# Registration and History

Patient's Name: _____ Today's Date: _____

C.O.R.E Health Centers
CHIROPRACTIC | WELLNESS
*Jeremiah Holmes D.C.*

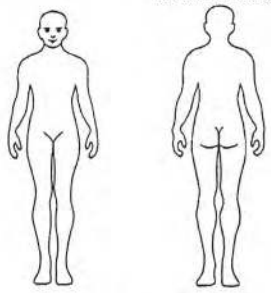
## 1 Patient Condition

Chief complaint _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ NA

Activities or movements that are painful: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ NA

## 2 Medical History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____
MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | Chemical Depend./ Alchoholism | ☐ Yes ☐ No | Hernia | ☐ Yes ☐ No | Pinched Nerve | ☐ Yes ☐ No |
| Allergies | ☐ Yes ☐ No | Chicken Pox | ☐ Yes ☐ No | Herniated Disk | ☐ Yes ☐ No | Pneumonia | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Clotting Disorder | ☐ Yes ☐ No | Hypertension | ☐ Yes ☐ No | Prostate Problem | ☐ Yes ☐ No |
| Anxiety/Depression | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No |
| Appendicitis | ☐ Yes ☐ No | Eating Disorder | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Rheum. Arthritis | ☐ Yes ☐ No |
| Arthritis | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | Migraines | ☐ Yes ☐ No | STD | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Epilepsy/Seizure Dis. | ☐ Yes ☐ No | Mononucleosis | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Autoimmune Dis. | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | MS | ☐ Yes ☐ No | Thyroid Disease | ☐ Yes ☐ No |
| Bleeding Disorder | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Bronchitis | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Tumors, Growths | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | | | Parkinson's | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No |
| | | | | | | ☐ Other _____ | |

## 3 Family History

| | | | | | | |
|---|---|---|---|---|---|---|
| Autoimmune Dis. | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Migraines | ☐ Yes ☐ No | ☐ Other _____ |
| Bleeding Disorder | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | |
| Clotting Disorder | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No | |
| Cancer | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Thyroid Disease | ☐ Yes ☐ No | |

Are you pregnant? ☐ Yes ☐ No

| Please list all injuries/surgeries you have had: | Description | Date |
|---|---|---|
| Falls: | | |
| Head Injuries: | | |
| Broken Bones/Fractures: | | |
| Dislocations: | | |
| Surgeries: | | |

## 4 Lifestyle


**Exercise**

- ☐ None
- ☐ Light
- ☐ Moderate
- ☐ Heavy

**Work Activity**

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

**Habits**

- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine Drinks
- ☐ High Stress Level

**Values**

Please list your interests in order of importance from 1 to 7 (1= most important)

_____Family _____Financial _____Social _____Physical

_____Mental _____Spiritual _____Work

## 5 Medications | Vitamins/Supplements | Allergies

**Medications**

1) _____
2) _____
3) _____

Pharmacy Name: _____

Pharmacy Phone: (____) _____

**Vitamins/Supplements**

1) _____
2) _____
3) _____
4) _____

☐ Daily ☐ Weekly ☐ Occasionally

**Allergies**

1) _____
2) _____
3) _____
4) _____

How often do they occur? _____

## 6 Patient Information

Patient Name (Last Name)_____ (First Name) _____ (Middle Initial) _____

Email: _____ Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Address: _____ City: _____

State: _____ Zip: _____ Sex ☐ M ☐ F Age: _____ Birth Date: _____

Social Security/DL # _____ ☐ Married ☐ Single ☐ Partnered

Occupation: _____ Patient Employer/School: _____

Address: _____ Phone: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you? Event you attended? _____

## 7 Payment/Insurance Information

Who is responsible for this account? _____

☐ Self-Pay Name(s) of responsible parties: _____

Relationship to patient: _____

☐ Government Program Name: _____ ID # _____

☐ Health Insurer Name: _____ ID # _____ Group # _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Is this policy associated with an ☐ HSA ☐ FSA ☐ HRA? ☐ Yes ☐ No

Is patient covered by additional/ secondary insurance? ☐ Yes ☐ No

Insurance Co. Name: _____ ID # _____ Group # _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

### Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up-to-date, 2) consent to treatment by CORE H.C. 3) assign to CORE H.C. any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by CORE H.C., authorize their payment directly to CORE H.C., and authorize the use of your signature for this limited purpose, 4) agree to be primarily responsible for all charges owed to CORE H.C. (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to CORE H.C. releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt of CORE H.C.'s notice of privacy practices.

