CORE
Chiropractic Solutions
YOUR BODY IN BALANCE

Patient Intake Form

Today's Date: _______________

Welcome to Core Chiropractic Solutions. Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form completely and to the best of your knowledge. Be sure to sign the consent and authorization form on page 4 and 5.

Patient Information

Personal Information

First Name: ___________________________
Middle Name: ___________________________
Last Name: ___________________________
Gender: ☐ Female ☐ Male

Date of Birth: __________________ Age: _____
Social Security #: _____-_____-______
Height: _____ Feet _____ Inches
Weight: _____

Marital Status: ☐ Married ☐ Single

Occupation: ___________________________

Referred By: ___________________________

Emergency Contact

Contact Name: ___________________________
Relationship: ___________________________
Phone: ___________________________

Contact Information

Email: ___________________________
Home Phone: ___________________________
Cell Phone: ___________________________
Work Phone: ___________________________

Home Address

Address Line 1 ___________________________
Address Line 2 ___________________________
City: ___________________________
State: _____
Zip/Postal Code: ___________

If patient is a minor, Parent/Legal Guardian Contact Information

First Name: ______________________________
Last Name: ______________________________
Phone: ______________________________
Address: ______________________________
City, State ______________________ _____
Zip Code: ___________

Insurance Information

Who is the policy holder? ___________________________________
Relationship to Patient: ___________________________________
Insurance Company: ___________________________________
Group Number: ___________________________________
Primary Policy Holder Information
Date of Birth: __________________
Social Security #: _____-_____-______

Accident Information

Is condition due to an accident? ☐ Yes ☐ No
Date of accident: ______________
Type of accident: ☐ Work ☐ Auto ☐ Home ☐ Other ___________

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Workman's Comp ☐ Other ___________
Attorney's Name: ____

Current Symptoms

Patient Condition:

1. What is your **worst** complaint?____________________
   When and how did your condition begin?____________________

   Rate your pain/ discomfort on a scale (circle) **None = 0 1 2 3 4 5 6 7 8 9 10 = Severe**

   How often do you experience this complaint (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

   How are your symptoms changing? **Improving** **Not Changing** **Worsening**

2. What is your **2nd worst** complaint?____________________
   When and how did your condition begin?____________________

   Rate your pain/ discomfort on a scale (circle) **None = 0 1 2 3 4 5 6 7 8 9 10 = Severe**

   How often do you experience this complaint (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

   How are your symptoms changing? **Improving** **Not Changing** **Worsening**

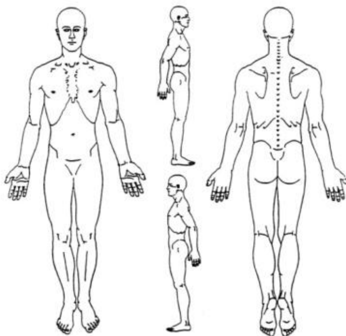
3. Briefly describe any other complaints:____________________
   ____

Type of Pain: Circle **Sharp** **Dull** **Weakness** **Numbness** **Aching** **Shooting** **Burning** **Stiffness** **Other**

Activities That Are Painful: **Sitting** **Standing** **Bending** **Walking** **Laying Down**

Does the Pain Interfere with… **Work** **School** **Daily Routine** **Recreation**

What Treatments Have You Already Received For This Condition? **Medication** **Surgery** **Chiropractic** **Physical Therapy** **Other**____________________



Please indicate on the diagram to the left where you are experecing your symptoms

How were you referred to our office? Flyer( ) Postcard( ) Walk By( ) Other( ) Doctor / Friend( ) Who? ___________
Have you ever had chiropractic care before? (YES / NO) If yes, when was your last treatment? ____________________
Have you ever had a professional massage before? (YES / NO) If yes, when was your last massage? ____________________
What are your health goals? (Check one of the following)
( ) Reduce symptoms only **( )** Reduce symptoms and show me how to prevent flair-ups **( )** Reduce symptoms, prevent flair-ups and maintenance care

Review of Systems

Health History

Date of Last:	Physical Exam	X-ray	MRI, CT or Bone Scan	Blood Test or Urine Test
	________________	________________	________________	________________

Name of your family physician __________________________Last appointment with your physician _________Phone # ____________________
Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? ____

Place a mark on "Yes" or "No" to indicate if you have had any of the following

AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Gout	☐ Yes ☐ No		☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
				Pacemaker			
Breat Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No		☐ Yes ☐ No	Other___________	☐ Yes ☐ No
				Prosthesis			
Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		☐ Yes ☐ No	___________	☐ Yes ☐ No

Past Medical History

Social History

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _______________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _______________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _______________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ____________________

Medications	Allergies	Vitamins/Herbs/Minerals
____________________________	___________________________	___________________________
____________________________	___________________________	___________________________
____________________________	___________________________	___________________________
____________________________	___________________________	___________________________
____________________________	___________________________	___________________________

Surgeries you have had

Car Accidents ____
Falls ____
Head Injuries ____
Broken Bones ____
Dislocations ____
Surgeries ____

Privacy Policy Notice

Consent for the use and/or disclosure of protected health information to carry out treatment, payment and/or health care operations.

