

PATIENT INFORMATION

Patient Name: _____
Last Legal First Middle Initial
Parent Name: _____ Social Security #: _____
Phone #:() Fax #:() Cell #:()
E-mail: _____ Driver's License #: _____
Address: _____ City: _____ State: ___ Zip: _____
Age: _____ Birth Date: _____ Sex: _____
Emergency Contact: _____ Relationship: _____ Phone: () _____

Note: Fill out this section only if insured is different than patient. Name of Insured: _____
Relationship to insured: (please circle one): spouse/domestic partner child other: _____
Address: _____ City: _____ State: ___ Zip: _____
Social Security #: _____ Phone #:() Birth Date: _____
Insured's Employer (if different from patient): _____ Phone #:()
Work Address: _____ City: _____ State: ___ Zip: _____

PERSONAL HEALTH HISTORY

Have you seen Dr. Steinys for anything before? No/Yes, explain: _____
Have you ever been to chiropractor before? No/Yes, what for? _____
Who referred you to our practice? Person: _____ Advertisement: _____
Purpose of this visit: _____
Number of Siblings: _____ Patient Birth Length: _____ Current Length: _____ Birth Weight: _____ Current Weight: _____
Type of Birth: Normal Vaginal _____ Forceps _____ Breech _____ Cesarean _____ Home _____ Birth Center _____ Hospital _____
Problems during pregnancy? _____
Problems during labor/ delivery? _____
APGAR Scores: _____ Was there presence at birth of : Jaundice Cyanosis (blue) _____
Please list all current medications, vitamin/mineral supplements, herbs, including dosage: _____
List any known allergies: _____
Immunization History: _____
Infant Feeding: Breast _____ Bottle _____ Formula _____ Number of hours of sleep per night: _____
Quality of Sleep: Good _____ Fair _____ Poor _____
Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.): _____
Please list and describe all significant previous surgeries: _____
Congenital anomalies/ defects: _____

CHIEF COMPLAINT

Name: _____ Date: _____ Condition #: _____ (use separate form for each condition)

1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury someone else might be legally liable for? Yes/No **Please Initial:** _____ If yes, please fill out accident-specific form at the front desk
2. Please describe the nature of your condition at this time: _____

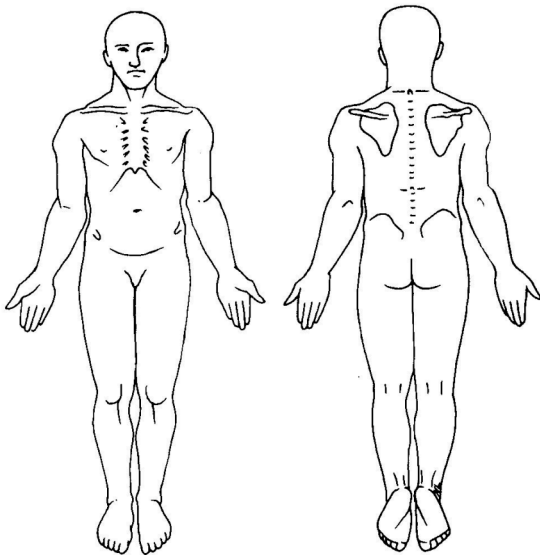
3. When did your condition first begin? Year: _____ Month: _____ Day/Date: _____ Time: _____
4. Cause of condition (circle all that apply & explain): auto accident work injury sudden trauma reoccurrence repetitive trauma unknown/gradual other explain: _____

5. Have you had anything like this before? No/Yes: when?: _____
6. How often does the problem re-occur?: _____
7. Is the pain (circle): constant, on & off, usually lasting: ___minutes ___hours ___days ___weeks other: _____
8. Lately, has the pain been(circle): getting better getting worse staying about the same
9. Does the pain radiate?, to where: _____
10. What makes it feel better? _____
11. What makes it feel worse? _____
12. If you have seen another professional for this problem, or done any self-care, describe the type of treatment and results: _____

13. At what time of day (AM, PM) or week (M-F/wknd) is your pain worst? _____
14. In what setting (home, recreation, work) is your pain worst? _____
15. Please list any activities you are unable to perform/have not performed due to the pain, or for fear of making the pain worse? _____

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:

ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

<u>PAIN CURRENTLY</u>									
1	2	3	4	5	6	7	8	9	10

<u>PAIN AT ITS WORST</u>									
1	2	3	4	5	6	7	8	9	10

<u>PAIN TYPICALLY</u>									
1	2	3	4	5	6	7	8	9	10

FAMILY HISTORY

Please list any significant health problems of parents, grandparents, or siblings: _____

REVIEW OF SYSTEMS

Please write a **number** in the spaces below: 1. presently have 2. previously had 3. related to accident

GENERAL

Frequent or recurring Chills
 Convulsions
 Frequent or recurring Dizziness
 Frequent or recurring Fainting
 Frequent or recurring Fatigue
 Frequent or recurring Fever
 Headache
 Frequent or recurring Sleep loss
 Recent Weight Change
 High Cholesterol
 Cancer
 Diabetes
 Anxiety/ Hyperactivity
 Depression

GENITO-URINARY/ENDOCRINE

Bedwetting
 Frequent urination
 Urinary tract infections
 Painful urination
 Painful menstruation
 Prostate trouble
 Loss of bowel/bladder control
 Vaginal burning/itching
 Breast Lump/Pain
 Sexually Transmitted Infection

Date Last Period Began _____
Date of last PAP test _____

RESPIRATORY

Spitting up phlegm
 Chest pain
 Spitting up blood
 Difficulty breathing
 Asthma
 Wheezing
 Chronic cough

GASTROINTESTINAL

Bloating, belching, gas
 Pain over stomach
 Esophageal reflux
 Vomiting
 Nausea
 Ulcer
 Hernia
 Difficulty Swallowing
 Frequent heartburn
 Diarrhea
 Constipation
 Poor appetite

CARDIOVASCULAR

Hardening of arteries
 High blood pressure
 Varicose Veins
 Pain over heart
 Poor circulation
 Rapid heart beat
 Swelling of ankles

EYES, EARS, NOSE, THROAT

Frequent/recurring sore throat
 Deafness
 Dental problems
 Ear problems
 Sinus problems
 Frequent/recurring nose bleeds
 Vision problems

MUSCULOSKELETAL - pain or numbness in:

Low Back
 Neck
 Upper Back
 Mid Back
 Between Shoulder Blades
 Shoulder Blade: R/L both
 Shoulder: R/L both
 Arm: R/L both
 Elbow: R/L both
 Hand: R/L both
 Leg: R/L both
 Hip: R/L both
 Knee: R/L both
 Ankle: R/L both
 Foot: R/L both
 Spinal curvature
 Paralysis
 Other: _____

NUTRITION

Height: _____ Present Weight: _____ Weight one year ago: _____ Preferred Weight: _____

Please indicate which you eat on a typical day: { } Breakfast { } Lunch { } Dinner # of snacks/day: _____

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

<input type="checkbox"/> Eggs	<input type="checkbox"/> Red Meat	<input type="checkbox"/> Fruits	<input type="checkbox"/> Fats/Oils:
<input type="checkbox"/> Cheese	<input type="checkbox"/> Pork	<input type="checkbox"/> Vegetables	<input type="checkbox"/> Canola <input type="checkbox"/> Corn
<input type="checkbox"/> Skim Milk	<input type="checkbox"/> Fish	<input type="checkbox"/> Desserts	<input type="checkbox"/> Olive <input type="checkbox"/> Peanut
<input type="checkbox"/> 1% Milk	<input type="checkbox"/> Ham	<input type="checkbox"/> Grains, Rice, Pasta, Cereal, Bread	<input type="checkbox"/> Safflower <input type="checkbox"/> Sunflower
<input type="checkbox"/> 2% Milk	<input type="checkbox"/> Beans	<input type="checkbox"/> Butter	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Whole Milk	<input type="checkbox"/> Chicken/Turkey	<input type="checkbox"/> Margarine	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Yogurt	<input type="checkbox"/> Tofu/Soy	<input type="checkbox"/> Nuts/Seeds/Peanut Butter	<input type="checkbox"/> Bacon/Hot Dogs, etc.
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Sausage/Lunch Meats	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Spicy Foods

Please indicate the estimated # of servings (6-8 oz. cups) of each of the following, which you drink on a typical day:

<input type="checkbox"/> Caffeinated Coffee	<input type="checkbox"/> Regular Soft Drinks	<input type="checkbox"/> Water	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Decaffeinated Coffee	<input type="checkbox"/> Diet Soft Drinks	<input type="checkbox"/> Fruit Juices	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Regular Tea	<input type="checkbox"/> Herbal Tea	<input type="checkbox"/> Sports Drinks (i.e., Gatorade)	<input type="checkbox"/> Other: _____

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet: _____

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: _____

Was your special diet prescribed by a physician or nutritionist? Yes _____ No _____

FINANCIAL POLICY

Patient Name: _____ **Social Security #:** _____
 Last Legal First Middle Initial
Name of Insured: _____ **Social Security #:** _____
 (if different from patient) Last Legal First Middle Initial
Primary Insurance Company or Health Care Plan Name: _____ **Effective Date:** _____
ID#: _____ **Policy/Group#:** _____
Secondary Insurance Company or Health Care Plan Name: _____ **Effective Date:** _____
ID#: _____ **Policy/Group#:** _____

▶ **If you would like our office to bill your insurance, please provide your credit card information below. Your card will be kept on file but not charged without prior notification. Without a card on file, payment is due in full at the time services are rendered.**

CREDIT CARD #: _____ **EXPIRATION DATE:** _____
CARDHOLDER SIGNATURE: _____ **DATE:** _____

▶ **We offer the following billing options. Please *initial* the one that applies to you & sign at the bottom of the page. Also, to avoid a missed appointment fee of \$50.00, kindly give at least 24-hour notice if you need to reschedule an appointment.**

- _____ **Private Pay:** I will pay for all services, as they are rendered, and submit my own insurance claims.
- _____ **PPO/Preferred Provider Organization:** You are in my PPO network. I am responsible for any co-payment, deductible, and non-covered services, according to my plan. I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan.
- _____ **Group/Health:** I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan. I understand that if my insurance company does not pay the balance within 60 days of submission, I am responsible for the entire balance overdue.
- _____ **HMO/POS:** My primary care physician (PCP) has agreed to authorize a referral to your office. It is my responsibility to make sure that the number of visits authorized remain current. I understand that I am responsible for, and will pay, whatever co-payment and non-covered services that my plan sets forth.
- _____ **Medicare:** I am a Medicare participant and I understand that Medicare only pays for spinal manipulation procedures at 80% of their approved amount, and only after my yearly deductible has been met. Your office will bill Medicare directly. Medicare should then reimburse your office at 80% of the spinal manipulation fee. Any supplemental policy should also reimburse your office, according to the benefits allowed by that policy. If I have a supplemental policy, it may cover the 20% of the portion of the spinal manipulation fee not paid by Medicare, and/or some percentage of any other procedures (besides spinal manipulation) not covered by Medicare. Regardless of my insurance coverage, I understand that I am ultimately personally responsible for the balance of all charges for all services rendered and supplies purchased.
- _____ **Worker's Compensation:** I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (ie, accident report, etc.). I understand that it is my right to have any bills incurred as a result of a work-related accident paid for. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this is the case, my rights may have been violated and I have the option to seek legal counsel.
- _____ **Auto Accident/Personal Injury:** I was involved in an automobile accident/personal injury and would like to have you submit all charges to my insurance company for me. I will sign all liens necessary to protect your office. If the first insurance payment is not received within 45 days of my first date of service, I agree to pay \$100.00 per month while your office awaits final payment. I will be promptly reimbursed should any overpayment occur on my account. I understand that regardless of payment arrangements, I am personally responsible for the entire balance within 90 days of completion of treatment.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION (to release information & settle insurance appeals or disputes)

I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____
SIGNATURE OF INSURED(if different from patient)/GUARDIAN: _____ **DATE:** _____

ASSIGNMENT (of benefits to doctor)

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Core Chiropractic Health Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____
SIGNATURE OF INSURED(if different from patient)/GUARDIAN: _____ **DATE:** _____

**WE TYPICALLY SUBMIT AN INITIAL REPORT TO YOUR PRIMARY CARE DOCTOR.
 PLEASE PROVIDE US WITH THE NECESSARY INFORMATION:**

Primary care Dr: _____ **Tel:** _____ **Address:** _____