



**PATIENT INFO**

Name: \_\_\_\_\_  
(LAST) (MI) (FIRST)

Address: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Soc. Sec # : \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Marital Status: S M W Spouse's Name: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: \_\_\_\_\_

Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurer's Name (If Different From Patient): \_\_\_\_\_

Insurer's DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insurer's Soc. Sec #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insurer's Employer: \_\_\_\_\_

Person responsible for 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. 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.

**Patient Signature**

**Date:**

\_\_\_\_\_

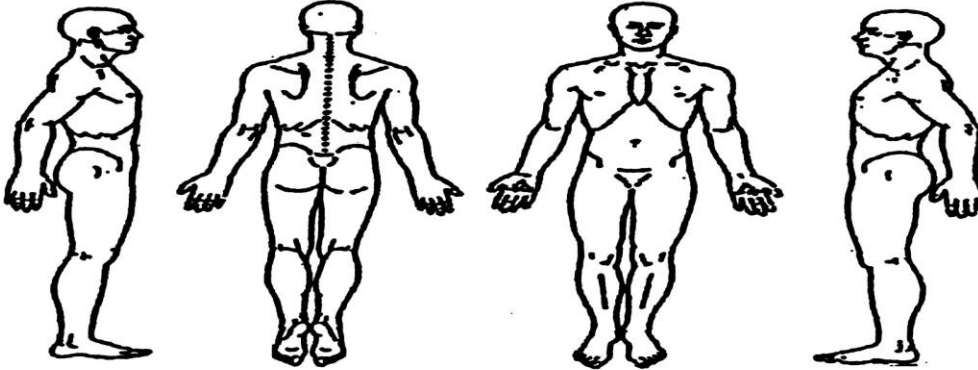
## PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation  Not Applicable

2. What is your primary area of concern/pain? \_\_\_\_\_

3. Indicate on the drawings below where you have pain/symptoms



4. How would you describe the type of pain?

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

5. How long have you had this problem? \_\_\_\_\_

6. How do you think your problem began?

\_\_\_\_\_

7. How often do you experience your symptoms?

- |   |   |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time)  |
| <input type="checkbox"/> Frequently (51-75% of the time)  | <input type="checkbox"/> Intermittently (1-25% of the time) |

8. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

9. What aggravates your problem?

\_\_\_\_\_

10. What alleviates your problem?

\_\_\_\_\_

11. How are your symptoms changing with time?

- Getting Worse     Staying the Same     Getting Better



12. What is your Height \_\_\_\_\_ Feet \_\_\_\_\_ Inches

13. What is your Weight \_\_\_\_\_

14. What is your Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

15. What is your Occupation \_\_\_\_\_

16. How would you rate your overall Health?

- Excellent     Very Good     Good     Fair     Poor

17. What type of exercise do you do?

- Strenuous     Moderate     Light     None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis                       Diabetes                       Lupus  
 Heart Problems                               Cancer                         ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column. **If you have had the condition in the past and presently have the condition, place a check in both the "past" and "present" columns.**

Past	Present	Past	Present	Past	Present			
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			<b>Other:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy

**20. List all prescription and over-the-counter medications you are currently taking:**

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**21. List all of the supplements you are currently taking:**

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**22. List all surgical procedures you have had (please be specific):**

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**23. What activities do you do at work?**

<b>Sit:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<b>Stand:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<b>Computer work:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<b>On the phone:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<b>Driving:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<b>Other Activities:</b>	<input type="checkbox"/> Perform manual labor	<input type="checkbox"/> Read a lot	<input type="checkbox"/> Travel frequently

**24. What activities do you do outside of work?**

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**25. Have you ever been hospitalized overnight?**  No  Yes

If yes, why \_\_\_\_\_

**26. Have you had significant past trauma?**  No  Yes

If yes, please explain: \_\_\_\_\_

**27. Is there anything else you wish to let the doctor know about your visit today?**

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**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Vehicle Accident Information Form

Patient Name: \_\_\_\_\_

1. What was the date of the accident? \_\_\_\_\_
2. Approximately what time did the accident occur? \_\_\_\_\_:\_\_\_\_\_AM / PM
3. How many vehicles were involved in the accident? \_\_\_\_\_
4. What was the estimated damage to the vehicle you were in? \_\_\_\_\_
5. What street were you on when the accident occurred? \_\_\_\_\_
6. What direction were you traveling in? \_\_\_\_\_
7. What city did the accident occur in? \_\_\_\_\_
8. What state did the accident occur in? \_\_\_\_\_
9. What type of impact was the auto accident? (Example: Rear ended, Passenger side impact, Driver side Impact)  
\_\_\_\_\_
10. Did your vehicle hit anything after the accident (i.e. tree or guard rail)? If yes, please describe  
\_\_\_\_\_
11. Were you the driver, front passenger, or rear passenger? \_\_\_\_\_
12. Did you know the accident was coming?  No  Yes If yes, were you braced for impact  No  Yes
13. What type of vehicle were you in? \_\_\_\_\_
14. What type of vehicle impacted yours? \_\_\_\_\_
15. At the time of the impact you were:  
-Slowing down  
-Stopped  
-Gaining Speed  
-Moving at a steady speed
16. At the time of the impact, approximately how fast was your vehicle moving? \_\_\_\_\_MPH
17. At the time of the impact was the other car was:  
-Slowing down  
-Stopped  
-Gaining Speed  
-Moving at a steady speed
18. At the time of impact, approximately how fast was the other vehicle moving? \_\_\_\_\_MPH
19. During and after the crash what happened to your vehicle? (Please circle all that apply)  
- Kept going straight  
- Kept going straight hitting a car in front  
- Was hit by another vehicle  
- Not Applicable  
- Spun around  
- Spun around and hit a stationary object  
- Hit a stationary object

