

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 _____ ok to leave message ____yes

Sex M F Marital Status _____ Date of Birth _____ Age _____

Social Security # _____ Email Address: _____

Have you ever received Chiropractic Care in the past? If yes, when and by whom? _____

How did you hear about us? _____

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) _____

Reasons for seeking chiropractic care today: __New Injury __Old Injury __Chronic Pain __Wellness __Other: Explain: _____

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: _____

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: _____

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

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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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 or Representative

Date

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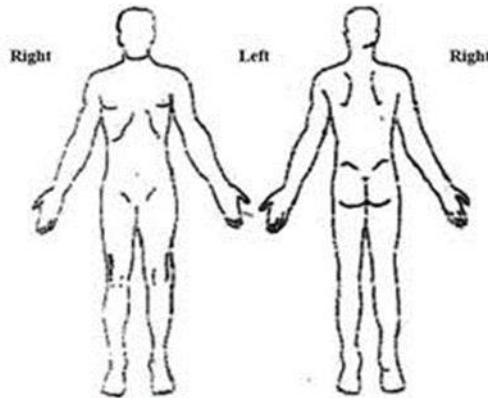
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NEW PATIENT HISTORY FORM

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 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? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- 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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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? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- 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? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- 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