

**PATIENT INFORMATION**

Patient Name: Dr./Mr./Mrs./Ms. \_\_\_\_\_  
Last Legal First Middle Initial  
Name you prefer to be called (nickname): \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Phone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_  
E-mail: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
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: \_\_\_\_\_  
Are you, or might you be pregnant? No/Yes Anticipated Due Date: \_\_\_\_\_ Do you have a pacemaker? No/Yes  
What do you hope to do better or enjoy more when you regain your health? \_\_\_\_\_  
When was your last physical exam? \_\_\_\_\_ Results: \_\_\_\_\_  
Date, and results, if known, of any recent tests: cholesterol: \_\_\_\_\_ other: \_\_\_\_\_  
Please list all current medications, vitamin/mineral supplements, herbs, including dosage: \_\_\_\_\_  
List any known allergies: \_\_\_\_\_  
If you smoke or have ever smoked, describe how much, and for how long: \_\_\_\_\_  
Describe your recreational drug use: \_\_\_\_\_ typical alcohol intake (#of drinks per day/per week): \_\_\_\_\_  
Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.): \_\_\_\_\_  
Please list and describe all significant previous surgeries: \_\_\_\_\_  
Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session: \_\_\_\_\_

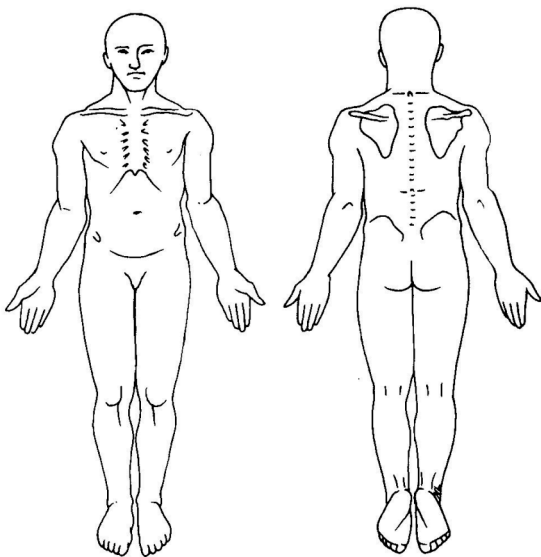
**CHIEF COMPLAINT**

**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)

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

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

<b><u>PAIN TYPICALLY</u></b>										
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: **H.**presently have      **P.**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  
 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

Frequent or recurring Sweats  
 Frequent/recurring hives/rashes  
 Frequent/recurring cold sores  
 Anemia

### 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  
 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:** \_\_\_\_\_