New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name _____ Last Name _____ Date of Birth _____ Date _____

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (Cell) _____ (home) _____

Age _____ Occupation _____ Email* _____

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Marital Status _____ Spouse's Name _____ Number of Children _____

Emergency Contact _____ Phone _____

Who can we thank for referring you? _____

Current Complaints

Nature of Injury ○ Automobile* ○ Work ○ Other

Please describe _____

Date of Injury _____ Date symptoms appeared _____

Have you ever had same condition? ○ No ○ Yes If yes, when? _____

List of other practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe _____

Signatures

Patient's Name (Print) _____

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ◯No ◯Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ◯No ◯Yes

Have you had X-rays taken? ◯No ◯Yes If Yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts. etc.)

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency)

_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	_____
Been hospitalized?	◯	◯	_____
Been in an auto accident?	◯	◯	_____
Had Sprains/Strains?	◯	◯	_____
Been struck unconscious?	◯	◯	_____
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

_____

_____

_____

_____

Do you experience pain every day?	◯No	◯Yes
Do your symptoms interfere with daily life?	◯No	◯Yes
Does pain wake you up at night?	◯No	◯Yes
Are your symptoms worse during certain times of the day?	◯No	◯Yes
Do changes in weather affect your symptoms?	◯No	◯Yes
Do you wear orthotics?	◯No	◯Yes
Do you take vitamin supplements?	◯No	◯Yes
What activities aggravate your symptoms?		

_____

_____

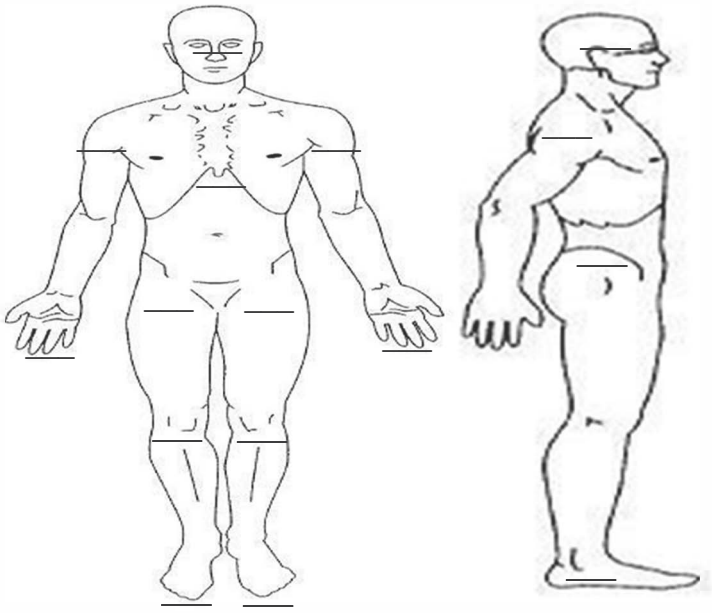
Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

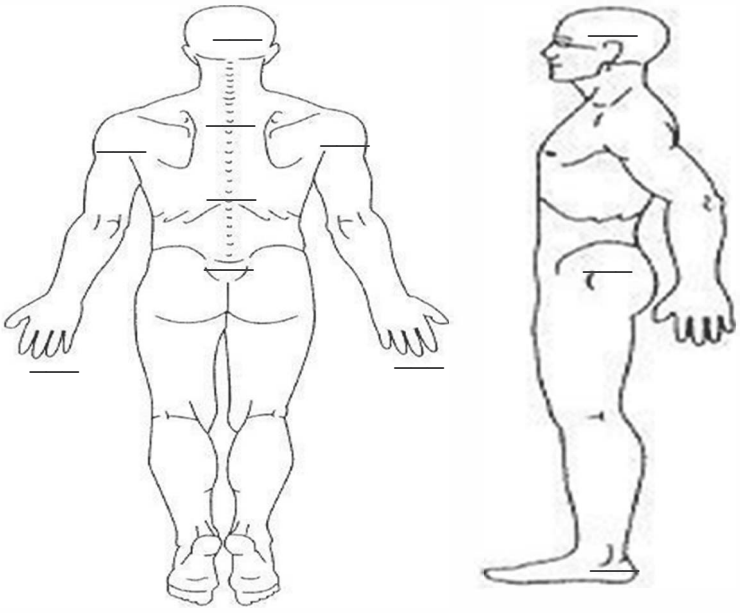
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

Please use the following letters in the boxes below to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing





Other area not listed above:

_____

_____

_____

_____

Core Chiropractic, 3070 Bristol St. #160, Costa Mesa, CA 92626

ACCIDENT INFORMATION

Name: _____ Today's Date: _____

Where did the collision occur: Street _____ City _____ State _____

Date of accident: _____ Time of accident: _____ AM ◯ PM ◯ Was the road: Dry ◯ Wet ◯ Other ◯

Were you the: Driver ◯ Front passenger ◯ Rear passenger ◯ Pedestrian ◯

Number of people in your vehicle _____ Were you struck from Behind ◯ Front ◯ Left ◯ Right ◯

Speed of your car _____ mph Speed of other car _____ mph

Describe what happened: _____

_____

_____

_____

ACCIDENT DETAILS

◯ Yes ◯ No If driving, were both hands on the wheel at impact?

