CORE CHIROPRACTIC

12627 San Jose Blvd., Suite 305, Jacksonville, FL 32223
P: 904-683-4376 | F: 904-683-4378 | backbonejax.com

Patient Name: _____ Birth Date: _____-_____-_____ ☐ Male ☐ Female

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

Home Phone: _____ Cell Phone: _____ Cell Phone Provider: _____

Email: _____ Social Security #: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Minor

Spouse or Patient's Guardian Name _____ How were you referred to us? _____

Person to contact in case of emergency _____ Phone _____

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American
☐Native Hawaiian or Pacific Islander ☐White ☐Other ☐Decline to specify

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to specify

In case of emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____
Parent or Guardian Signature Date

Insurance Carrier _____ Policy ID _____
Guarantor Name _____ Guarantor DOB _____ Relationship to Patient _____

Was this an auto injury? ☐Yes ☐No Date of Accident: _____ Claim Number _____
Adjustor Name _____ Phone _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS DESIGNATION AS MY PERSONAL REPRESENTATIVE

Initials _____ For good and valuable consideration, including the agreement of Core Chiropractic to accept this assignment of benefits in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Core Chiropractic the right to receive insurance benefits, to me or on my behalf, for services rendered by Core Chiropractic, for a motor vehicle accident that occurred on or about _____.

Initials _____ I authorize and assign to Core Chiropractic the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Core Chiropractic including the assignment to pursue declaratory relief or any other legal remedies.

Date: _____/_____/_____ X_____
(patient signature)

X_____ X_____
(signature of Guardian if applicable) (please print patient name)

HEALTH HISTORY

HISTORY OF COMPLAINT

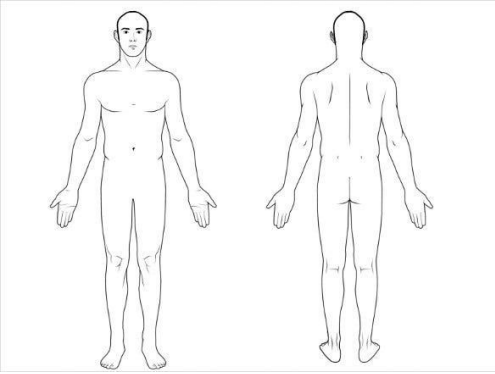
Health Concerns: List according to severity	Rate of Severity: 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

What daily activities are restricted by your current health problems? _____

_____

What else should the doctor know about your current condition?_____

_____



***PLEASE MARK** the areas on the diagram with the following

letters to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A = A**ching

N = Numbness **S = S**harp / **S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

FAMILY MEDICAL HISTORY

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

PAST MEDICAL HISTORY

CIRCLE ANY CONDITION(S) YOU HAVE NOW OR HAVE HAD IN THE PAST:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

OTHER: _____

Previous Hospitalizations/Surgeries/Serious Illness	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (include nonprescription)

_____

_____

_____

REVIEW OF SYSTEMS

Indicate which of the below you have experienced on the last 1-2 months

☐ Headache	☐ Pregnancy (Now)	☐ Dizziness	☐ Prostate Problems	☐ Ulcers
☐ Neck Pain	☐ Frequent Cold/Flu	☐ Loss of Balance	☐ Sexual Dysfunction	☐ Heartburn
☐ Jaw Pain/ TMJ	☐ Convulsions/Epilepsy	☐ Fainting	☐ Digestive Problems	☐ Heart Problem
☐ Shoulder Pain	☐ Tremors	☐ Double Vision	☐ Colon Trouble	☐ High Blood Pressure
☐ Upper Back Pain	☐ Chest Pain	☐ Blurred Vision	☐ Diarrhea/Constipation	☐ Low Blood Pressure
☐ Mid Back Pain	☐ Pain w/ Cough/Sneeze	☐ Ringing in Ears	☐ Menopausal Problems	☐ Asthma
☐ Low Back Pain	☐ Foot or Knee Problems	☐ Hearing Loss	☐ Menstrual Problems	☐ Difficulty Breathing
☐ Hip Pain	☐ Sinus/Drainage Problem	☐ Depression	☐ PMS	☐ Lung Problems
☐ Back Curvature	☐ Swollen/Painful Joints	☐ Irritable	☐ Bed Wetting	☐ Kidney Trouble
☐ Scoliosis	☐ Skin Problems	☐ Mood Changes	☐ Learning Disability	☐ Gall Bladder Trouble
☐ Numb/Tingling arms, hands, fingers		☐ ADD/ADHD	☐ Eating Disorder	☐ Liver Trouble
☐ Numb/Tingling legs, feet, toes		☐ Allergies	☐ Trouble Sleeping	☐ Hepatitis (A,B,C)

SOCIAL HISTORY

Use of Alcohol?	Never	Rarely	Moderate	Daily
Use of Tobacco?	Never	Rarely	Moderate	Daily
Exercise?	Never	Rarely	Weekly	Daily

Excessive Exposure at work or home to:

Fumes Dust Solvents

Noise Airborne Particles

INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, 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 twenty million, have been associated with chiropractic adjustments. I have been informed about other treatment options I might have considered, such as over-the-counter analgesics, medical care, hospitalization, and surgery.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Core Chiropractic 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.

_____ _____ _____

Patient (or Guardian's) Signature Date Witness Initials

ACKNOWLEDGEMENTS

Initials _____ To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Initials _____ **FEMALES ONLY:** I realize that X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual cycle (MM/DD/YYYY):_____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ 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 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 that I receive at this office.

_____ _____

Patient (or Guardian's) Signature Date (MM/DD/YYYY)

NOTICE OF PRIVACY PRACTICES

Core Chiropractic, LLC
12627 San Jose Blvd Ste 305
Jacksonville, FL 32223

(904) 683-4376

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on your first date of treatment and remains in effect until we replace it.

1. **OUR PLEDGE REGARDING MEDICAL INFORMATION**

   The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe the rights and certain duties we have regarding the use and disclosure of medical information.

2. **OUR LEGAL DUTY**

   Law Requires Us To:

   1. Keep your medical information private.
   2. Giving you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
   3. Follow the terms of the current notice.

   We Have The Right To:

   1. Change our privacy practice and the terms of this notice at any time, provided that the changes are permitted by law.
   2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

   Notice of Change To Privacy Practices:

   1. Before we make any important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

   The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked any time by writing to us at the address provided at the end of this notice.

   FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to Doctors, nurses, technician, medical students, or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.

   FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

I acknowledge that I have received the notices of privacy practices and I have been provided an opportunity to read it.

Name: _____ Date of Birth _____/_____/_____

Signature: _____ Date _____

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ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gym/Exercise	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

_____ _____

Patient (or Guardian's) Signature Date (MM/DD/YYYY)

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain											worst possible pain
0	1	(2)	3	4	(5)	6	7	(8)	9	10	

1 – What is your pain RIGHT NOW?

No pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

2 – What is your TYPICAL or AVERAGE pain?

No pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain											worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.