay at Home Parent
☐ Unemployed
☐ Disabled
☐ Retired

If Student, where and what grade level:
-

If Employed, where and how many hours per week:

-

List any sports/athletic activities you are involved in and how many hours per week:

-

Do any of the following apply:

- ☐ smoke
- ☐ drink alcohol
- ☐ use illicit drugs

During the past month have been feeling down, depressed, or hopeless?

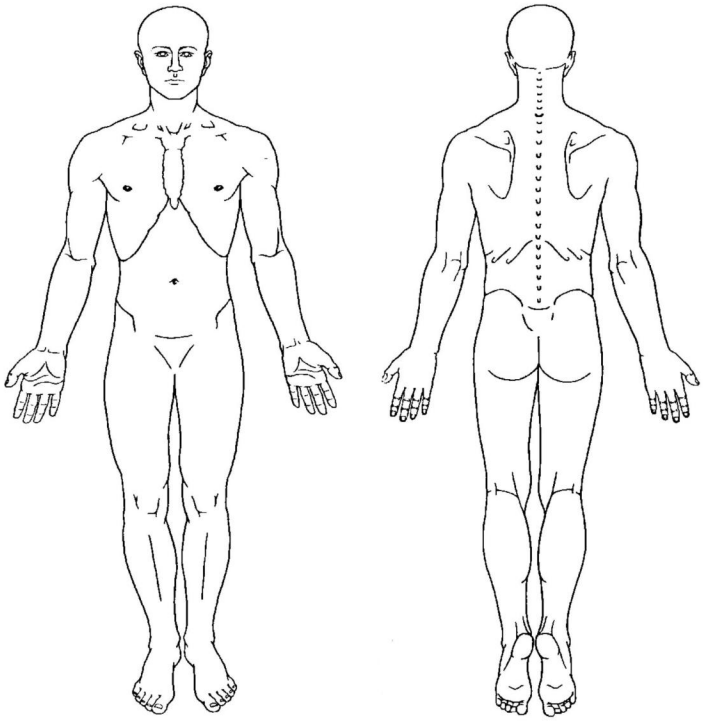
☐ yes ☐ no

During the past month have you been bothered by having little interest in doing things?

☐ yes ☐ no

Pain:

Mark your Pain Point



Current Pain Level:

☐ no pain ☐ little pain ☐ medium pain ☐ high pain

☐ worst imaginable pain

Past Medical History:

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- ☐ cancer
- ☐ high blood pressure
- ☐ pacemaker
- ☐ chemical dependency (alcoholism)
- ☐ stroke/TIA
- ☐ anemia
- ☐ thyroid problems
- ☐ diabetes
- ☐ kidney/liver problems
- ☐ epilepsy
- ☐ heart disease
- ☐ asthma
- ☐ osteoporosis
- ☐ rheumatoid arthritis
- ☐ depression
- ☐ lung problems
- ☐ osteoarthritis
- ☐ multiple sclerosis
- ☐ stomach ulcers/GERD
- ☐ Parkinson's disease

Any other conditions not listed:

-

Have you ever been diagnosed with:

- ☐ learning disability/dyslexia
- ☐ seizure disorder
- ☐ anxiety, depression, psychiatric condition
- ☐ ADD/ADHD
- ☐ migraine headache

Please list all current prescription medications:

-

Please list all current supplements:

-

Do you have or have you ever had ANY of the following:

- ☐ shortness of breath
- ☐ metal implants/pins
- ☐ lyme disease
- ☐ dizziness or fainting
- ☐ energy loss
- ☐ incontinence
- ☐ shoulder injury/surgery
- ☐ knee injury/surgery
- ☐ fibromyalgia
- ☐ heart attack/heart surgery
- ☐ joint replacement
- ☐ vision difficulty
- ☐ weakness
- ☐ blood clot/emboli
- ☐ bowel/bladder problem
- ☐ elbow or hand injury/surgery
- ☐ leg/ankle/foot injury/surgery
- ☐ allergies
- ☐ infectious disease
- ☐ hearing difficulty
- ☐ weight loss
- ☐ headaches
- ☐ neck injury/surgery
- ☐ back injury/surgery
- ☐ gout

Please list any injury or illness not listed above:

-

Do you smoke?

☐ yes ☐ no

Are you pregnant?

☐ yes ☐ no

This next section is regarding the issue/symptoms you are currently seeking out Physical Therapy for:

When did you first notice symptoms?
-

Gradual or sudden onset?
☐ gradual ☐ sudden onset

Have your symptoms changed all at since onset and how?
-

Is your pain constant or intermittent?
☐ constant ☐ intermittent

Is there a better or worse time of day?
-

What activities/motions exacerbate your symptoms?
-

What can you do to alleviate your pain?
-

What activities have been affected or modified?
-

What sports or recreational activities do you want to return to?
-

What do you want to get out of therapy?
-

Anything else we should know about/precautions?
-

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 appointments 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 $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
-	-

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
-

Member ID #
-

Signature

Date Signed
-

Printed Name
-

Email
-

CONCUSSION ONLY: Please fill out the following section

Date of most recent concussion:
-

Have you ever had a previous concussion?
☐ yes ☐ no

Please describe how your most recent concussion occurred:
-

The injury was a result of:
☐ collision with another player/person
☐ collision with a piece of equipment or object
☐ collision with the ground
☐ non-contract trauma (whiplash)

Did you receive medical treatment after the injury?
☐ yes ☐ no

If so, what kind?
-

On the day of the injury did you continue to play/work/participate in activity?
☐ yes ☐ no

Were you wearing a helmet?
☐ yes ☐ no

Have you continued to exercise since your injury?
☐ yes ☐ no

Did you lose consciousness?
☐ yes ☐ no

If yes, how long?
-

Have you lost memory of events which occurred BEFORE your injury?
☐ yes ☐ no

Have you lost memory of events which occurred AFTER your injury?
☐ yes ☐ no

Have you had the following?
☐ Brain MRI
☐ Cervical Spine MRI
☐ Brain CT
☐ Skull or Cervical X-Ray
☐ Neuropsychological Testing
☐ ImPACT Test

Are you still able to go to school/work?
☐ yes ☐ no

How many hours?
-

Are classes/job more difficult for you?
☐ yes ☐ no ☐ NA

Has your mood changed?
☐ yes ☐ no

Is it more difficult to spend time with family and friends?
☐ yes ☐ no

If yes, explain:
-

How many hours of sleep are you getting per night?

-

Are you able to read without increase in symptoms?

☐ yes ☐ no

Does computer/phone aggravate symptoms?

☐ yes ☐ no

Are you able to ride in a car?

☐ yes ☐ no

Are you currently driving?

☐ yes ☐ no

Do you wear corrective lenses?

☐ yes ☐ no

Date of last eye exam:

-

How do you learn best?

☐ visual ☐ auditory ☐ demonstration ☐ written

Do you receive any special services/therapy/nursing?

☐ yes ☐ no

If yes, what?

-

Are you able to perform all your self care activities independently? If no, what are you not able to do?

-

Are there any special cultural and/or religious concerns you would like to share or be considered during treatment?

-