CORE CHIROPRACTIC

Chiropractic Patient Information

Referral:

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____
○ Male ○ Female

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Would you like text message reminders? YES NO Who is your phone carrier? _____

E-mail Address: _____ Marital Status: ○ Single ○ Married
Do you have insurance? ○ Yes ○ No

Social Security #: _____ 6 Digit Code (for Apt. Arrival): _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary: _____Secondary: _____

Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*****:**

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ mid-day

How long does it last? ○ It is constant ○ on and off during the day ○ on and off during the week

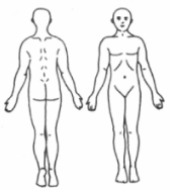
Name of previous chiropractor: _____ ☐ **N/A**

Condition(s) treated by anyone in the past? ○ No ○ Yes When? _____ by whom? _____

How did the injury happen? _____

How long were you under care? _____ What were the results? _____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:



R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY LEVEL	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY

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_____ _____ _____

_____ _____ _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

Please list any and all prescription and non-proscription drugs you take:

_____

_____

PAST HISTORY

Have you suffered with this or a similar problem in the past? ○ No ○ Yes How many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ○ No ○ Yes What type of treatment: _____,
and who provided it? _____ How long ago? _____

Were the results. ○ Favorable ○ Unfavorable Please explain: _____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have

Broken Bone ____	Arthritis____	Heart Attack ____
Dislocations ____	Fracture ____	Diabetes ____
Tumors____	Cancer____	Cerebral Vascular ____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	TREATED BY WHOM
INJURIES			
SURGERIES			
DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)
Have they ever been treated for their condition? ○ No ○ Yes ○ I don't know

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes: _____

Financial Agreement

I hereby authorize payment to be made directly to Core 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 Chiropractic for any and all services I receive at this office.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

Informed consent REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.

3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr Heather Wedding at (812) 777-4004. If you are still not satisfied with the way this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I have received a copy of Core Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date