_____ _____

Printed name of Patient, Parent, Guardian or Personal Representative | Signature of Patient, Parent, Guardian or Personal Representative

Relationship: _____ Date: _____

## 8 Family Information

| Children's Name(s) | Sex | Date(s) of Birth | Children's Name(s) | Sex | Date(s) of Birth |
|---|---|---|---|---|---|
| _____ | M F | _____ | _____ | M F | _____ |
| _____ | M F | _____ | _____ | M F | _____ |
| _____ | M F | _____ | _____ | M F | _____ |

## Informed Consent and Terms of Acceptance

C.O.R.E Health Centers
CHIROPRACTIC | WELLNESS
*Jeremiah Holmes D.C.*

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both the patient and chiropractor to be working towards the same objective. Chiropractic has only one goal: to alleviate vertebral subluxation, thus minimizing interference to the nervous system and restoring optimal health. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae 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.

**Adjustment:** The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Chiropractic care, like all forms of healthcare, offers considerable benefits and may also carry 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 reported secondary to chiropractic care include sprain/strain injuries, muscle spasms for short periods of time, aggravation and/or temporary increase in symptoms, lack of improvement in symptoms, dislocations, disc injuries, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. You cannot expect the doctor to be able to anticipate and explain all risks and complications, and you agree to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in your best interests.

Prior to your receiving chiropractic care from CORE H.C. , a health history and physical examination will be completed. These procedures are performed to assess your specific condition, 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 modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you, along with any recommended future chiropractic care, in a document known as your "treatment recommendations."

We do not offer to diagnose or treat any disease regardless of what the disease is called, nor do we offer advice regarding treatment prescribed by others. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body maintain the adjustments.

If during the course of a chiropractic spinal examination, 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 another healthcare provider. You understand and have been informed that you have the right to a second opinion and secure other opinions if you have concerns as to the nature of your symptoms and treatment options. You also understand that there are treatment options available for your condition other than chiropractic procedures. These treatment options include, but are not limited to self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery.

You hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies for yourself (or for the patient for whom you are the parent or legal guardian) by the CORE H.C. doctor of chiropractic and supporting healthcare staff. You acknowledge that you have had an opportunity to discuss with the CORE H.C. doctor of chiropractic the nature and purpose of chiropractic adjustments and procedures and that you understand and are informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure.

You have read, or have had read to you, the above terms of acceptance and consent to treatment. You have also had an opportunity to ask questions about its content, and by signing below you agree to the above-named procedures. You intend this consent to cover the entire course of treatment for your present condition and for any future condition(s) for which you seek treatment.

_____

(Signature) (Date)

## Consent to evaluate and adjust a minor child

You, _____ ,being the parent or legal guardian of _____ ,have read and fully understand the above terms of acceptance and hereby grant permission for your child to receive chiropractic care.

_____

(Signature) (Date)

## Pregnancy Release

You certify that you are NOT pregnant and that 's staff has your permission to perform an x-ray evaluation.
You have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: ____ /____ /____

_____

(Signature) (Date)

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## Pre-Paid Offer Restrictions

If you purchased a pre-paid package of services, it is for certain introductory services rendered to new patients only. Pre-payment of services connected with any offers may not be applied to services previously rendered or to be rendered for any established patient. If applicable, government-issued identification and health insurance cards will need to be presented at the initial visit. Based upon our evaluation of your healthcare needs, CORE H.C. reserves the right to decline non-emergency treatment and to refund the purchase price of any offer at our sole discretion. Further, based upon initial patient examination, additional services may be recommended.

