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CONFIDENTIAL

Thank you for choosing our practice to meet your chiropractic needs. Please complete this entire form in ink. If you have any questions, do not hesitate to ask for assistance. We will gladly help you.

PATIENT INFORMATION:

Name: ______________________ S/S:______________________ Date:______________________

Address: ______________________ City:____________ State:________ Zip____________

Sex: ☐ Female ☐ Male Birth Date:________________ Email: ______________________

Home Phone:________________ Work Phone:________________ Cell Phone______________________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell

Are You ☐ Married ☐ Minor ☐ Divorced ☐ Single ☐ Other

Your employer:______________________ Occupation:______________________

Business Address:______________________ City:____________ State:________ Zip________

Spouse or parent's name:______________________

Work Place:______________________ Work Phone #:______________________

How did you learn about our office:______________________

Person to contact in case of an emergency:______________________ Phone #:________________

RESPONSIBLE PARTY:
Name of person responsible for this account:______________________

Relationship to patient:______________________ Phone #________________

Address:______________________ City:________________ State:________ Zip:________

Name of Employer:______________________ Work Phone #:________________

INSURANCE INFORMATION:
Name of Insured:______________________ Relationship to patient:______________________

Name of Primary Insurance Co:______________________

Phone#:________________ Group #;______________________ ID#:______________________

DETAILS OF YOUR COMPLAINT:
Reason for your visit:______________________ Date you first noticed the symptoms:____________

Did anything contribute to the onset: ______________________

Where specifically is the problem (s) located:______________________

Type of Pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Aching

☐ Shooting ☐ Crimp ☐ Tingling ☐ Stiffness ☐ Swelling ☐ Other

Is the pain: ☐ Constant ☐ Comes and Goes

Is there any radiation of pain: ☐ Yes ☐ No, if yes where______________________

Rate the severity of your pain. (1 mild pain, 10 severe pain) 1 2 3 4 5 6 7 8 9 10

Is the condition getting progressively worse: ☐ Yes ☐ No

Have you found anything that makes the condition worse: ☐ ☐ Yes ☐ No

☐ Rest ☐ Morning ☐ Evening ☐ Certain Positions ☐ Other, please describe, ______________________

Is the condition getting progressively better: □ Yes □ No

Have you found anything that makes your condition better: □ Yes □ No

□ Rest □ Morning □ Evening □ Certain Position □ Other, please describe ______________________________

Have there been any changes in your bodily functions: □ Yes □ No

□ Vision □ Urination □ Sexual □ Digestion □ Bowel Movement □ Respiration □ Other

Have you sought other professional care for this complaint: □ Yes □ No

If yes, Dr's. name and location:______________________________

Have you ever received chiropractic care before: □ Yes □ No

If yes, Dr.'s name and location:______________________________

HEALTH HISTORY:
Check only those conditions that apply:

□ AIDS/HIV	□ Diabetes	□ Herniated Disc	□ Osteoporosis
□ Allergies	□ Digestive Disorders	□ High Cholesterol	□ Pacemaker
□ Asthma	□ Emphysema	□ High Blood Pressure	□ Parkinson's Disease
□ Arthritis	□ Fractures	□ Liver Disease	□ Prostate Problems
□ Bleeding Disorders	□ Glaucoma	□ Measles	□ Prosthesis
□ Bronchitis	□ Gout	□ Migraine/Headaches	□ Rheumatoid Arthritis
□ Cancer	□ German Measles	□ Miscarriages	□ Stroke
□ Chicken Pox	□ Heart Disease	□ Muscular Dystrophy	□ Sinusitis
□ Depression	□ Hernia	□ Mumps	□ Tuberculosis

Date of last Physical Exam:______________________________

List types of surgeries you have had and the dates on which they occurred: ______________________________

____

List all medications you are currently be taking: ______________________________

____

DAILY HABITS
What type of exercise do you perform: □ None □ Light □ Moderate □ Heavy

Do you perform this exercise: □ Daily □ Bi-Weekly □ 3 xs per week □ Other______________

What do your daily work habits include, (sitting, standing, heavy labor, computer work, etc.) :______________________________

____

Do you smoke: □ Yes □ No

How much alcohol do you consume on a weekly basis:______________________________

How much coffee or caffeinated beverages do you consume on a daily basis:______________________________

How many hours of sleep do you get per night?: 1 2 3 4 5 6 7 8 9 10 11 12

AUTHORIZATION
I certify that I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I clearly understand and agree that all services rendered to me are charged directly to me and, that I am personally responsible for payment. It is my understanding that my credit may be checked if Core-Chiropractic, PLLC. extends credit to me. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors of Core-Chiropractic ,PLLC and whomever they may designate as their assistants to administer treatment as they so deem necessary. I also authorize the release of any information acquired in the course of my examination or treatment. I certify the above information is true and correct.

Patient's (Parent or Guardian's) signature: ______________________________ ***Date:*** ______________________________