core
CHIROPRACTIC + WELLNESS

11525 Cantrell Rd. #301 • Little Rock, AR 72212
www.corelittlerock.com
(501) 246-4485

WELCOME TO CORE CHIROPRACTIC AND WELLNESS!

Today's Date: _____

Patient Information

Patient's Name:_____
Address _____
City _____ State _____Zip_____
Home Phone _____Cell _____
Sex: ❒M ❒F
Birthdate _____ Age _____
Social Security number: _____
Do you wish to receive e-mail reminders? ❒Yes ❒No E-mail: _____
Do you wish to receive text reminders? ❒Yes ❒No Carrier/Provider: _____
Emergency Contact:_____Phone #_____
Whom may we thank for referring you? _____
Dentist: _____
Number_____Last seen?_____
Eye Doctor: _____
Number_____Last seen?_____
Medical Doctor: _____
Number: _____Last seen?_____

Health Information

- Primary complaint_____
- When did your symptoms appear? _____
- Is the condition getting: ❒Better ❒Worse ❒Same
- Have you had this before? ❒Yes ❒No
- Rate the severity of your pain on a scale from 1 to 10 _____
  (1-3 mild pain, 4-6 moderate pain, 7-10 severe pain with 10 being the worst pain imaginable)
- Type of pain: ❒Sharp ❒Dull ❒Throbbing ❒Numbness ❒Aching ❒Shooting ❒Burning ❒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: ❒Sleep ❒Work ❒Daily Routine ❒Recreation
- Activities that are painful to perform: ❒Sitting ❒Standing ❒Walking ❒Bending ❒Lying down
- What care have you received for your condition? ❒Medications ❒Surgery ❒Chiropractic ❒Physical Therapy ❒Ice/Heat ❒Stretching/Exercises ❒Homeopathic ❒None ❒Other _____
- List other doctors who have treated you for this condition _____

Acknowledgement of HIPPA Privacy Act

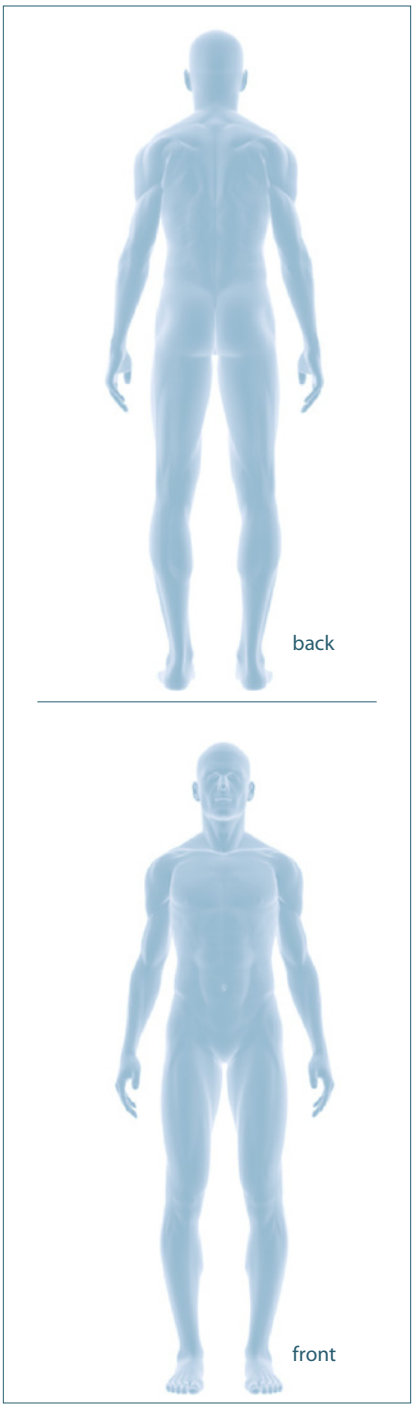
My signature acknowledges that I have read and understand the HIPPA Act.
Signature: _____ Date:_____
Patient Name Printed: _____
Guardian Name Printed:_____
Relation to patient:_____

Payment Information

How will your payment be made? ❒Cash ❒Check ❒Visa/MC/Discover/American Express
Do you plan to submit your receipts to your insurance? ❒Yes ❒No
Do you have Medicare? ❒Yes ❒No

Health Information (diagram)

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



I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that responsible for payment of any and all services covered or not covered. I also understand that if I suspended or terminate my care for any reason, any fee for professional services rendered me will be immediately due payable.

Patient or Guardian Signature__ _____Date_____

Note: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. Thank You!

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at Core Chiropractic and Wellness or any other office or clinic, whether signatories to this form or not.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, vascular injury, dislocations, burns, and sprains. I wish 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 my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited 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. I understand I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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

Name of Patient: _____ Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____Date: _____

Medicare Patients

I authorize Core Chiropractic and Wellness to release copies of any and all information contained in my file necessary to file Medicare claims to use for tax purposes.

Signature: _____Date: _____

Pregnancy Release

This is to certify to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform x-ray evaluation. I understand that x-ray can be hazardous to an unborn child.

Date of my last menstrual period: _____

Signature: _____Date: _____