core chiropractic

1448 S Teut Rd, Suite D
Burlington, WI 53105
p. 262.767.0500
f. 262.767.1534

Patient Information

Patient Name: _____
LAST *FIRST* *M.I.*

Address: _____
STREET ADDRESS CITY STATE ZIP

Birthdate: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Phone: (home)_____ (cell) _____

Email: _____

Emergency Contact:_____Relationship:_____ Emergency Contact Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Gender : ☐ Female ☐ Male Number of children/ages: _____

Work Status: ☐ Full Time ☐ Part Time ☐ Homemaker ☐ Unemployed ☐ Retired ☐ Student

Employer Name: _____ Employer City, State: _____

Occupation: _____ Years Employed: _____ Physical Work Duties: _____

Have you ever had chiropractic care before? ☐ Yes ☐ No

If yes, please tell us the doctor's name _____ Were you pleased with your care? ☐ Yes ☐ No

Please share any relevant details about previous care _____

How did you find out about our office? _____

Is this appointment related to an auto accident or work injury? ☐ Yes ☐ No If yes, please fill out the Auto/WC Questionnaire

Are you receiving care from other health professionals? ☐ Yes ☐ No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Are you seeking chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

Health Insurance Information **Please present your Insurance Card to the front desk.**

Policy Holder's Information— Full Name: _____ Birth Date: _____/_____/_____
LAST *FIRST* *M.I.*

Social Security #: _____-_____-_____ Relationship to you:_____

Current Health

Please list any drugs/medications or vitamins/herbs/homeopathics/other you are taking/have taken_____

_____

What health condition brings you to our office? Be specific. _____

_____

When did the symptoms first begin? _____

Was the onset? □ Sudden □ Gradual □ Post-Injury

Which best describes the frequency of your discomfort?

□ Constant (76%-100%) □ Frequent (51%-75%) □ Occasional (26%-50%) □Intermittent (0%-25%)

Rate your symptoms? □ Mild □Moderate □ Severe □ Intolerable

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

□ it is worse in the morning □ it is worse in the afternoon □ it is worse at night

□ it changes with the weather □ it does not change □ it is worse with activity

Is the condition □ Getting Worse □ Improving □ Not Changing

What makes the problem better? _____

What makes the problem worse? _____

Have you ever had a similar condition? ☐ Yes ☐ No

Please explain _____

What activities are limited or affected by the condition? (select one or more)

□ Bending	□ Bowel Movements	□ Coughing	□ Daily Routine
□ Driving	□ Changing Positions	□ Lifting	□ Lying down
□ Pulling	□ Pushing	□ Reading	□ Sitting
□ Sleeping	□ Sneezing	□ Standing	□ Turning my head
□ Urination	□ Walking	□ Working	

□ Other (please describe): _____

Do your symptoms travel to any other area? _____

Health History

Have you ever been checked for vertebral subluxations? ☐ Yes ☐ No ☐ Don't Know

Has a physician ever diagnosed you with allergies? If so, please specify what type: _____

_____

Please list any broken bones/surgeries/hospitalizations with dates: _____

_____

Have you been struck unconscious? ☐ Yes ☐ No Have you been in an auto accident? ☐ Yes ☐ No If yes, list date: _____

Where applicable, specify the approximate date of you most recent: (month/year)

Physical exam:	_____/_____	Dental x-rays:	_____/_____
Spinal x-ray:	_____/_____	CT scan:	_____/_____
MRI:	_____/_____	Other scans or x-rays:	_____/_____

Female Only

Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Do you experience painful periods?	☐ Yes ☐ No
Do you have irregular cycles?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Do you perform regular self-breast exams?	☐ Yes ☐ No
Do you take HRT?	☐ Yes ☐ No

Social History & Life Choices

Alcohol	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Diet Food Products	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Energy Products or OTC Stimulants	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Fresh & Homemade Foods	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Soft Drinks	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Water	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Caffeine Drinks & Products	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Drugs	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Exercise	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Processed, Packaged, Restaurant Foods	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Tobacco	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Ice Pack Usage	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Detailed Review of Systems

