True Core Chiropractic

Premier Sports & Family Chiropractor

Welcome To Our Office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask our qualified Chiropractic Assistant.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic Care.

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Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell:_____

Cell Phone Provider/Carrier:_____

E-mail:_____

Birthdate:_____Age:_____

Gender: Male Female Number of Children _____

Employer:_____

Work Address:_____

City:_____State:_____Zip:_____

Work Phone Number:_____Ext:_____

Occupation:_____

Status: Married____Single____Divorced____

Separated____Widowed_____

Social Security Number:_____

Spouse/Parent Information

Name:_____

Employer:_____

Work Phone:_____Occupation:_____

Who can we thank for referring you?

Name:_____

Have you ever been adjusted by a chiropractor before?

Yes ____ No_____

Reason for those visits?_____

Name of Chiropractor:_____

Approximate date of last visit:_____

Reason for discontinuing care:_____

Reason for today's visit:_____

_____

Is the current injury/pain related to:

Work___Sports____Car Accident____ Fall/Trauma___

Home injury_____Chronic Discomfort_____Other_____Please explain: _____

_____

If work related, have you reported the accident to your employer?

Yes____ No____

When did the symptoms begin?_____

Has this condition: Become worse_____Come and go_____

Remain Constant_____

Does this condition interfere with:

Work Sleep Daily routine Child rearing Other

Explain:_____

Has this happened before: Yes No___

Explain:_____

Have you been seen by a doctor for this problem? Yes____No____

When and Where?_____

Treatment and Result:_____

_____

Current Medications

Nerve Pills ____ Stimulants____Pain Killers____Aspirin_____

Blood Thinners____Muscle Relaxers_Tranquilizers_____

Bloop Pressure Meds____Insulin____Other_____

Health Habits

Do You:

Smoke? Yes____No____Packs per day_____

Drink alcohol? Yes____No____Drinks Per day____

Drink Coffee? Yes____No____Cups Per day ____

Exercise? No____Moderate____Daily____

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Surgeries and X-Rays

List all past surgeries, serious illnesses, and accidents:
Month/Year: City/State:

_____

_____

_____

_____

Recent X-Rays, lab tests/results:
Date: Facility/Doctor's Name:

_____

_____

_____

_____

For women:

Are you pregnant? Yes No

Are you nursing? Yes No

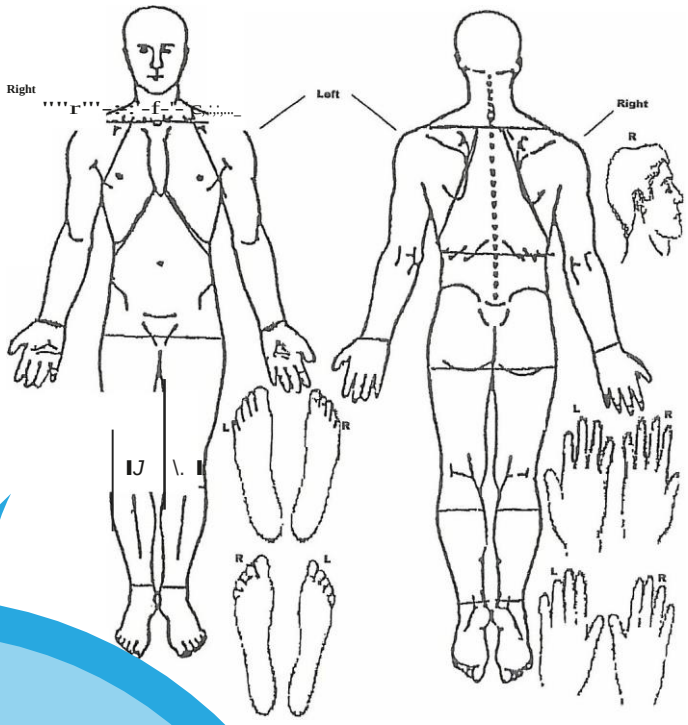
Are you on birth control? Yes No

Painful/irregular periods? Yes No

Do you have breast implants? Yes___ No

Mark it up

Place and X on the picture where you are experiencing pain , numbness, or tingling.



