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New Practice Member Paperwork

This form is for adults only. Please ask the front desk for our pediatric forms.

Today's Date: ___/___/___ Male/Female

Name: _____ Date of Birth ___/___/___ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____

Email: _____

Would you like to receive text or email appointment reminders, newsletters, and office updates?

YES NO

Occupation: _____ Company Name: _____

Please Indicate If You or Your Spouse Are: **TEACHER/STUDENT** **FIRST RESPONDER**
MILITARY/VETERAN

Single / Married / Divorced / Widowed Spouse's Name: _____

Who may we thank for referring you? _____

Current Health Information

List your primary health concerns or health goals below:

*If you are primarily focused on health goals (i.e. better sleep, more energy, maintain wellness etc.) please use the bottom two lines

Health Concerns/Goals: (List according to severity)	Rate of Severity 1= Mild 10=Unbearable	When did the Symptoms Start?	Are the Symptoms Constant or Intermittent?
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____

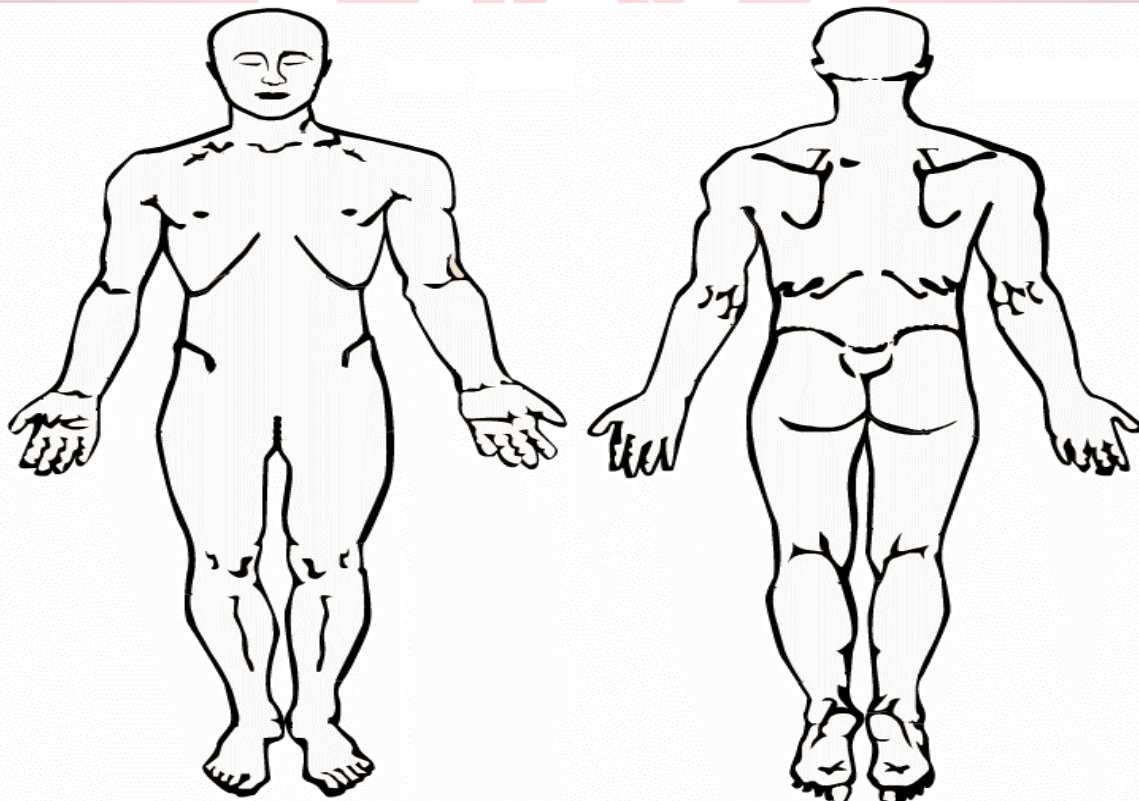
Please circle if you are currently experiencing:

ADD/ADHD	Chronic Sinusitis	Headaches	Liver Disease	Sciatica			
Anxiety	Depression	Heart Disorder	Low Back Pain	Shoulder Pain			
Asthma	Dizziness	Hip Pain	Menstrual Irregularities	Stomach Disorder			
Allergies	Ear Infection	Irritable Bowel	Mid Back Pain	Thyroid Problems			
Bladder Complications	Epilepsy	Infertility	Migraines	TMJ Disorder			
Chest Pain	Fibromyalgia	Kidney Stones	Nausea	Ulcers			
Chronic Fatigue	Gastric Reflux	Knee Pain L/R	Neck Pain	Vertigo			
Numbness in:	<u>Face</u>	<u>Arms</u>	<u>Hands</u>	<u>Fingers</u>	<u>Legs</u>	<u>Feet</u>	<u>Toes</u>

Any other health condition not listed above: _____

If your CURRENT condition was caused by an accident, please explain what happened:

Please Circle / Star / or Mark any and all areas of complaint:



Please list all medications or prescriptions you are currently taking:
(If you have a list please provide along with this paperwork)

Have you ever consulted with another Doctor for these conditions? YES / NO
Chiropractor? YES / NO Medical Doctor? YES / NO Other? _____

Who and When did you consult? _____

Please rate your health in following areas:

Rate the following by drawing an 'X' at the point that represents your current condition.

Physical Activity:	None	1	2	3	4	5	6	7	8	9	10	Very Active
Energy Levels:	No Energy	1	2	3	4	5	6	7	8	9	10	Energetic
Spiritual Interest:	No Interest	1	2	3	4	5	6	7	8	9	10	Very Interested
Flexibility:	Can't Move	1	2	3	4	5	6	7	8	9	10	Very Flexible
Emotional Stress:	No Stress	1	2	3	4	5	6	7	8	9	10	Much Stress

Past Health Information

Please circle any of the following health conditions that you have experienced:

- Stroke- When did it occur? _____
- Cancer: What type? When did it occur? _____
- Heart Disease/Issues: More specifically what type: _____
- Spinal Surgery - please indicate what type and where: _____
- Seizures – What kind and how often? _____
- Spinal Bone Fracture – please indicate when and which bone/s: _____

List all surgical operations:

Have you ever been knocked unconscious? YES / NO Fractured a bone? YES / NO

When was your last leisure, auto, home, or work accident?

_____/_____/_____/_____/_____

Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activities:	Effect:			
Lifting 10 – 20 LBS	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting 25 – 50 LBS	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Exercising	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the Doctor and the Patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each practice member understand both the objective and the method that will be used to ascertain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

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

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.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Cornerstone Family Chiropractic's objective is to eliminate interference within the Central Nervous Systems. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read & fully understand the above statements.
Print Name

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 _____
(Required)

Date: ____/____/____

Notice of Privacy Practices Acknowledgment

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my care and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and Physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out care, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature _____
(Required)

Date: ____/____/____

X-Ray Authorization

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF CORNERSTONE FAMILY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS & CONDITIONS

Print _____

Signature _____
(Required)

Date: ____/____/____

FEMALE PATIENTS ONLY:

TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT CORNERSTONE FAMILY CHIROPRACTIC.

Signature _____
(Required)

Date: ____/____/____

Informed Consent for Chiropractic Care

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE 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 THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/ STRAIN INJURIES, IRRITATION OF A DISC CONDITION, 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 INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, 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 HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN, PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND I GIVE CONSENT TO THE EXAMINATION/S AND ANY/ALL ADJUSTMENTS THAT THE DOCTOR DEEMS NECESSARY FOR CHIROPRACTIC CARE.

Print _____

Signature
(Required)

CORNERSTONE
FAMILY CHIROPRACTIC

Date: ____/____/____

Witness Signature (Office Staff)

Practice Member Insurance Information

(Must be Completed Before Services Can Be Rendered)

NAME: _____
FIRST MIDDLE LAST

PHONE: Home _____ Cell _____ Work _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured _____ Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured _____ Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- Consultation- includes practice member history. This service is complimentary
- Assessment (new or established practice member)- includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check \$50-\$250.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. \$35-\$65.
- X-rays- Specific x-ray views taken of your spine to help determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. \$50-\$300.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Cornerstone Family Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed _____ **Date** _____