CORE CHIROPRACTIC

MVA Information

Patient Name: _____

Date of Birth: _____

Date of Accident: _____

1. Personal Auto Insurance (PIP)

Company Name: _____

Phone Number: _____

Policy Number: _____

Max or Limits: _____

Claim Number: _____

Adjuster Name: _____

Adjuster Phone: _____ Ext._____

Adjuster Fax: _____

Mailing Address: _____

_____

_____

2. Attorney Information

Attorney Name: _____

Contact Name: _____

Phone Number: _____

Fax Number: _____

Mailing Address: _____

_____

_____

Phone: (972) 899-2258
2851 Cross Timbers Road, Suite 111, Flower Mound, Texas 75028

CORE CHIROPRACTIC

Patient Information

Name: _____
(LAST) (FIRST) (MIDDLE INITIAL)

Address: _____
(STREET) (APT #) (CITY) (STATE) (ZIP)

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

DOB: / /

Marital Status: S M W Spouse's Name: _____

Your Employer: _____ Occupation: _____

Employer Address: _____
(STREET) (Sute #) (CITY) (STATE) (ZIP)

Primary Care Physician:

Referral Information

□ Google □ Insurance □ Doctor: _____ □ Family/Friend: _____

□ Yelp □ Sign □ Staff: _____ □ Other: _____

Insurance Information

Insurance Type: Health Personal Pay PI/Auto Workers Comp Medicare

Insurance Name: _____

Insurer's Name (If Different From Patient): _____ Relationship to Patient: _____

Insurer's DOB: / /

Insurer's Employer: _____

Member #: _____ Group #: _____

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 Signature_____ **Date:** _____

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CORE CHIROPRACTIC

Vehicle Accident Information Form

Patient Name: _____

1. What was the date of the accident? _____
2. Approximately what time did the accident occur? _____:_____AM / PM
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What street were you on when the accident occurred? _____
6. What direction were you traveling in? _____
7. What city did the accident occur in? _____
8. What state did the accident occur in? _____
9. What type of impact was the auto accident? (Example: Rear ended, Passenger side impact, Driver side Impact)

_____

10. Did your vehicle hit anything after the accident (i.e. tree or guard rail)? If yes, please describe

_____

11. Were you the driver, front passenger, or rear passenger? _____
12. Did you know the accident was coming? □ No □ Yes If yes, were you braced for impact □ No □ Yes
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact you were:

    □Slowing down □Gaining Speed □Stopped □Moving at a steady speed

16. At the time of the impact, approximately how fast was your vehicle moving? _____MPH
17. At the time of the impact was the other car was:

    □Slowing down □Gaining Speed □Stopped □Moving at a steady speed

18. At the time of impact, approximately how fast was the other vehicle moving? _____MPH

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19. During and after the crash what happened to your vehicle? (Please circle all that apply)
    - □ Kept going straight
    - □ Kept going straight hitting a car in front
    - □ Was hit by another vehicle
    - □ Not Applicable
    - □ Spun around
    - □ Spun around and hit a stationary object
    - □ Hit a stationary object
20. Did you lose consciousness during the accident? No / Yes
21. How was your head positioned during the accident? _____
22. How was your torso positioned during the accident? _____
23. How were your hands positioned during the accident? _____
24. Did your head hit anything during the accident? No / Yes, please describe _____
25. Did your face hit anything during the accident? No / Yes, please describe _____
26. Did your shoulders hit anything during the accident? No / Yes, please describe _____
27. Did your neck hit anything during the accident? No / Yes, please describe _____
28. Did your chest hit anything during the accident? No / Yes, please describe _____
29. Did your hips hit anything during the accident? No / Yes, please describe _____
30. Did your knees hit anything during the accident? No / Yes, please describe _____
31. Did your feet hit anything during the accident? No / Yes, please describe _____
32. What kind of headrest was in your vehicle? □ Movable fixed headrest □ Non-movable fixed headrest □ No headrest
33. Where was the headrest positioned on your head? (Please circle which applies best)
    - □ At the top of the back of your head
    - □ At the middle height of the back of your head
    - □ At the lower portion of the back of your head
    - □ At level with the back of your neck
    - □ At the level of your shoulder blades
34. Did you have your seatbelt on during the accident? □Yes □No
35. Did you slide out of your seatbelt during the accident? □Yes □No □Partially
36. Choose the items that dented inward:
    - □ Floorboards □Side door □ Dashboard □ Not Applicable

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37. Choose the doors that would not open as a result of the accident:

□ Front left □ Rear left □ front right □ Rear right □Not Applicable

38. What was damaged in your vehicle? (Please circle all that apply)

□ Completely totaled	□ Windshield	□ Rear window	□ Trunk
□ Steering wheel	□ Mirror	□ Front left door	□ Front right door
□ Dashboard	□ Knee bolster	□ Rear bumper	□ Front bumper
□ Seat frame	□ Back left door	□ Side window	□ Back right door

Other: _____

39. Did you go to the hospital/urgent care/doctor? If no, why and do not answer 40-48 _____

_____

40. How did you get to there? _____

41. What was the name of the facility/office?_____

42. Were you hospitalized overnight? _____

43. Circle what you were prescribed at the hospital (if applicable):

□Pain Medication □Muscle Relaxers □Not Applicable

44. Did you receive any stitches for any cuts at the hospital? If yes, which area(s) of the body?

_____

45. Did you receive any of the following at the hospital?

□Neck Brace □Back Brace □Not Applicable

46. Were x-rays taken at the hospital? If yes, which area(s) of the body were they taken?

_____

47. Was an MRI/CT Scan taken at the hospital? If yes, which area(s) of the body were they taken?

_____

48. Were there any other special imaging or testing done? If yes what imaging/testing was done and which area(s) of the body were they performed on?

