Health History Form

Name: _____ Date: _____

DOB_____ Age_____ Gender: Male/Female SSN#: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Would you like to receive appointment reminders via text? YES (Cell Phone Provider_____) NO

Email address: _____

Occupation: _____ Employer's Name: _____

Single/Married/Divorced Spouse's Name: _____

#of Children, Names, Ages & Gender_____

Who may we thank for referring you? _____

Main Health Concern History

Health Concerns: In order of Severity	Rate of Severity 1=Mild 10= Unbearable	How long have you had this?	Did this start with an injury?	Have you had this before?	Is this constant or comes/goes?
1.					
2.					
3.					
4.					

1. Please check all that apply when describing the pain?
   □ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiffness □ Spasm □ Burning □ Ache
   □ Weakness □ Numbness □ Shooting
2. Does the pain travel anywhere else? □ YES or □ NO Describe:_____
3. How often is this present? □ Constant (81-100%) □ Frequent (51-80%) □ Occasional (26-50%) Intermittent (25% or less)
4. Since it started, has the pain gotten better, worse or stayed the same? _____
5. What makes your health concern worse? □ Nothing □ Walking □ Standing □ Sitting □ Exercise (moving) □ Lying Down □ Other
6. Have you seen anyone for this health concern? (Chiropractor, Medical Doctor, etc.) If so, who?
   _____
7. How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?
   _____
8. Please list all medications, including vitamins/supplements, you are taking and for what?
   _____

9. Please list any broken bones, surgeries, or hospitalizations you have had and when:
   _____
10. Please list any auto accidents or major slips/falls/traumas you have been involved in:_____
11. Spinal health is especially important during pregnancy; **any chance** that you are pregnant? Y or N

Past Health History

Please circle all problems <u>you have or have had</u> now or in the past:

ADD/ADHD	Headache	Nervousness
Anxiety	Heart Disorder/Disease	Numbness in Arms
Arm Pain	Hip Pain	Numbness in Hands
Asthma	Infertility	Numbness in feet
Bladder Disorder	Irritable Bowel	Numbness in legs
Cancer	Kidney Problems	Sciatica
Chest Pain	Knee Pain	Scoliosis
Chronic Fatigue	Leg Pain	Shoulder Pain
Chronic Sinus	Liver Disease	Stomach Disorder/Disease
Disc Problem	Low Back Pain	Stroke
Dizziness	Lupus	Throat issues
Ear Infections	Menstrual Disorder	Thyroid Problems
Nausea	Mid Back Pain	TMJ
Epilepsy	Migraines	Ulcers
Fibromyalgia	Neck pain	Vertigo
Gastric Reflux		Diabetes

Lifestyle

Exercise? □ None □ Moderate □ Daily □ Heavy

Work Activity? □ sitting □Standing □ Light Labor □ Heavy Labor

Smoking Yes or No Packs/Day_____ Coffee/Caffeine Yes or No Cups/Day_____

Alcohol Yes or No Drinks/Day _____ Water Glasses/Day_____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem:

_____

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

_____ _____ _____

Printed Name Signature Date

INFORMED CONSENT

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTANCES PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFIY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTHCARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

WE DO NOT OFFER TO DIAGNOSE OR TREAT ANY DISEASE. OUR FOCUS IN THIS OFFICE IS THE VERTEBRAL SUBLUXATION. HOWEVER, IF WE ENCOUNTER NON-CHIROPRACTIC OR UNUSUAL FINDINGS WE WILL ADVISE YOU. IF YOU DESIRE ADVICE, DIAGNOSES, OR TREATMENT FOR THOSE FINDINGS WE RECIMMEND THAT YOU SEEK ANOTHER HEALTHCARE PROVIDER.

REGARDLESS OF WHAT THE DISEASE IS CALLED, WE DO NOT OFFER TO TREAT IT. NOR DO WE OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS. OUR ONLY PRACTICE OBJECTIVE IS TO LOCATE, ANALYZE AND CORRECT VERTEBRAL SUBLUXATION BY SPECIFIC NEUROLOGICAL BASED CHIROPRACTIC ADJUSTMENTS.

CHIROPRACTIC IS A VERY SPECIFIC SCIENCE, AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH CONCERNS AND NEEDS. CHIROPRACTIC IS A SEPARATE AND DISTINCT SCIENCE, ART AND PRACTICE. IT IS NOT THE PRACTICE OF MEDICINE.

THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISIDICTION, INVOVLES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION OR REGIONS OF THE SPNE WITH THE SPECIFIC INTENT OF RE-POSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE.

YOUR COMPLIANCE WITH CARE PLANS, HOME AND SELF-CARE, ETC. IS ESSENTIAL TO MAXIMUM HELAING AND OPTIMAL HEALTH.

WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTORS ON ANY MATTER RELATED TO YOU CARE AT THIS FACILITY.

_____ _____ _____

Printed Name Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

All questions regarding the chiropractors' objectives to my care in this office have been answered to mu complete satisfaction. I therefore accept care on this basis. I have read and fully understand the above statements.

_____ _____ _____

Printed Name Signature Date

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

Legal Guardian Signature _____ Date _____

Relationship to Minor _____ Witness Signature (Office Staff) _____

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES. **THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00, THIS FEE MUST BE PAID IN ADVANCE.**

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCAT E AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF CTC CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE. **BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

_____ _____

PRINT YOUR NAME HERE DATE

_____ _____

SIGNATURE YOUR AGE

FEMALE PATIENTS: TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT AND THE ABOVE DOCTOR AND HIS STAFF HAVE MY **PERMISSION TO PERFORM X-RAYS.**

Date of last menstrual period: _____ SIGNATURE _____

Insurance Verification Form

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of insured _____ Insured Date of Birth_____ Insured Social Security: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of insured _____ Insured Date of Birth_____ Insured Social Security: _____

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Dr. Cornell Cornish Sr, D.C. and/or Dr. Teandra L. Cornish, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. **All professional services rendered are charged to the patient**. **It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.**

Signature_____ Date _____

Office Policies

FEES: We have a zero balance policy. Payment for services is due at the time of services rendered. Payment options include; cash, check, debit/credit card, amex, and HSA/HRA cards. Returned checks will be billed to the patient for the amount of the check as well as a returned check fee of $15.00. We reserve the right to charge $35 late fee for all late payments.

CELL PHONES: As a courtesy to all patients, please silence and refrain from using your phones will in the office. If you should need to take a call, we ask that you please step outside until the call is complete. We thank you for your consideration in helping us to provide a completely relaxing atmosphere.

APPOINTMENTS: If you should need to reschedule an existing appointment, please contact us prior to your appointment time so that we are better able to find a time that works for you. We ask that you please provide us with 24 hour notice for any appointment cancellations; this office reserves the right to charge $25.00 for any no call, no show missed appointments.

MULITPLE DOCTOR CARE: At any given time you may be adjusted by anyone of our qualified Doctors. If you have a preference for a specific doctor, schedule accordingly at the front desk.

REFERRALS: We ask that you consider us for referrals to your friends/family. It's important to us to deliver the message of true health to the community and we ask for your help in doing so!

I have read the above and I understand and accept these policies.

Patient's Signature _____ Date_____