INNER STRENGTH CHIROPRACTIC – LAUREN HEDRIX, D.C.
Phone 623-882-3598 Fax 623-792-8435
www.innerstrengthchiro.com

Patient Name: _____ Date: _____

Address_____ City_____ State _____Zip Code _____

H. Phone _____ Cell Phone _____

Sex M F Marital Status _____ Date of Birth_____ Age_____

Social Security #_____ Email Address: _____

Primary Care Physician Name and Number_____

____ ____ May we contact your primary care physician to coordinate your care?
Yes No

Occupation_____ Job Duties _____

Employer of Insurance Holder (Company and Address) _____

Have you ever received Chiropractic Care? Yes No If yes, when?

_____

Name of most recent Chiropractor: _____

How did you hear about us? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____
_____
_____

Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: yes/no
   a. What body parts: _____
B. Visual Disturbance: yes/no □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
   % of time: ___ % of time: ___ % of time: ___ % of time: ___
C. Dizziness: yes/no % of time: ____
D. Anxiety: yes/no % of time: ____
E. Depression: yes/no % of time: ____
F. Difficulty Sleeping: yes/no

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____
_____

Please indicate if you have a history of any of the following:

□ Cancer □ Diabetes □ Osteopenia/Osteoporosis □ Arthritis □ Stroke/TIA's
□ Other Major Medical Conditions_____ □ None of the above

List Previous Injury or Trauma: _____

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Patient Name: _____ Date: _____

Have you ever broken any bones? Which? _____

List Any Allergies: _____

Please list any current medications:

Medication Reason for taking

_____
_____
_____

Please list any past surgeries:

Date Type of Surgery

_____
_____
_____

Females/ Pregnancies and outcomes: **Are you currently pregnant? __Yes, __No**

Pregnancies/Date of Delivery/Outcome

_____
_____

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family and age at death: _____

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: _____

Please tell me about your lifestyle (hobbies, alcohol, tobacco and drug use, diet):_____

_____

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Review of Systems and Past Health History

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Lung problems/shortness of breath □ None of the above □ Other

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□ Hypertension □ Angina/chest pain □ Irregular heartbeat □ High blood pressure □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory medication use □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hyper coagulation/DVT □ Anticoagulant therapy □ Other □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important for us to know?

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Lauren Hedrix, DC Inner Strength Chiropractic for services performed.

Patient or Guardian Signature _____ Date_____

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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 segmental dysfunction or vertebral subluxation. This occurs when one or joints in the body 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 and extremities. 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**.**

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Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to another provider that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for care may require that your relevant protected health information be disclosed to the health plan to obtain approval for your treatment or payment for your care. Your information may also be disclosed to your attorney or third party insurance carrier for processing for claims and reimbursement.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new employees, licensing, marketing, and appointment reminders. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your chiropractor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, legal proceedings, law enforcement, etc.
OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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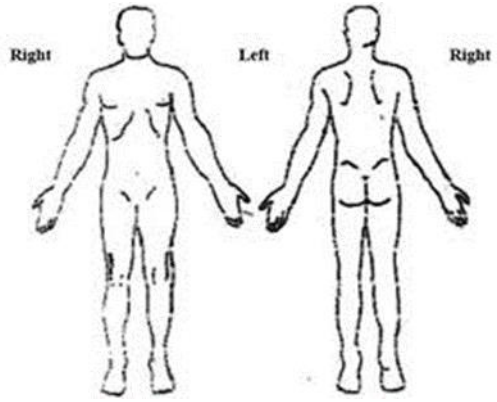
Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Please mark on the chart and then describe your complaint areas:



Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom on average and at the worst: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience pain:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
  - **Did you have this symptom before this motor vehicle collision?** Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply)
  - bending neck forward or backward, tilting side to side, bending at the waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing.
- Other please describe: _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom on average and at the worst: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above pain:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
  - **Did you have this symptom before this motor vehicle collision?** Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply)
  - bending neck forward or backward, tilting side to side, bending at the waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing.
- Other please describe: _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom on average and at the worst: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above pain:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
  - **Did you have this symptom before this motor vehicle collision?** Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply)
  - bending neck forward or backward, tilting side to side, bending at the waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing.
- Other please describe: _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ ___ a.m. ___ p.m.
Were you the: ___Driver ___ Front Passenger ___Rear passenger
Make and model of the vehicle you were occupying?
_____
If a traffic violation was issued, to whom was it issued? _____
Number of people in accident vehicle? _____
Did the police come to the accident site? __ Yes __ No
Was a police report filed? __ Yes __ No
Were there any witnesses? __ Yes __ No

Were you wearing a seat belt? __Yes __No
Was this vehicle equipped with airbags? __Yes __No
If yes, did it/ they inflate? __Yes __No
In relation to the base of your skull, where was the headrest? ___Above ___Below ___At base of skull
What did your vehicle impact? ___Another vehicle ___Other
If other, explain: _____
Did any part of your body strike anything in the vehicle? ___Yes ___No
If yes, please describe:
_____
Make and model of the other vehicle(s) involved?
_____
Name of the location/ street on which you were traveling?
_____
In which direction were you headed? ___N ___S ___E ___W
What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the : ___Front ___Rear ___Right Side ___Left Side

Other During impact, were you facing: __Right __Left __Forward

Were you _____aware or _____surprised by the impact?

If accident vehicle made impact with another vehicle…
Direction other vehicle was headed? ___N ___S ___E ___W
Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

_____

_____

Patient Name: _____ Date: _____

After Injury

Did accident render you unconscious? ___Yes ___No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ___Yes ___No

When did you go? ___Just after accident ___The next day ___2 days plus

Name of hospital and/ or attending doctor:

_____

Was he/she a: __D.C. __M.D __D.O __D.D.S

Describe any treatment you received: _____

Were X-Rays taken? ___Yes ___No

Was medication prescribed? ___Yes ___No
Have you been able to work since this injury? ___Yes ___No
Are your work activities restricted as a result of this injury? ___Yes ___No
Indicate the symptoms that are a result of this accident:

__Dizziness	__Difficulty Sleeping	__Jaw problems	__Nausea
__Memory loss	__Irritability	__Arms/ shoulder pain	__Back pain
__Headache(s)	__Fatigue	__Numb hands/ fingers	__Lower back pain
__Blurred vision	__Tension	__Chest pain	__Back stiffness
__Buzzing in ear	__Neck pain	__Shortness of breath	__Leg pain
__Ears ringing	__Neck stiff	__Stomach upset	__Numb feet/ toes

Other

_____
_____
_____

Is your condition getting worse? __Yes __No __Constant __Comes and goes

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

___Adult patient ___Parent or Guardian ___Spouse

Patient Name: _____ Date: _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back……	____	____	____
Lying on side……	____	____	____
Lying on stomach…….	____	____	____
Sitting…….	____	____	____
Standing……..……	____	____	____
Stretching……	____	____	____
Lovemaking……..	____	____	____
Walking……	____	____	____
Running……	____	____	____
Sports……..	____	____	____
Working……	____	____	____
Lifting……	____	____	____
Bending……...	____	____	____
Kneeling……...	____	____	____
Pulling……..	____	____	____
Reaching…….	____	____	____

Have you retained an attorney: ___Yes ___No
If yes, whom? _____
His/ Her phone #:_____

Recovery
How many hours are in your normal workday? _____
Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

What positions can you work in with minimum physical effort and for how long?

_____