CORE
HEALTH & PERFORMANCE

Confidential Patient Information

Patient's Name_____ Today's Date:____/____/_____

Home Phone: _____ Cell Phone: _____

Mailing Address:_____

City:_____ State:_____ Zip:_____

E-Mail: _____ Male __ Female__

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

Occupation:_____ Hours/Week:_____ Employer:_____

Business Phone:_____

Spouse's Name:_____ Employer:_____

Business Phone:_____

Emergency Contact:_____Relationship:_____

Phone: _____Address:_____

City:_____ State:_____ Zip: _____

Concurrent Health Care

Are you currently receiving treatment for this problem? Yes / No

Family Physician: _____

City: _____ State:_____ Phone:_____

How were you referred to us?

_____

Insurance Information

Do you have health insurance?_ Yes _ No Company Name: _____

Is Today's Visit Due To a: Work Related Injury _ Yes _ No **Auto Accident:** _ Yes _ No

Date Of Injury:_____/_____/_____

(If yes to either questions above, additional information is needed)**Please complete this brief health questionnaire. If you need assistance, please ask. Your answers will help us determine how chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.**

Chief complaint:_____

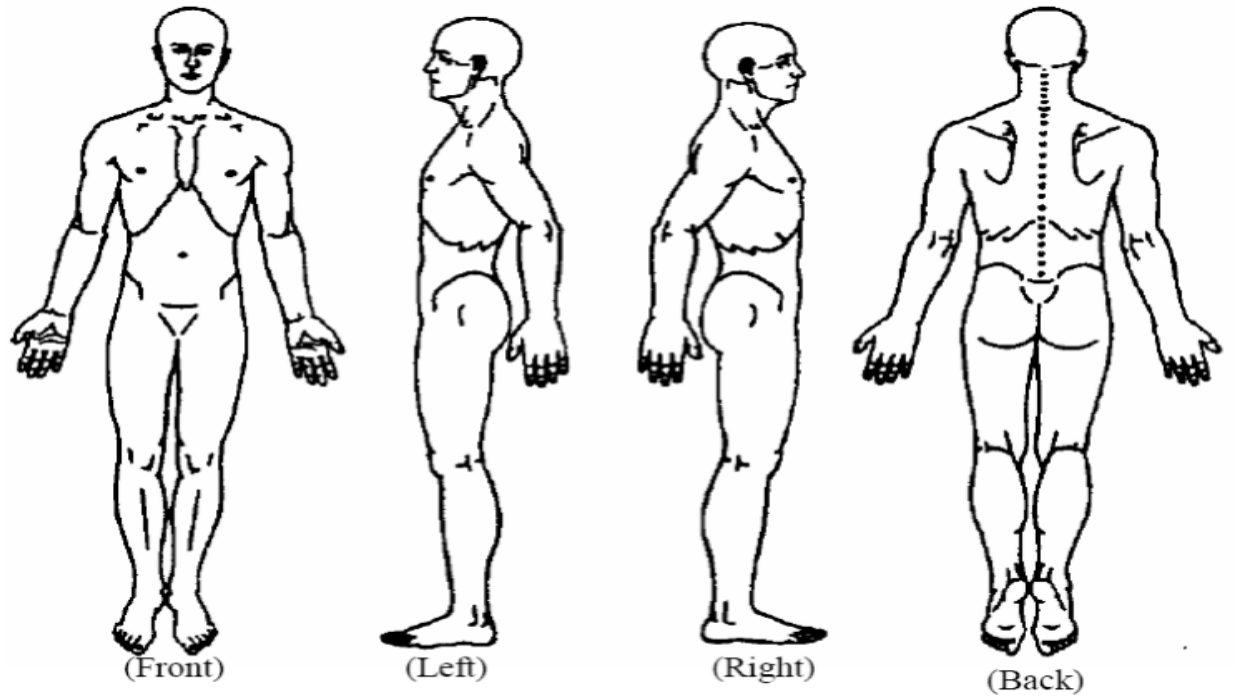
Secondary or related complaint if any:_____

Date of Onset: _____

Was the Onset: __ Gradual __ Sudden Since onset, has it gotten: __Worse __ Better

Describe what caused the pain:_____

PLEASE MARK WHERE YOUR PAIN IS LOCATED:



SEVERITY OF PAIN:

Circle the number which represents the intensity of your pain.

