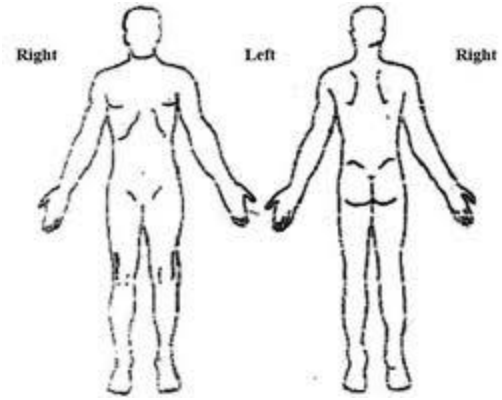
INNER STRENGTH CHIROPRACTIC – LAUREN HEDRIX, D.C.
PHONE 623-882-3598 FAX 623-792-8435
WWW.INNERSTRENGTHCHIRO.COM

Name: _____Date: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____
Email Address: _____ Social Security #: _____
Age: ____ Birth Date: _____ Gender: __M __F
Marital Status: __S __M __W__D Number of children:__
Spouse's Name: _____ Spouse's Occupation: _____
Your Occupation: _____
Employer of Insurance Holder: _____
Employer's Address: ____City: _____ State: _____
Zip: _____
Reason for today's visit: __Emergency __New Injury __Old Injury __Chronic Pain __Wellness
Did your injury occur during: __Auto Accident, __Sports/Play, __Routine/Household Activity
If your injury is auto related please let us know if you have not done so already.
Please mark on the chart and then describe your complaint areas:



When did your symptoms start? _____

Rate your pain on a scale from 1 to 10: _____

Circle words that describe your pain: Sharp, Dull, Achy, Throbbing, Numb, Shooting, Burning, Tingling, Stiff, Swelling, Other

How often do you have this pain?
_____

What activities or movements are you unable to perform because of this pain?
_____
_____
_____

Reason(s) for Visit:
_____
_____

Any Other Complaints or Concerns please list here:

_____

Are you taking any prescription medications? __Yes, __No If yes, what: _____
Are you taking any non-prescription drugs? __Yes, __No If yes, what: _____
Do you take dietary supplements or vitamins? __Yes, __No If yes, what kind: _____
Do you exercise? __Yes, __No If yes, # of hours per week: _____
Do you smoke? __Yes, __No If yes, how much: _____ For how long: _____
Are you taking birth control? __Yes, __No Are you pregnant? __Yes, __No

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Name: _____ Date: _____

Please provide your Primary Care Physician's information:

Name: _____

Office Address: _____

Date of Last Visit: _____Purpose of Last Visit: _____

Have you seen other doctor's for the condition(s) that you wish to be treated for in our office?

If yes please fill in information below:

Doctor 1: _____ Diagnosis: _____ X-rays: _____

Treatment: __Medication, __Physiotherapy, __Other: _____

Results: _____ Length of time under care: _____

Doctor 2: _____ Diagnosis: _____ X-rays: _____

Treatment: __Medication, __Physiotherapy, __Other: _____

Results: _____ Length of time under care: _____

Are you <u>currently</u> or in the past <u>6 months</u>, have you had any of the following diseases, medical conditions or procedures?

Y N Light Sensitivity Y N Migraines/Headaches Y N Epilepsy Y N Depression Y N Low Back Pain
Y N Ringing in Ears Y N Dizziness/Fainting Y N Thyroid Issues Y N Neck Pain Y N Asthma
Y N Arm Numbness Y N Psychiatric Problems Y N Sinus Problems Y N Fatigue Y N Allergies
Y N Gallbladder Issues Y N Heartburn/Gastric Reflux Y N Pneumonia Y N Anemia Y N Ulcers
Y N Mid-Back Pain Y N High or Low Blood Pressure Y N Alcohol/Drug Use Y N Leg Numbness
Y N Urinary or Kidney Issues Y N Irregular Periods Y N HIV/AIDS Y N Stomach Issues

Have you had any of the following diseases, medical conditions or procedures?

Y N Arteriosclerosis Y N M.S. Y N Osteopenia/Osteoporosis Y N Tuberculosis Y N Hepatitis
Y N Cancer Y N Heart Problem Y N Heart Attack/Stroke Y N Diabetes Y N Arthritis
Y N Artificial Joints Y N Artificial Implants Y N Disc Herniation Y N Pinched Nerve

Personal History Notes:

_____

_____

List surgical operations and dates:

_____

_____

List any past serious accidents with dates:

_____

Family Health History (Grand Parents/Parents/Brothers/Sisters) Please list arthritis, blood disorders, cancer, diabetes, epilepsy, heart problems, neurological disorders, or other major illnesses:

_____

_____

_____

Immediate Family Deaths:

_____

Who may we thank for referring you to us or how did you hear about us: _____

All of the above is accurate to the best of my knowledge:

Signature_____ Date: _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation.

Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included. All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name: _____ Signature:_____ Date:_____

Consent to evaluate and adjust a minor child: I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.
Signature: _____ Date:_____

I understand that if I do not appear for a scheduled appointment, or I cancel with less than 24 hour notice, Inner Strength Chiropractic may charge me a $25 cancellation fee**.**

Notice Of Privacy – HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU HAVE ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY. As your health care provider, we are required, by law, to maintain the privacy and confidentiality of your protected health information and provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure Of Your Health Care Purposes: We may disclose your health care information to staff and other healthcare professionals within our practice for the purpose of consultation, treatment, payment, or healthcare operations. Additionally, we disclose your health information to your insurance provider(s), billing and insurance personnel, or medical billing clearinghouse or collection agencies for the purpose of payment for your health care services.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or on the event of an emergency.

Other: As required by law, we may disclose your health information to the following persons or entities: -Public Health Authorities, -Law Enforcements Officials, -Medical Examiners or Coroners, -Specialized Government Agencies

Communications We may contact you for additional communications, or other purpose, as described below: *It is our policy to call your home regarding your scheduled appointment to remind you of your appointment time or reschedule appointments as needed. A reminder message is left with a person or answering machine if you are not at home. Birthday cards and/or seasonal greeting cards may be sent to your home periodically throughout the year, which may offer you a discounted or free service, a gift, or medical reminders. If this is not desired, please tell the receptionist so alternative methods might be utilized to protect your privacy.*

Change of Ownership: In the event that this practice is sold of merged with another organization, your health record will become the property of the new owner.

Your health Information Rights: You have the right to request restrictions on certain uses and disclosers of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested. -You have the right to inspect and copy your health information. -You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If you requested to amend your health information has been denied, you will be provided with a explanation of our denial reason(s) and information about how you can disagree with the denial. -You have a right to receive an accounting of disclosures of your protected health information made by our office. -You have a right to paper copy of this Notice of Privacy Practices at any time upon request.

Changes to This Notice of Privacy Practices: We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. We are required by law to maintain the privacy of your health information and provide you with notice of our legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about our privacy rights, please contact our office manager.

Complaints about our Privacy Rights or how our office handles the use or disclosure of your health information should be directed to our office manager. If you are not satisfied with the manager in which this office handles your complaint, you may submit a formal complaint to: DDHS, Office of Civil Rights, 200 Independence Ave., S.W., Room 509F HHH Building, Washington, DC 20201

I have read the privacy notice and understand my rights contained in the notice.

Printed Name of Patient: _____ Date: _____

Signature of Patient: _____