CARDIOVASCULAR ☐ **N/A**

Past	Present	
☐	☐	Poor Circulation
☐	☐	High Blood Pressure
☐	☐	Aortic Aneurysm
☐	☐	Heart Disease
☐	☐	Heart Attack
☐	☐	Chest Pain
☐	☐	High Cholesterol
☐	☐	Pacemaker
☐	☐	Jaw Pain
☐	☐	Irregular Heartbeat
☐	☐	Swelling of Legs
☐	☐	Stroke

GENITOURINARY ☐ **N/A**

Past	Present	
☐	☐	Kidney Disease
☐	☐	Lower Side Pain
☐	☐	Burning Urination
☐	☐	Frequent Urination
☐	☐	Blood in Urine
☐	☐	Kidney Stones
☐	☐	Bed Wetting/Enuresis
☐	☐	Prostate Problems
☐	☐	Rectal Prolapse

HEMATOLOGICAL/LYMPHATIC ☐ **N/A**

Past	Present	
☐	☐	Lymphoma
☐	☐	Anemia
☐	☐	Leukemia
☐	☐	Mononucleosis
☐	☐	Hemophilia
☐	☐	Other: _____

RESPIRATORY ☐ **N/A**

Past	Present	
☐	☐	Asthma
☐	☐	Shortness of Breath
☐	☐	Upper Resp Infection
☐	☐	Cold/Flu
☐	☐	Pneumonia
☐	☐	Cough/Wheezing
☐	☐	Emphysema
☐	☐	RSV
☐	☐	Tuberculosis

EAR/NOSE/THROAT ☐ **N/A**

Past	Present	
☐	☐	Sinus Congestion
☐	☐	Sinus Infection
☐	☐	Nosebleed
☐	☐	Sore Throat
☐	☐	Difficulty Swallowing
☐	☐	Ear Ache
☐	☐	Ear Infections
☐	☐	Dizziness
☐	☐	Hearing Loss
☐	☐	Bleeding Gums

EYES ☐ **N/A**

Past	Present	
☐	☐	Glaucoma
☐	☐	Double Vision
☐	☐	Blurred Vision
☐	☐	Red, Itchy (Allergy)

ALLERGIC/IMMUNOLOGICAL ☐ **N/A**

Past	Present	
☐	☐	Autoimmune Disorder
☐	☐	Chronic Allergies
☐	☐	Seasonal Allergies
☐	☐	Food Allergies
☐	☐	Environmental Allergies
☐	☐	Allergy Shots
☐	☐	Cortisone Use
☐	☐	HIV/AIDS
☐	☐	Hives
☐	☐	Weak Immune System

GASTROINTESTINAL ☐ **N/A**

Past	Present	
☐	☐	Pancreatitis
☐	☐	Acid Reflux
☐	☐	Bowel Problems
☐	☐	Constipation
☐	☐	Upset Stomach
☐	☐	Gas Pains
☐	☐	Ulcers
☐	☐	Gallbladder Problems
☐	☐	Liver Problems
☐	☐	Diarrhea
☐	☐	Nausea/Vomiting
☐	☐	Poor Appetite
☐	☐	Bloody Stools
☐	☐	Crohn's Disease
☐	☐	Hiatal Hernia

MUSCULOSKELETAL ☐ **N/A**

Past	Present	
☐	☐	Chronic Hip Dislocation
☐	☐	Torticollis
☐	☐	Poor Posture
☐	☐	Neck Pain
☐	☐	Back Pain
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Joint Stiffness
☐	☐	Muscle Weakness
☐	☐	Osteoporosis
☐	☐	Broken Bones
☐	☐	Joint Replacement
☐	☐	Gout

NEUROLOGICAL ☐ **N/A**

Past	Present	
☐	☐	Tic Disorder
☐	☐	Seizures
☐	☐	Head Injury
☐	☐	Brain Aneurysm
☐	☐	Numbness/Tingling
☐	☐	Pinched Nerves
☐	☐	Radiating Pain
☐	☐	Sciatica