◯ Yes ◯ No If passenger, did your hands brace yourself?

◯ Yes ◯ No Were you wearing your seatbelt?

◯ Yes ◯ No Did the airbag engage?

◯ Yes ◯ No Did you hit the dash, steering wheel, window or headrest? If so, which?

◯ Yes ◯ No Did you know you were going to be hit?

◯ Yes ◯ No Did you brace yourself with hands or feet?

◯ Yes ◯ No If driving, was your foot on the brake at impact?

◯ Yes ◯ No Was your head turned at impact? If yes, which way?

◯ Yes ◯ No Did you get hit into another car, tree, railing, etc.?

◯ Yes ◯ No Were you knocked unconscious?

◯ Yes ◯ No Were the police notified?

What part of the vehicle was hit? _____

Amount of damage to your car? _____

◯ Yes ◯ No Did the accident force you to take any medications? If yes, what? _____

◯ Yes ◯ No Did you see an MD, go to the ER or Urgent Care? I so, when? _____

◯ Yes ◯ No Did you lose any days from work? _____

◯ Yes ◯ No Did the car that hit you have insurance?

◯ Yes ◯ No Do you have Medical Pay on your car insurance? If so, what dollar amount? ◯ $5,000 ◯ $10,000

◯ Yes ◯ No Did your head hurt after the collision?

What make and model of vehicle were you in? _____ The other vehicle? _____

Was the headrest positioned ◯ below ◯ level with ◯ above the center of your head

How soon after the collision did you notice any pain?

Did the crash affect: ☐ Dizziness ☐ Memory ☐ Concentration ☐ Headaches ☐ Balance ☐ Nightmares ☐ Breathing ☐ Fatigue ☐ Irritability ☐ Ability to read ☐ Ability to listen ☐ Appetite ☐ Nausea ☐ Vision

Is there anything else you want us to know? _____

#1 MAIN COMPLAINT

Area of complaint: _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Achy ☐ Numb / Tingly ☐ Stabbing ☐ Sore ☐ Other _____

The complaint is: ◯ Constant ◯ Occasional ◯ Off & On ◯ Worse in the morning ◯ Worse in evening

There is numbness into: ☐ Arms/Hands ☐ Legs/Feet

It affects: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving ☐ Other: _____

What makes it feel better? _____

What makes it feel worse? _____

How bad is the pain? No pain) 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ (Worst possible pain

OTHER COMPLAINT(S): _____

_____

_____

#2 MAIN COMPLAINT

Area of complaint: _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Achy ☐ Numb / Tingly ☐ Stabbing ☐ Sore ☐ Other _____

The complaint is: ◯ Constant ◯ Occasional ◯ Off & On ◯ Worse in the morning ◯ Worse in evening

There is numbness into: ☐ Arms/Hands ☐ Legs/Feet

It affects: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving ☐ Other: _____

What makes it feel better? _____

What makes it feel worse? _____

How bad is the pain? No pain) 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ (Worst possible pain

OTHER COMPLAINT(S): _____

_____

_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Core Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my Insurance benefits (if applicable) directly to the provider.
- The above Information is true and accurate to the best of my knowledge

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

CORE CHIROPRACTIC

INFORMED CONSENT TO CARE

CORE CHIROPRACTIC | 949-662-1616 | 3070 BRISTOL ST. #160 COSTA MESA, CA 92626

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient: Print Name:_____ Signature:_____ Date:_____

Parent/Guardian: Print Name:_____ Signature:_____ Date:_____

CORE
CHIROPRACTIC

HIPAA NOTICE OF PRIVACY PRACTICES

CORE CHIROPRACTIC | 949-662-1616 | 3070 BRISTOL ST. #160 COSTA MESA, CA 92626

How We Store Your Information: Practice member information is stored on secured servers with no outside access. X-Ray images are also stored on a server. All storage is secure and meets or exceeds HIPAA requirements and regulations.

What We Do Not Do With Your Information: Information about your financial situation, medical conditions, and care that you provide us with in writing, via email, on the phone (including information left on voicemails), texts, contained in or attached to applications, or directly or indirectly given us, is held in strict confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about our practice members to anyone who receives our services. Know that any and all practice member information is considered confidential, is restricted by law, or has been specifically restricted by a patient/practice member in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your care, billing to an insurance company or to provide you with health or services which may require communication between Core Chiropractic and any health care providers, insurance companies, attorneys/law firms, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, and insurance.

No practice member information and no identifying information (photos, addresses, phone numbers, contact information, last names, or uniquely identifiable names) will ever be used without patient's expressed written advanced permission.

Patient Name (Print)_____

Patient Signature_____ Date_____