20. Did you lose consciousness during the accident? Yes / No
21. How was your head positioned during the accident? \_\_\_\_\_
22. How was your torso positioned during the accident? \_\_\_\_\_
23. How were your hands positioned during the accident? \_\_\_\_\_
24. Did your head hit anything during the accident? No / Yes, please describe \_\_\_\_\_
25. Did your face hit anything during the accident? No / Yes, please describe \_\_\_\_\_
26. Did your shoulders hit anything during the accident? No / Yes, please describe \_\_\_\_\_
27. Did your neck hit anything during the accident? No / Yes, please describe \_\_\_\_\_
28. Did your chest hit anything during the accident? No / Yes, please describe \_\_\_\_\_
29. Did your hips hit anything during the accident? No / Yes, please describe \_\_\_\_\_
30. Did your knees hit anything during the accident? No / Yes, please describe \_\_\_\_\_
31. Did your feet hit anything during the accident? No / Yes, please describe \_\_\_\_\_
32. What kind of headrest was in your vehicle?
- Movable fixed headrest
  - Non-movable fixed headrest
  - No headrest
33. Where was the headrest positioned on your head? (Please circle which applies best)
- At the top of the back of your head
  - At the middle height of the back of your head
  - At the lower portion of the back of your head
  - At level with the back of your neck
  - At the level of your shoulder blades
34. Did you have your seatbelt on during the accident? -Yes -No
35. Did you slide out of your seatbelt during the accident? \_\_\_\_\_
36. What was damaged in your vehicle? (Please circle all that apply)
- |                      |                |                    |
|----------------------|----------------|--------------------|
| - Windshield         | - Rear window  | - Trunk            |
| - Steering wheel     | - Mirror       | - Front left door  |
| - Dashboard          | - Knee bolster | - Front right door |
| - Seat frame         | - Rear bumper  | - Back left door   |
| - Side window        | - Front bumper | - Back right door  |
| - Completely totaled | - Other: _____ |                    |
37. Choose the items that dented inward:
- Floorboards - Side door - Dashboard - Not Applicable
38. Choose the doors that would not open as a result of the accident:
- Front left - Rear left - front right - Rear right -Not Applicable

39. Did you go to the hospital? If no, why and do not answer 40-48 \_\_\_\_\_  
\_\_\_\_\_

40. How did you get to the hospital? \_\_\_\_\_

41. What was the name of the hospital? \_\_\_\_\_

42. Were you hospitalized over night? \_\_\_\_\_

43. Circle what you were prescribed at the hospital (if applicable):

Pain Medication      Muscle Relaxers      Not Applicable

44. Did you receive any stitches for any cuts at the hospital? If yes, which area(s) of the body?  
\_\_\_\_\_

45. Did you receive any of the following at the hospital?

Neck Brace      Back Brace      Not Applicable

46. Were x-rays taken at the hospital? If yes, which area(s) of the body were they taken?  
\_\_\_\_\_

47. Was an MRI/CT Scan taken at the hospital? If yes, which area(s) of the body were they taken?  
\_\_\_\_\_

48. Were there any other special imaging or testing done? If yes what imaging/testing was done and which area(s) of the body were they performed on?  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Insurance Verification Disclosure/Agreement

As a courtesy, Core Chiropractic and Physical Medicine will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. I understand that the information provided through the insurance verification is not a guarantee of coverage. I also understand that actual benefits are determined only when the claim is received. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Office Manager \_\_\_\_\_ Date \_\_\_\_\_





## Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

**Stroke:** Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

**Disk Herniations:** Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

**Soft Tissue Injury:** Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

**Rib Fractures:** The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.



**Physical Therapy Burns:** Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

**Soreness:** It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

**Other Problems:** There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Secondary Number: \_\_\_\_\_

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Office Manager \_\_\_\_\_ Date \_\_\_\_\_



## Assignment of Benefits

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns to Provider any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Provider: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Provider, and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Provider.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Office Manager \_\_\_\_\_ Date \_\_\_\_\_



## HIPAA Disclosure

### Standard Authorization of Use and Disclosure of Protected Health Information

#### Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

#### Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Core Chiropractic and Physical Medicine

Other Persons: \_\_\_\_\_

#### Expiration Date of Authorization

This authorization is effective through 12/2017 unless revoked or terminated by the patient or patient's personal representative.

#### Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Core Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Office Manager \_\_\_\_\_ Date \_\_\_\_\_



## Release of Medical Records

I, \_\_\_\_\_, hereby authorize the release of my medical records

**From:** (Doctor or Facility Name/Phone number)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To:**

Core Chiropractic and Physical Medicine

Fax to: 972-899-2425

Mail to: 3400 Long Prairie Rd., Ste 100  
Flower Mound, TX 75022

Records to be released:

- |   |   |
|---|---|
| <input type="checkbox"/> All Records          | <input type="checkbox"/> Physical Evaluation            |
| <input type="checkbox"/> Emergency Room Visit | <input type="checkbox"/> Diagnostic Testing (MRI/X-ray) |
| <input type="checkbox"/> Clinic Notes         | <input type="checkbox"/> Operative Report/Notes         |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consult Report                 |
| <input type="checkbox"/> Other _____          |   |

\_\_\_\_\_  
Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date