CORE Health Chiropractic

PATIENT INFORMATION

PATIENT NAME: (First) _____ (MI)_____ (Last)_____

Date of Birth: _____/_____/_____ Age: _____ Male_____ Female _____

Mailing Address: _____

City _____ State_____ Zip _____ E-Mail: _____

Home Phone: (_____)_____ Cell: (_____)_____ Cell carrier:_____

Employer:_____ Address: _____

Work Phone: (_____)_____ Ext:_____ How long employed? _____

(Please circle one) Married Widowed Separated Divorced Single

SPOUSE NAME: (First) _____ (MI)_____ (Last)_____

Date of Birth: _____/_____/_____ Age: _____

Spouse Cell Phone: (_____)_____ Spouse Work Phone: (_____)_____

*"I authorize **CORE Health Chiropractic,** to release patient health information (PHI) to my spouse listed above. This includes diagnoses, treatment options, appointments, treatments and test results".* X_____

EMERGENCY CONTACT: _____ Relationship to Patient: _____

Emergency Phone: #1: (_____)_____ #2: (_____)_____

*"I authorize **Core Health Chiropractic,** to release patient health information (PHI) to my emergency contact, listed above. This includes the nature of the emergency, diagnoses, treatment options, appointments, treatments and test results".*

X_____

Medical History

PATIENT NAME _____ Date: _____ ID:_____

Have You Had:

( ) Aneurysm	( ) Tuberculosis	( ) Osteoporosis
( ) Angina	( ) Multiple Sclerosis	( ) Parkinson's
( ) Heart Attack	( ) Cancer: _____	( ) Alzheimer's
( ) TIA	( ) HIV/AIDS	( ) Hemophilia
( ) Stroke	( ) Hepatitis A B C D E F	( ) Atherosclerosis
( ) PAD	( ) Rheumatoid Arthritis	( ) Ulcer/Acid Reflux
( ) Diabetes	( ) High Blood Pressure	( ) Depression/Anxiety

Other#1 _____

Other#2 _____

Childhood Illnesses: _____

Medication List: (Please include herbs and vitamin supplements if needed write additional list on back of form)

Medication	Dose	Reason
1.		
2.		
3.		
4.		
5.		
6.		

Systems Review:

CARDIAC	**( ) None ( ) Short of Breath ( ) Chest Pain ( ) Fainting Spells ( ) Arrhythmia**
PULMONARY	( ) None ( ) Productive cough ( ) Wheezing ( ) Bloody cough ( ) Asthma
CONSTITUTIONAL	( ) None ( ) Fever ( ) Unexplained Wt. loss ( ) Night Sweats ( ) Lethargy
G-I	( ) None ( ) Rectal Bleeding ( ) Loss of Bowel Control ( ) Constipation ( ) Diarrhea
G-U	( ) None ( ) Bloody Urine ( ) Increased Frequency ( ) Loss of Bladder control
INTRA-CRANIAL	( ) None ( ) Memory Loss ( ) Vision Changes ( ) Dizzy ( ) Confused
INTEGUMENT	( ) None ( ) Skin Rash ( ) Bruising ( ) Mole Changes; itch, bleed, shapes, color etc.

PATIENT NAME _____ Date: _____ ID:_____

PLEASE LIST YOUR **SURGERIES:**

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____

Hospitalizations: Reason for Stay:_____

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____

Prior Injuries / Traumas: (Falls, Broken Bones, Car Accidents, etc…..)

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____

Do you Smoke? ( ) No ( ) Yes **Packs per day:** _____ **How long have you smoked?** _____

Do you Chew? ( ) No ( ) Yes **Cans per day:** _____ **How long have you chewed?** _____

Use Alcohol? ( ) No ( ) Seldom ( ) Occasionally ( ) Regularly

Average Hours of Sleep per Night: _____ **How many pillows do you use?** 0 1 2 3 4 (under your head/neck)

Mattress Type: ( ) Traditional ( ) Air Bed ( ) Memory Foam ( ) Water Bed

Do you engage in physical labor or work? ( ) No ( ) Light ( ) Moderate ( ) Heavy

Do you sit at a desk for work or school? ( ) No ( ) Yes **Hours per day:** _____

Pregnancies: _____ **Births:** _____ **Dominant Hand**: Right Left

Do you currently wear orthotics? ( ) No ( ) Yes

Insurance Information

Primary Insurance Information
Who is the INSURED: □ check here if patient is the insured
(Last)_____ (First)_____ (MI)____
Insured Date of Birth:_____
Insured SS#:_____
Relationship to Patient: □ spouse □ parent □ _____
Insurance
Company:_____
Patient ID#: Group #:

Secondary Insurance Information
Who is the INSURED: □ check here if patient is the insured
(Last) (First) (MI)
Insured Date of Birth:_____
Insured SS#:
Relationship to Patient: □ spouse □ parent □ _____
Insurance
Company:_____
Patient ID#: Group #:

Signatures and Release Information

Consent to Health Care Services / Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf) hereby request and consent to Patient health care services from Core Health Chiropractic, PC. The Patient health care services will be provided by licensed, Doctors of Chiropractic. Health care services will also be provided by non-physician health care professionals employed, under contract, or otherwise retained by Core Health Chiropractic, PC. Medical nursing and other health care personnel who are in training may also participate in the Patient's care as part of their education. I authorize payment of insurance benefits directly to Core Health Chiropractic, PC. I authorize Core Health Chiropractic, PC staff to release all information necessary to communicate with other physicians and healthcare providers and payers and to secure the payment of benefits on my behalf. I understand that I am responsible for all costs of my care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by Dr. Cartwright, or a staff chiropractor at Core Health Chiropractic, PC, any fees for professional services up to termination will become immediately due and payable. I further understand and agree that I will bear all collection costs and attorney fees should I fail to pay Core Health Chiropractic, PC in a timely manner necessitating the need for hiring an outside collection service and/or an attorney for my account balance.

Payment Guarantee

In consideration of the services provided by Core Health Chiropractic, PC, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to Core Health Chiropractic, PC, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to Core Health Chiropractic, PC. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits and the payment of any legal fees incurred by Core Health Chiropractic, PC for efforts to collect any delinquent balances of aforementioned unpaid Patient Charges.

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, then you are responsible for the non-covered services at the time they were rendered. (Excludes introductory screening offer if applicable, all services will be discussed prior to being provided)

Missed Appointment Fee

A $45.00 fee will be charged for any missed appointments or appointments cancelled with less than 24 hour notice. This fee must be paid before a new appointment is scheduled or services provided. This fee is not billable or payable by insurance. We understand that emergencies do occur and will attempt to make reasonable accommodations for that. If the appointment can be made up within the week of the missed appointment the $45.00 fee may be waived.

X_____(initial)

Medicare

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medial or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claim. You authorize payment or authorized benefits to Core Health Chiropractic, PC on Patient's behalf.

Consent to Release of Information

Here at Core Health Chiropractic, PC we respect your privacy, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Core Health Chiropractic, PC to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnoses and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, payment of Patient Charges, this

authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide Core Health Chiropractic, PC or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the patient's employer, or an insurance company representing such employer, request Patient Information relating to health care services provided for worker's compensation injuries, it is understood and agreed that Core Health Chiropractic, PC is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative.

X_____ _____

(Patient Signature) (Date Signed)

Patient Privacy Acknowledgement

For use and/or disclosure of Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations

I, _____, hereby state that by signing this Consent I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the privacy Notice carefully prior to my signing this Con-sent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. The Practice's "Notice of Privacy Practices" is also provided at the front desk. I also may request a copy from this office at any time via US Mail.

4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

X_____

(Name of Individual—Printed) (Date Signed) (Signature of Individual)

_____

(Signature of Legal Representative) (Date Signed) (Relationship)

_____

(Witness—Office Personnel) (Date Signed)

Informed Consent Document

Patient Name: _____

Please read this entire document prior to signing. It is important that you understand the information within this document. Please ask the Doctor any unanswered questions you may have before signing.

The Nature of the Chiropractic Adjustment

Spinal manipulation therapy otherwise known as spinal manipulation therapy is the primary treatment used by Doctors of Chiropractic. The techniques used in this office may utilize instruments or the Doctor's hands to specifically adjust/move joints. This type of treatment may cause an audible "*pop*" or "*click*" much like the experience of "*popping*" your knuckles.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment you are consenting but not limited to the following procedures:

Spinal manipulative therapy, palpation, vitals, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, orthotic testing, ultrasound, hot/cold therapy, electric therapy/interferential, radiological studies, traction/decompression, flexion distraction therapy, laser therapy.

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separation, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Some patients will feel some stiffness and soreness following the first few days of treatments. The Doctor will make every reasonable effort during the examination to screen for contradictions to care. If you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone. We check for these occurrences during your x-ray and examination and through your medical history. Some medications will cause such demineralization and it is your responsibility to report those to the doctor.

Stroke and/or arterial dissections caused by chiropractic manipulation of the neck have been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

Self administers, over-the-counter analgesics and rest

Medical care & prescription drugs: anti-inflammatory/muscle relaxants/pain medication

Hospitalization

Surgery

The Risks and Dangers Associated With Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduced mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Consent to Treatment of a Minor

I hereby request and authorize CORE Health Chiropractic, PC to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____.
This authorization also extends to all other doctors and office staff members and is intended to include radiographic examinations at the Doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

X_____

(Guardian Name) (Date Signed) (Guardian Signature)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPOROPRIATE BLOCK AND SIGN BELOW.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with CORE and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

X_____

(Patient Name) (Date Signed) (Patient Signature)

CORE Health Chiropractic

Neck Pain

PATIENT NAME _____ ID: _____

[ ] Dull [ ] Aches [ ] Sharp [ ] Burns [ ] Tingles [ ] Pins & Needles [ ] Numb

(PLEASE CIRCLE)_____

On a 1 to 10 scale (with 10 being the worst and 1 being no pain) 1 2 3 4 5 6 7 8 9 10

When did this start? _____ [ ] Suddenly, [ ] Gradually, [ ] Off and On

How did this start? _____

Do you have pain or numbness (or any other symptoms) that **radiates into** *arms, hands or head?*

[ ] No [ ] Yes (Please describe) _____

_____

Is it **worse** in the [ ] morning, [ ] afternoon, [ ] night, [ ] constant

What makes it feel **better?** _____

What makes it feel **worse?** _____

What **treatments have you already tried** for this problem?

1. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot
2. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot
3. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot

Have You Had?

Dizziness	[ ] No	[ ] Yes	Double Vision	[ ] No	[ ] Yes	Trouble Swallowing	[ ] No	[ ] Yes
Fainting	[ ] No	[ ] Yes	Vomiting/Nausea	[ ] No	[ ] Yes	Trouble Speaking	[ ] No	[ ] Yes
Numbness	[ ] No	[ ] Yes	Spinal Stenosis	[ ] No	[ ] Yes	Trouble Walking	[ ] No	[ ] Yes
Spine Surgery	[ ] No	[ ] Yes	Whiplash Injury	[ ] No	[ ] Yes	Carotid Artery Surgery	[ ] No	[ ] Yes

Patient Signature: _____ Date: _____

Core Health Chiropractic

11859 N. Pecos St.

Westminster CO 80234

CORE
Health Chiropractic

Upper Back Pain

PATIENT NAME _____ ID: _____

[ ] Dull [ ] Aches [ ] Sharp [ ] Burns [ ] Tingles [ ] Pins & Needles [ ] Numb

(PLEASE CIRCLE)_____

On a 1 to 10 scale (with 10 being the worst and 1 being no pain) 1 2 3 4 5 6 7 8 9 10

When did this start? _____ [ ] Suddenly, [ ] Gradually, [ ] Off and On

How did this start? _____

Do you have pain or numbness (or any other symptoms) that **radiates into** *arms, hands or head?*

[ ] No [ ] Yes (Please describe) _____

_____

Is it **worse** in the [ ] morning, [ ] afternoon, [ ] night, [ ] constant

What makes it feel **better?** _____

What makes it feel **worse?** _____

What **treatments have you already tried** for this problem?

1. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot
2. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot
3. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot

Have You Had?

Dizziness	[ ] No	[ ] Yes	Chest Pain	[ ] No	[ ] Yes	Shortness of Breath	[ ] No	[ ] Yes
Fainting	[ ] No	[ ] Yes	Chest Pressure	[ ] No	[ ] Yes	Skipped Heart Beats	[ ] No	[ ] Yes
Numbness	[ ] No	[ ] Yes	Swollen Ankles	[ ] No	[ ] Yes	Racing Pulse	[ ] No	[ ] Yes
Spine Surgery	[ ] No	[ ] Yes	Swollen Hands	[ ] No	[ ] Yes	A Rash	[ ] No	[ ] Yes

Patient Signature: _____ Date: _____

Core Health Chiropractic

11859 N. Pecos St.

Westminster CO 80234

CORE
Health Chiropractic

Lower Back Pain

PATIENT NAME _____ ID: _____

[ ] Dull [ ] Aches [ ] Sharp [ ] Burns [ ] Tingles [ ] Pins & Needles [ ] Numb

(PLEASE CIRCLE)_____

On a 1 to 10 scale (with 10 being the worst and 1 being no pain) 1 2 3 4 5 6 7 8 9 10

When did this start? _____ [ ] Suddenly, [ ] Gradually, [ ] Off and On

How did this start? _____

Do you have pain or numbness (or any other symptoms) that **radiates into** *hips, legs or feet?*

[ ] No [ ] Yes (Please describe) _____

_____

Is it **worse** in the [ ] morning, [ ] afternoon, [ ] night, [ ] constant

What makes it feel **better?** _____

What makes it feel **worse?** _____

What **treatments have you already tried** for this problem?

1. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot
2. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot
3. _____ [ ] Didn't Help [ ] Helped Somewhat [ ] Helped A Lot

Have You Had?

Bloody Stools	[ ] No [ ] Yes	Blue colored skin	[ ] No [ ] Yes	Loss of Bowel Control	[ ] No [ ] Yes
Bloody Urine	[ ] No [ ] Yes	Foot Drop	[ ] No [ ] Yes	Loss of Bladder Control	[ ] No [ ] Yes
Numbness	[ ] No [ ] Yes	Leg Weakness	[ ] No [ ] Yes	Burning with urination	[ ] No [ ] Yes
Spine Surgery	[ ] No [ ] Yes	Toe Weakness	[ ] No [ ] Yes	Fever in last 72 hours	[ ] No [ ] Yes

Patient Signature: _____ Date: _____

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