_____

Patient Signature_____ Date: _____

CORE CHIROPRACTIC

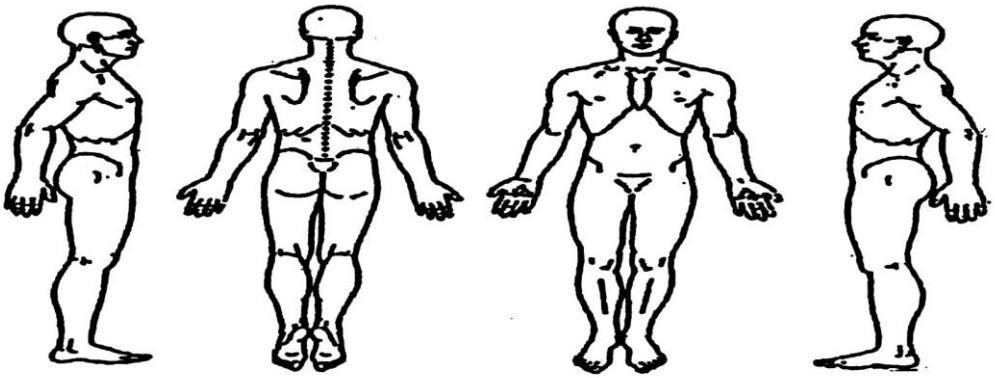
PATIENT INTAKE FORM

Patient Name: _____

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

2. What is your primary area of concern/pain? _____

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. How long have you had this problem? _____

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. What aggravates your problem?

_____

10. What alleviates your problem?

_____

11. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

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12. What is your Height _____ Feet _____ Inches

13. What is your Weight _____

14. What is your Date of Birth _____/_____/_____

15. What is your Occupation _____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

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

18. List all surgical procedures you have had (please be specific):

_____

_____

_____

19. Have you ever been hospitalized overnight? □ No □ Yes

If yes, why _____

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

If yes, please explain: _____

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21. List all allergies:

_____

_____

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

_____

_____

_____

_____

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

_____

_____

24. What type of exercise do you do?

□ **Strenuous** □ **Moderate** □ **Light** □ **None**

25. 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

26. Please mark any of that apply:

	Father	Mother	Brother	Sister
Heart Disease				
High Blood Pressure				
Diabetes				
Cancer				
Autoimmune Disease				
Rheumatoid Arthritis				
Lupus				
ALS				
Asthma				

27. What activities do you do outside of work?

_____

28. Is there anything else you wish to let the doctor know about your visit today?

_____

Patient Signature_____ **Date:** _____

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CORE CHIROPRACTIC

Insurance Verification Disclosure/Agreement

As a courtesy, Core Chiropractic will verify and file my health insurance. However, the verification of insurance benefits do NOT guarantee payment for services rendered.

I understand that the information provided through the insurance verification is not a guarantee of coverage. I also understand that actual benefits are determined only when the claim is received. 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_____

Office Manager _____ Date _____

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CORE CHIROPRACTIC

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 effects 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 the 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_____

Office Manager _____ Date _____

CORE CHIROPRACTIC

Assignment of Benefits

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns to Provider any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Provider: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Provider, and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Provider.

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

Patient Name (Printed) _____ Date _____

Patient Signature_____

Office Manager _____ Date _____

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HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed:

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

From: Core Chiropractic

□ To Other Persons: _____
□ No Other Persons

The information covered by this authorization includes:

□ All information (Billing, Appointments, and Records)
□ Billing Information (including but not limited to statements, insurance processing, or payments)
□ Appointments (including but not limited to appointment times and dates, cancelation, or rescheduling)
□ Medical Records (including but not limited to diagnosis, lab test results , diagnostic test results, or treatment notes)

Form of Disclosure

□ All forms
□ Verbal
□ Electronic Copy
□ Hard Copy

Expiration Date of Authorization

This authorization is effective through 12/2025 unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

- I 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 the Core Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature_____

Office Manager _____ Date _____

Phone: (972) 899-2258
2851 Cross Timbers Road, Suite 111, Flower Mound, Texas 75028

CORE CHIROPRACTIC

Release of Medical Records

I,_____, hereby authorize the release of my medical records

From: (Doctor or Facility Name/Phone number)

_____

_____

_____

To:

Core Chiropractic

□ Fax to: 972-899-2425

□ Mail to: 2851 Cross Timbers Rd Ste 111
Flower Mound, TX 75028

Type of records to be released:

□ All Records
□ Emergency Room Visit
□ Clinic Notes
□ History and Physical
□ Other _____

□ Physical Evaluation
□ Diagnostic Testing (MRI/X-ray)
□ Operative Report/Notes
□ Consult Report

_____ _____/_____/_____
Patient Name Date of Birth

_____ _____/_____/_____
Signature Date