Through this consent form, Core Chiropratic Solutions is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or health care operations.
2. We will only disclose protected health information with your expressed written authorization.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosure necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. This office reserves their right to change its privacy practices that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
5. You have the right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or health operations.
6. You have the right to inspect your records and amend or correct health information.
7. If this office agrees to a requested restriction it will take approximately 30 days to do so.
8. You have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.
9. Should you revoke this consent at any time, the office retains the right to refuse treatment based upon the revocation and the future lack of such consent.
10. You will sign and date all consents requested to which you agree.
11. I hereby authorize Core Chiropractic Solutions/ Dr. Alison Stamos to use and/or disclose health information for the purpose of filing your health insurance claims, consult with other health care providers, and for billling purposes.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____ Name of Individual (printed)

____ Signature of Individual

____ Signature of Legal Representative (Attorney-in-fact, Guardian, Parent of a minor, etc…)

____ Relationship

Date Signed ____/____/____

____ Witness – Core Chiropractic Solutions

This consent/authorization form will be valid for one year from date of signing.

Consent to Treatment

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare occasions case 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 disk condition and rarely fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke: rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of stroke. In essence, there may be a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with an upper cervical adjustment is extremely remote.

If deemed necessary the use of Rock Tape will be used, this may cause skin irritation or even a rash. If you have a skin condition, please notify the doctor.

I understand and agree that health/ accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Prior to receiving chiropractic care in this office, 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 before treatment. In addition, they will help us to determine if there is any reason to modify your care or provide you with a referral to another health care provider.

I understand and agree that all services rendered will be charged to me, and I am responsible for timely payment of such services.

I also understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including chiropractic adjustments and other modalities as reported following my assessment.

I certify that I am the patient or legal guardian listed below. I have read/ understand the included information and certify it to be true and accurate to the best of my knowledge.

____ ____
Patient Name (printed) Signature of Patient or Legal Guardian

____ ____
Patient's Legal Guardian (printed) Relationship

Date Signed ____/____/____

____
Witness – Core Chiropractic Solutions

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, 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.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules, different treatment techniques and patient management. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Please consult with our office manager before your treatment if you have any questions.

CURRENT CUSTOMARY FEE SCHEDULE OF OUR MOST COMMON FEES

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. If you have any questions about your EOB or bill please discuss them with our office manager. These fees may change without notice. We will provide a copy of this form if requested.

Service	Code	Description	Fee
Intial Exam *(New Patient)*	99201	Limited	$75.00
	99202	Expanded	$100.00
	99203	Detailed	$150.00
	99204	Comprehensive	$200.00
Re-Exam *(Established Patient) (Treated within 3 years)*	99211	Minimal	$30.00
	99212	Limited	$60.00
	99213	Expanded	$100.00
	99214	Detailed	$140.00

Service	Code	Fee	Notes
Range of Motion	95851	$55.00	
Chiropractic Adjustments	98940	$50.00	1-2 regions
	98941	$65.00	3-4 regions
	98942	$70.00	5 regions
	98943	$40.00	Extremities
Massage	97124	$35.00 / Unit	Ex. 30 min = $70.00
Muscle Testing	95831	$55.00	
Manual Therapies	97140	$45.00	
Therapeutic Exercises	97110	$45.00 / Unit	
Therapeutic Activities	97530	$50.00 / Unit	
Mechanical Traction	97012	$30.00	
Physical Performance Testing	97750	$60.00	
Electrical Muscle Stimulation	97014	$30.00	
Ultrasound	97035	$30.00	
Neuromuscular Ed	972112	$45.00	

X-Rays

Region	Code	Fee	Views
Cervical Spine	72040	$90.00	2-3 views
	72050	$125.00	4 views
	72052	$150.00	5 views
Thoracic Spine	72070	$90.00	2 views
	72072	$105.00	3 views
Lumbar Spine	72100	$100.00	2-3 views
	72110	$125.00	4 views

All X-rav fees are not listed such as extremities. Ask the front desk for these fees.

____________________ PRINT NAME

____________________ SIGNATURE

____________ DATE

Core Chiropractic Solutions— 510 Hacienda Dr. Ste. 107 Vista, CA 92081—Ph: 760.630.0683 Fax: 760.630.7715

Core Chiropractic Solutions

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:______________________________ **Date of Birth:__________________**

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **___Core Chiropractic Solutions.**

I understand that the Notice describes the uses and disclosures of my protected health information by **Core Chiropractic Solutions** and informs me of my rights with respect to my protected health information.

____ ____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

____ ____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):____

____

____ ____

Employee Name *Today's Date*

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