CORE FLEX CHIROPRACTIC HEALTH HISTORY FORM

Please print and fill out this form as completely and accurately as possible.

PERSONAL INFORMATION

Today's Date_____

Name_____ Age _____ Date of Birth _____

Parent's names (if you are under 18) _____

Home Address_____ City _____ State_____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____E-mail address_____

Occupation_____Employer _____

Business Address_____ City_____State_____ Zip _____

SS# (opt'l)_____ Emergency contact _____

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner _____

Names and Ages of Children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Core Flex Chiropractic can address for you?

_____

Are these concerns affecting your quality of life? (Please check only those applicable to you)

Work:	❑	Driving:	❑	Sleep:	❑
School:	❑	Walking:	❑	Sitting:	❑
Exercise/sports	❑	Eating:	❑	Love life:	❑

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C._____

How long under care? ❑ _____days ❑_____weeks ❑_____ months ❑ years_____

Date of last visit: _____Why did you stop?_____

_____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician	❑ Naturopath	❑ Acupuncturist	❑ Homeopath
❑ Massage Therapist	❑ Psychotherapist	❑ Energy Healer	❑ Dentist

Reason why: _____

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM.
The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Chiropractors are specialists trained in "early detection" of injury to the
SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and* health *status.***

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any **accidents or injuries in your life** related to any of the following? (check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state ***type of injury and date:***

_____

_____

Have you ever **hurt/injured your** spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? ❑ Y ❑ N

If yes, state ***type of injury and date:***

_____

_____

Have you ever **hurt, broken, fractured or sprained** any bones or joints? ❑ Y ❑ N

If yes, list ***body parts injured and dates:***

_____

_____

Have you ever been hospitalized? ❑ Y ❑ N

If yes, ***state reason and dates:*** _____

_____

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy ❑ Other

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have intensely experienced any of the emotional stresses below:

Childhood Trauma	❑	Loss of loved one	❑	Abuse	❑
Work or School	❑	Divorce/separation	❑	Financial	❑
Lifestyle change	❑	Parents divorce	❑	Illness	❑

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Have you been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Cigarette smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have **allergies** to any foods? ❑ Y ❑ N **If yes, please list:** _____
_____

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____
_____
_____
_____

Note: It is imperative that you list all medications as they may have an influence on your care.

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

Do you **exercise** regularly? If yes, how often? _____

Do you take **supplements**? If yes, please list:_____

Do you follow a **special dietary regime**? If yes, what? _____
_____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

❒ Relief of a symptom or problem
❒ Relief and Prevention of a symptom or problem
❒ Healthier spine and nerve system
❒ Optimal health and function on all levels

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. (Please read booklet attached). The Chiropractic Exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

FINANCIAL INFORMATION

Payment in full is expected on **first visit** services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

First Visit Fees: Comprehensive Exam: $140
Subsequent office visits/adjustments: $75

INSURANCE

Insurance coverage varies greatly. Core Flex Chiropractic, Inc does submit your insurance claims. Core Flex Chiropractic is an out of network health care provider. We cannot predict whether your policy will cover the services we provide **in our office**. Please obtain an **Insurance Verification Form on your first visit**, and contact your insurance company to determine the amount and extent of coverage if you wish to claim. Until this form is complete and submitted by yourself, your account will be on an up front cash basis.

PLEASE READ AND SIGN BELOW

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Amy Denicke permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature_____ Today's Date_____

Signature of Parent (for minor):_____ Today's Date_____

Thank you for choosing Core Flex Chiropractic.
We look forward to helping you.

INFORMED CONSENT

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES
A chiropractic adjustment is the application of a quick precise movement to a specific segmental contact point on the musculoskeletal system. Adjustments are usually performed by hand but may be performed by hand-guided instruments.

You should understand that the chiropractic care, analysis, and screening procedures provided on any occasion are NOT a substitute for your personal medical doctor, a full physical examination and/or a pre-participation physical evaluation. You should understand that all health care procedures including the chiropractic adjustment have some risks associated with them, which may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, and in extremely rare instances, vertebral artery syndrome (stroke). Please ask any questions if you want further understanding of risks and benefits of chiropractic care.

AUTHORIZATION FOR CHIROPRACTIC CARE

I have read the above paragraphs. I understand the nature and purpose of the chiropractic care provided the possible consequences, and the risk that the care may not accomplish the desired objective. I acknowledge that no guarantees have been made to me concerning the results of the care and/or treatment. I authorize Dr. Amy Denicke of Core Flex Chiropractic to proceed with chiropractic care and/or treatment from this day and forward.

*Printed name of client:*_____

*Signature *:* _____ *Date:* _____
**Parent or legal guardian must sign if patient is under 18 years of age*