PATIENT INFO

Name:

(LAST) (MI) (FIRST)

Address:

(STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell 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): Relationship to 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/Guardian Signature **Date:**

PHONE 972.393.8067
Core Physical Medicine
3400 Long Prairie Road, Suite 100, Flower Mound, Texas 75022 • 546 E. Sandy Lake Road, Suite 110, Coppell, TX 75019
7200 N. State Highway 161, Suite 300, Irving, Texas 75039 • 601 S. Main St., Suite 260, Keller, Texas 76248

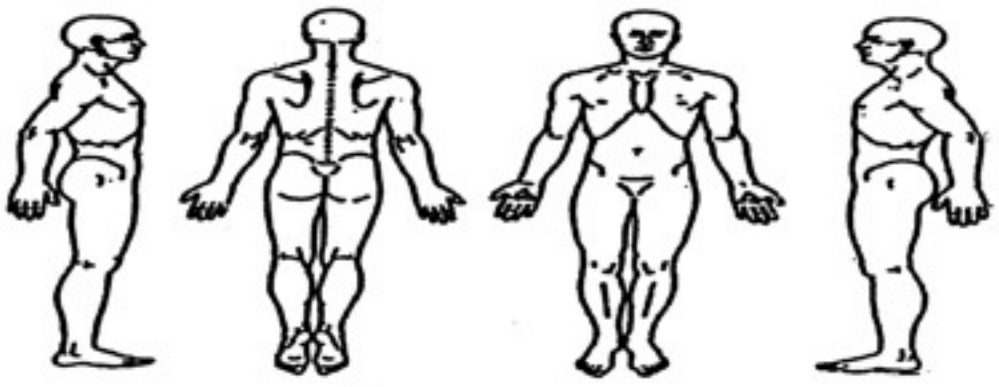
PATIENT INTAKE FORM

Patient Name: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. What is your Chief Complaint? _____

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



4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other: _____

5. On what date did your problem begin? _____

6. How do you think your problem began?

_____

7. How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ 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. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

10. What aggravates your problem?

_____

11. What alleviates your problem?

_____

12. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

PHONE 972.393.8067
Core Physical Medicine
3400 Long Prairie Road, Suite 100, Flower Mound, Texas 75022 • 546 E. Sandy Lake Road, Suite 110, Coppell, TX 75019
7200 N. State Highway 161, Suite 300, Irving, Texas 75039 • 601 S. Main St., Suite 260, Keller, Texas 76248

13. What concerns you the most about your problem; what does it prevent you from doing?

_____

14. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

15. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

16. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

17. What is your: Height_____ Weight _____ Date of Birth _____

18. Occupation _____

19. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

20. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

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

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

22. 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	
□	□	Headaches	□	□	Chronic Sinusitis	□	□	Dizziness
□	□	Neck Pain	□	□	High Blood Pressure	□	□	Visual Disturbances
□	□	Upper Back Pain	□	□	Heart Attack	□	□	Diabetes
□	□	Mid Back Pain	□	□	Chest Pains	□	□	Excessive Thirst
□	□	Low Back Pain	□	□	Stroke	□	□	Frequent Urination
□	□	Shoulder Pain	□	□	Angina	□	□	Smoking/Tobacco Use
□	□	Elbow/Upper Arm Pain	□	□	Kidney Stones	□	□	Drug/Alcohol Dependence
□	□	Wrist Pain	□	□	Kidney Disorders	□	□	Allergies
□	□	Hand Pain	□	□	Bladder Infection	□	□	Depression
□	□	Hip Pain	□	□	Painful Urination	□	□	Systemic Lupus
□	□	Upper Leg Pain	□	□	Loss of Bladder Control	□	□	Epilepsy
□	□	Knee Pain	□	□	Prostate Problems	□	□	Dermatitis/Eczema/Rash
□	□	Ankle/Foot Pain	□	□	Abnormal Weight Gain/Loss	□	□	HIV/AIDS
□	□	Jaw Pain	□	□	Loss of Appetite			
□	□	Joint Pain/Stiffness	□	□	Abdominal Pain	***Other:***		
□	□	Arthritis	□	□	Ulcer			
□	□	Rheumatoid Arthritis	□	□	Hepatitis	**For Females Only**		
□	□	Cancer	□	□	Liver/Gall Bladder Disorder	□	□	Birth Control Pills
□	□	Tumor	□	□	General Fatigue	□	□	Hormonal Replacement
□	□	Asthma	□	□	Muscular Inco ordination	□	□	Pregnancy

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

_____

24. List all of the supplements you are currently taking:

_____

25. List all surgical procedures you have had:

_____

26. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Driving:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Other Activities:**	□ Perform manual labor	□ Read a lot	□ Travel frequently

27. What activities do you do outside of work?

_____

28. Have you ever been hospitalized? □ No □ Yes

If yes, why _____

29. Have you ever seen a chiropractor before? □ No □ Yes
If yes, how long ago and what were the results_____

30. Have you had significant past trauma? □ No □ Yes

If yes, please explain: _____

30. Anything else pertinent to your visit today? _____

Patient/Guardian Signature_____ Date: _____

Insurance Verification Disclosure/Agreement

As a courtesy, Core Physical Medicine will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. 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 _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

PHONE 972.393.8067
Core Physical Medicine
3400 Long Prairie Road, Suite 100, Flower Mound, Texas 75022 • 546 E. Sandy Lake Road, Suite 110, Coppell, TX 75019
7200 N. State Highway 161, Suite 300, Irving, Texas 75039 • 601 S. Main St., Suite 260, Keller, Texas 76248

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 _____

Parent/Guardian Signature _____

Witnessed By _____ Date _____

PHONE 972.393.8067
Core Physical Medicine
3400 Long Prairie Road, Suite 100, Flower Mound, Texas 75022 • 546 E. Sandy Lake Road, Suite 110, Coppell, TX 75019
7200 N. State Highway 161, Suite 300, Irving, Texas 75039 • 601 S. Main St., Suite 260, Keller, Texas 76248

Assignment of Benefits

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities (“payers”), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future (“condition”) to **pay directly and exclusively in the name of Core Physical Medicine** (“office”) such sums as may be owed said offices for charges incurred by me at the office relating to my condition)”charges”), with such payment to **be made exclusively in the name of Core Physical Medicine.** For the purposes of this document (herein, “assignment”), “proceeds” shall include, but not be limited to, monies/proceeds from any settlement, judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker’s compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to office any information regarding any coverage or benefits which I may have including, but not limited to , the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Core Physical Medicine to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

I understand that I remain personally responsible for the total amounts due Core Physical Medicine for said services. If I discontinue treatment against the medical opinion/advice of my treating doctor, the balance of charges for services rendered will be due and payable immediately. If the office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Core Physical Medicine** for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

This assignment shall not be modified or revoked without the mutual written consent of Core Physical Medicine and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this assignment.

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

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian 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 Physical Medicine

Expiration Date of Authorization

This authorization is effective through __12/2012__ 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 _____

Parent/Guardian Signature _____

Office Manager _____ Date _____