NEUROLOGICAL CONTINUED

☐	☐	Parkinson's Disease
☐	☐	Carpal Tunnel
☐	☐	Balance/Coordination
☐	☐	ADHD/ADD/SPD
☐	☐	Autism/Spectrum
☐	☐	Migraine Headaches
☐	☐	Bell's Palsy
☐	☐	Poor Fine/Gross Motor
☐	☐	Epilepsy
☐	☐	Inflammation
☐	☐	Trigeminal Neuralgia
☐	☐	Ear Ringing/Tinnitus
☐	☐	Toe Walking
☐	☐	Auditory Processing
☐	☐	Sinus Headache
☐	☐	Tension Headache
☐	☐	Vertigo/Dizziness
☐	☐	Sensory Integration

ENDOCRINE ☐ **N/A**

Past	Present	
☐	☐	Hyperthyroid Issues
☐	☐	Hypothyroid Issues
☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Hair Loss
☐	☐	Menopausal
☐	☐	Menstrual Problems
☐	☐	Hot Flashes
☐	☐	Endometriosis
☐	☐	PCOS
☐	☐	Hashimoto
☐	☐	Graves

PSYCHIATRIC ☐ **N/A**

Past	Present	
☐	☐	Depression
☐	☐	Anxiety Disorder
☐	☐	Unusual Stress
☐	☐	OCD
☐	☐	Bipolar Disorder
☐	☐	Seasonal Affective (SAD)
☐	☐	Mood Swings
☐	☐	Social Anxieties
☐	☐	Memory Loss
☐	☐	Night Tremors

CONSTITUTIONAL ☐ **N/A**

Past	Present	
☐	☐	Weight Loss/Gain
☐	☐	Energy Level Low
☐	☐	Energy Level High
☐	☐	Difficulty Sleeping
☐	☐	Chronic Fatigue
☐	☐	General Malaise
☐	☐	Compulsive Behavior
☐	☐	Behavior Issues
☐	☐	Learning Disabilities
☐	☐	Speech Delays
☐	☐	RLS
☐	☐	Pregnancy/Fertility
☐	☐	Obesity

Core Chiropractic & Wellness Center
1448 S Teut Rd, Suite D
Burlington, WI 53105

Authorizations and Releases

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and the duties of the chiropractic office with respect to my protected health information. I hereby give permission to Core Chiropractic & Wellness Center (CCWC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to CCWC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If CCWC contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to CCWC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give CCWC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving CCWC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at CCWC plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of CCWC. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this authorization;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by CCWC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this authorization. If I refuse to sign this authorization, CCWC will not refuse to provide care. However, it will not be possible for CCWC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since CCWC will be unable to contact me 3) all contact with CCWC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me. I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Signature_____ Date _____

Consent to Professional Treatment (Informed Consent)

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

- **Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.
- **Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.
- A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.
- The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence

does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE CORE CHIROPRACTIC & WELLNESS CENTER TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS ____ DAY OF _____, 20___

Signature_____

Parental Consent for Minor Patient:

Patient Name: _____ DOB: _____ Patient Age: _____

Printed name of person legally authorized to sign for the above named patient: _____

Signature: _____ Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Signature_____ Date _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the doctor of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payer.

INITIAL_____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payers. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. Understand that your insurance policy is a contract between you and the insurance company. Any claim that is denied is the responsibility of the patient. I understand that any insurance payment sent to me will be part of my balance due, and therefore it is my responsibility to forward such payment to Core Chiropractic & Wellness Center, LLC. The patient authorizes this office to release any information required by a third party payer necessary for reimbursement of charges incurred.

INITIAL_____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Out of consideration for other patients that may want to schedule, we require a minimum of 12 hours advanced notice when changing, rescheduling or canceling an appointment to avoid a charge of $25. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Should you choose to discontinue care early, the account is refigured on a per visit basis (without any discounts) and you either a) are responsible for the outstanding balance or b) will receive a refund on the care not yet received. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or doctor. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

INITIAL_____

Signature_____ Date _____

Our software enables us to send appointment reminders via text message or email. Please check below which method you prefer.

□ Text Message

Phone Number: _____

Cell Phone Provider:_____ Ex. Verizon, US Cellular, etc.

□ Email

Email Address: _____