Although welcome for treatment, these patients are excluded from pre-paid offers: 1) MEDICARE, MEDICAID, TRICARE, CHAMPUS, and other government healthcare program participants and 2) worker's compensation and personal injury claimants.

You have the right to rescind, within seventy-two (72) hours, any obligation to pay for services performed in addition to this free or discounted service.

_____ initial

## Payment and Assignment of Benefits

In consideration of any services provided by CORE H.C. in addition to those included in any pre-paid offer, you agree to: 1) be primarily responsible for all charges owed to CORE H.C. including attorney fees, court costs, and other expenses of collection, 2) irrevocably assign and transfer to CORE H.C., all right, title, and interest to health insurance or reimbursement benefits to which you are entitled for the purpose of payment of the charges owed to CORE H.C., and 3) authorize payment of such benefits directly to CORE H.C..

If you have health insurance, you acknowledge that our verification of your health insurance benefits is only an estimate of benefits payable to you, if any, and that health insurance benefits may vary due to the coverage the plan sponsor offered or the coverage you purchased, you or the plan sponsor's failure to pay premiums, termination of the plan by the sponsor, your failure to otherwise remain eligible (e.g., not maintaining full-time employment status), error, and other causes. You further acknowledge that you are primarily responsible for all charges for services rendered, whether or not covered by health insurance.

If you have a health savings account (HSA), flexible spending account (FSA), or a health reimbursement account (HRA), you must inform us so that we can make appropriate arrangements for payment.

You acknowledge that our verification of health reimbursement benefits is only an estimate of benefits payable to you, if any, and that health reimbursement benefits may also vary. We do not directly bill to any HSA, FSA, or HRA plan, but, depending upon your plan provisions, automatic withdrawals may occur when we submit charges to any primary health insurer. Any refund or reimbursement to an HSA, FSA, or HRA account cannot exceed your out-of-pocket contribution toward any treatment. You further acknowledge that you are primarily responsible for all charges for services rendered, whether or not eligible for health reimbursement benefits.


## Payment and Assignment of Benefits *(Continued)*

If you are a Medicare, Medicaid, or other government healthcare program participant, you assign, and request that payment of, all benefits be made on your behalf for healthcare services rendered, directly to us. You also authorize any holder of medical or other information about you to release to the Centers of Medicare and Medicaid Services or other applicable government program office and its agents, any information needed for payment of benefits.

_____ initial

## Medicare Release

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. You authorize payment or benefits to us on Patient's behalf.

_____ initial

## Medical Records Privacy and Consent to Release Information

CORE H.C. respects your privacy. We comply with the Health Insurance Portability and Accountability Act ("HIPAA"), and we may release your "protected health information," as defined by HIPAA, only as allowed by law, such as:

- For your treatment and care coordination;
- To obtain payment for your healthcare;
- To your family, friends, or others you identify who are involved with your healthcare or your healthcare bills, unless you object; or
- In response to a subpoena, court order, or otherwise in connection with a claim, lawsuit, or proceeding in which you are involved.

We do not sell any of your "protected health information" for marketing or any other purpose. Accordingly, you consent to us releasing your "protected health information" only as allowed by law. You also acknowledge receipt of CORE H.C.'s Notice of Privacy Practices.

_____ initial

Health Centers
CHIROPRACTIC | WELLNESS
*Jeremiah Holmes D.C.*

## General Conditions

You are responsible for your personal property while on our premises. The only time we are responsible for any personal property on our premises is when we accept it from you for safekeeping and acknowledge it in writing.

As the healthcare you are seeking is non-emergency care, you acknowledge that we have the right to decline treatment in our sole discretion.

We do not discriminate on the basis of any legally protected classification.

**No revisions or changes to this form, by you, will be accepted by CORE Health Centers.**

(Signature of Patient or Responsible Party; parent, guardian or other representative) (Date)

(Signature of Policyholder) (Relationship) (Date)

(Signature of Witness to signing of consent form) (Date)