Chief Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10

Secondary Complaint:_____ 0 1 2 3 4 5 6 7 8 9 10

Other Complaint(s):_____ 0 1 2 3 4 5 6 7 8 9 10

YOUR CHIEF COMPLAINT:

Describe the quality of your complaint/pain:

sharp
dull/ache
throbbing
tingling/numbness
other:_____

Does any of the following make the pain worse:

lifting bending pushing pulling
cough sneeze bowel movement
running/walking/sitting/standing
other:_____

Describe the pain as:

superficial deep
pin point radiating
burning sharp
stabbing numb
tingling other:_____

Does any of the following relieve the pain:

rest lying down sitting
walking exercise
other:_____

How often are you aware of the pain:

intermittent (less than 25% of time when awake)
occasional (25-50% of time when awake)
frequent (50-75% of time when awake)
constant (75-100% of time when awake)

Does it interfere with you daily activities:

minimal (annoyance)
slight (tolerated)
moderate (slight impairment)
marked (precludes any activity)

Have you detected any of the following since the onset of your complaint:

muscle weakness bowel/bladder problems indigestion cardiac/respiratory problems

Have you tried any self-treatment or taken any medication (over-the-counter or prescription): _Yes _No

If yes, explain:_____

Results:_____

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Past Health, Social and Family Health History

1. Is this the first time you have experienced this problem?:__ Yes __ No

If no, When:_____

2. Was treatment provided: __ Yes __ No

If yes, By whom:_____ Outcome:_____

3. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, or surgeries?**

If Yes, please list them:

Date	Injury/Illness/ Fracture	Treatment	Results

4. Is there any history of significant health problems in your family?

Relative	Problem/Illness

5. Approximate Weight: _____lbs Have you recently lost or gained weight? __ Yes __ No

Current Height: _____

6. Do you regularly exercise? __ Yes __ No

If yes, how many hours a week and what activities:_____

7. Do you smoke? __ Yes __ No If yes, how many packs/day& how long? _____

8. Do you drink alcohol? __ None__ light __moderate __heavy

How many glasses per week? _____

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9. Check any conditions you have had in the following areas:

AIDS/HIV	Anxiety/Depression	Arm/shoulder	Arthritis	Asthma	Cancer
Fatigue	Diabetes	Digestion problems	Earache	Ear ringing	Epilepsy
Headaches	Heart disease	Herniated disc	High/Low blood pressure		Insomnia
Menstrual pain/cycle		Kidney	Leg pain	Low back pain	Eye(s)
Neck pain	Osteoporosis	Circulation	Prostate	Sciatica	Stroke
TMJ	Venereal disease	Vertigo/Dizziness	Other:_____		

10. Please list any current medications you are taking. Please include Birth Control Pills, Vitamins, Supplements, ect.

_____

_____

_____

_____

_____

_____

Please read and Sign the below form before examination and treatment:

CANCELLATION AND NO-SHOW POLICY

We take this subject very seriously as this can make a difference between responding to treatment or not. We require a 24 hour notice in the event of a cancellation. CORE HEALTH AND PERFORMANCE **holds the right to charge up to $20 for a cancellation or no-show without proper notice**. For worker's compensation and personal injury cases, documentation of any missed appointment is forwarded to your case manager and/or primary physician. This charge will not be covered by your insurance, worker's compensation or personal injury cases, and **IS YOUR RESPONSIBILITY.**
Sign below

Signature:_____

STATEMENT OF FINANCIAL LIABILITY

I understand that I am fully responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges AT THE TIME OF SERVICE. I understand that unless otherwise indicated below¸ I hereby request and authorize CORE HEALTH AND PERFORMANCE to bill my insurance policy/policies on my behalf for services provided to me. I authorize payment to CORE HEALTH AND PERFORMANCE for all such services. I acknowledge that the fees charged by CORE HEALTH AND PERFORMANCE are considered to fall within the "usual, customary and reasonable" range by most insurance companies. Since your policy is an agreement between you and your insurer, CORE HEALTH AND PERFORMANCE will not enter into any dispute between you and your insurance company. When you begin treatment with CORE HEALTH AND PERFORMANCE, our billing department will call your insurance company to verify that you do have valid insurance coverage. However, that verification is only a confirmation of a valid policy and not a guarantee of coverage.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments.
Patient's Name: _____

Patient or Legal Guardian's Signature: _____ Date: _____

If Legal Guardian, Relationship to Patient: _____

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INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Rehabilitative exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

Sign below

Signature:_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
-The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
-The right to inspect and copy your protected health information.
-The right to amend your protected health information.
-The right to receive an accounting of disclosures of protected health information.
-The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

I have read and understand all of the above information regarding the Health Information Portability and Accountability Act (HIPAA).

Patient or Legal Guardian's Signature: _____ Date: _____