Health Conditions

While the following may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis, care plan, and the possibility of being acceptable for care.

Please check any of the diseases or conditions that you have had in the past:

Severe/frequent headaches_____Sinus problems____ Dizziness___

Loss of sleep____ Pain between shoulders_____Ulcer/colitis___ Asthma___

Frequent neck pain___ Numbness/pain in arms, legs, or hands___ Arthritis__

Lower back problems___ Digestive problems_____Heart murmur___

Heart attack/stroke___ Congenital heart defect___ Difficulty breathing___

Heart surgery/pacemaker___ Hight/low blood pressure___ Rheumatic fever___

Venereal disease___ HIV/AIDS___ Diabetes___ Hepatitis___ Tuberculosis___

Shingles__ Kidney problems___ Cancer___ Chemotherapy___ Anemia_

Alcohol/drug abuse___ Psychiatric problems___ Thyroid problems___

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Emergency Contact Information

Name:_____

Relationship to patient:_____

Cell phone number:_____

Work phone number:_____

Awareness of Chiropractic Principle

Please circle either Yes or No regarding the following questions:

Were you aware that:

...Doctor's of Chiropractic work with the nervous system? Yes/No

...The nervous system controls all the bodily functions and System? Yes/No

...Chiropractic is the largest natural profession in the world? Yes/No

...when chiropractic care starts at birth, a person can achieve a higher level of health throughout their life? Yes/No

Goals for My Care

People seek chiropractic care for a variety of reasons. Some go for pain relief, to correct the cause of their pain, or for correction of what is malfunctioning in their bodies Your doctor will consider your needs and desires when recommending a treatment program.

Please mark the type of care you are seeking below:

_____Relief Care: Relief of Pain and discomfort symptoms

_____Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.

_____Comprehensive Care: Bring what is malfunctioning in the body to the highest state of health possible with chiropractic care.

_____I want the doctor to select the appropriate care for my condition.

411 Camino Del Rio South • Ste #106 • San Diego, CA 92108

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Authorization for Care

I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate I I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment and all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or for any medical diagnosis. I also understand that if I choose to suspend or terminate my care, any fees for professional services rendered to me will be due immediately. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient Signature Date Parent/Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account?

Patient _____ Medicare_____ Auto Insurance _____ Parent_____

Spouse_____ Medicaid_____ Workers comp_____ Personal Health Insurance_____

Ownership of X-Rays

I understand and agree that payment made to this office for x-rays is for the examination of the x-rays only. The x-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Insurance Information

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

Insurance Company:_____ Policy Number:_____Group Number:_____

Address:_____Phone Number:_____Plan(circle one): PPO EPO Other_____

Insured's Name:_____DOB:_____Social Security Number:_____Employer:_____

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Massage Cancellation Policy

24 hour advance notice is required when canceling an appointment. This allows the opportunity for another patient to be scheduled in that appointment slot.

If you fail to cancel 24 hours before your scheduled massage appointment, there will be a $35.00 fee for the missed appointment. Which must be paid prior to your next scheduled appointment. Additionally, there is a $20.00 fee for insufficient funds.

Arriving Late:

Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate the patient scheduled following your massage. Out of consideration for your massage therapist and other patients, please plan accordingly and be on time. If you have a gift certificate or an Internet discount voucher such as Groupon, Living Social, Daily Deals, etc. you may forfeit your massage in place of paying the above mentioned cancellation fee.

_____
Initials

Thank You,
True Core Chiropractic

***I hereby Authorize True Core Chiropractic to automatically charge my card ending in __ __ __ __ when 24 hours notice is not given. _____
Initials

Patient Signature: _____ Date:_____

Print Name:_____

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