Cornerstone FAMILY CHIROPRACTIC

HEALTH HISTORY FORM

Discover Health Love Life

Name _____ Date of Birth _____ Gender: □M □ F

Cell Phone _____ Cell Carrier _____

Home Phone_____ Work Phone_____

Marital Status: □S □M □D □W Name of Spouse _____

Employer _____Occupation _____

Email _____ Social Security No. _____

Home Address _____ City_____ State_____ Zip_____

Whom may we thank for referring you to Cornerstone Family Chiropractic? _____

Reason for Seeking Chiropractic Care

What concerns do you feel Cornerstone Family Chiropractic can address for you?_____

_____

Have you had this condition before? □Yes □No If yes, When?_____ Have you seen other health care practitioners for this condition? □Yes □No If yes, Who?_____

Have you had imaging for this condition: □Yes □No If yes, When?_____Where?_____

On a scale from 0 – 10, with 0 being no pain and 10 being the worst pain you've ever experienced, rate your pain level: Currently____/10 Worst____/10 Best_____/10

What percentage of the time do you experience this problem? □Occasionally (Less than 25% of the time) □Often (26%-50% of the time) □Frequently (51%-75% of the time) □Constantly (76%-100% of the time)

Is this concern affecting any of the activities below?

Work:	□Yes	□No	Recreation/play:	□Yes	□No	Sleep:	□Yes	□No
Social Life:	□Yes	□No	Walking:	□Yes	□No	Sitting:	□Yes	□No
Exercise:	□Yes	□No	Eating:	□Yes	□No	Love life:	□Yes	□No
Dressing:	□Yes	□No	Bathing:	□Yes	□No	Standing:	□Yes	□No

Other Data

Have you ever received Chiropractic care? □Yes □No With Whom? _____

Date of last visit_____ Why did you stop care? _____

Do you have a family medical doctor? □Yes □No Who? _____

Date of last medical consultation and result _____

Have you been diagnosed with any of the following conditions:

□Arthritis □Diabetes □Heart Disease □High Blood Pressure □High Cholesterol □Anxiety □Depression

□Stroke □Cancer_____ □Auto Immune Disorder_____ Other:_____

Women: Date of last menstrual period_____ Is there a chance you are pregnant? □Yes □No

Health, Wellness, and Chiropractic Care

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as accurately and completely as possible.

History of Physical Stresses (Birth to Present)

Birth Stress

Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your knowledge how you were birthed:

Was your birth: (check all that apply) ☐ I do not know my birth history

☐ drug induced ☐ C section ☐ breech ☐ natural ☐ forceps

☐ prolonged ☐ cord around neck ☐ at home ☐ in hospital ☐ suction

General Physical Trauma

Many traumas occur in the early years (between birth and age 18-21). It is during those years that your spine and nerve system are growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates)

☐ automobile (even as a passenger) ☐ motorcycle ☐ bicycle ☐ sports ☐ other _____

If yes, please explain how and when: _____

_____

Have you ever injured your spine (neck, head, back, hips)? ☐ yes ☐ no

If yes, please explain how and when: _____

_____

Have you ever had any surgeries? ☐ yes ☐ no

If yes, please explain what and when:

_____

_____

Have you ever broken any bones or sprained any part of your body? ☐ yes ☐ no

If yes, please explain which and when:

_____

_____

History of Chemical Stresses

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated?	☐ yes	☐ no		
Do you or have you ever taken?	☐ prescription drugs	☐ over the counter drugs	☐ recreational drugs	
Have you been exposed to?	☐ chemicals	☐ fumes	☐ dust	☐ smoke
Do you consume?	☐ alcohol	☐ coffee/caffeine	☐ tobacco	

List Current Medications: _____

_____

_____

Any Medications Previously taken for more than 6 months? _____

History of Emotional Stresses

It can be difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below. (Please circle)

☐ Childhood trauma	☐ Loss of loved one	☐ Relationships	☐ Family
☐ Work or School	☐ Divorce/separation	☐ Financial	☐ Abuse
☐ Lifestyle change	☐ Parents' divorce	☐ Illness	☐ Other

Quality of Life

How do you grade your physical health?	☐ Good	☐ Fair	☐ Poor
How do you grade your emotional/mental health?	☐ Good	☐ Fair	☐ Poor
How do you rate your overall "quality of life"?	☐ Good	☐ Fair	☐ Poor

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

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

Financial Information

Payment in full is expected for all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

****The self-pay fee for a new patient is $60.00, which includes the first consult and a chiropractic exam. If it is appropriate and you consent to being adjusted, the first adjustment fee is an additional $45.00****

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process, please fill out the "Insurance Permission" section below.

Signature _____ Today's Date _____

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:

"I authorize Cornerstone Family Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims."

"I authorize payment be made directly to Cornerstone Family Chiropractic. I permit a copy of this authorization to be used in place of the original."

Signature: _____ Date _____

Relationship to insured: ☐self ☐spouse ☐child ☐other

Also, if you are not the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber's name: _____ Subscriber's date of birth: _____

Subscriber Gender: ☐Male ☐Female

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Cornerstone Family Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We occasionally have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We occasionally take and post photos of our practice members/patients in the office and in our newsletters.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Cornerstone Family Chiropractic. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

We at Cornerstone Family Chiropractic are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Cornerstone Family Chiropractic's *Notice of Privacy Practices for Protected Health Information.* Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

Patient name printed	Date
Patient Signature	CFC representative

Terms and Consent to Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I, _____ (print name) have read and fully understand the above. Outcomes and options relative to care have been discussed and noted. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____	_____
(signature)	(date)