

# INWOOD CHIROPRACTIC CENTER

7979 Inwood Road, Suite 123, Dallas, Texas 75209  
Telephone (214) 902-0092. Fax (214) 902-4848. www.BackPro.net

## PATIENT INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Email: \_\_\_\_\_

Best Time and Place to Reach You: \_\_\_\_\_

Sex:  M  F  OTHER

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

SINGLE  MARRIED  WIDOWED  SEPERATED  DIVORCED

## WHAT SERVICES ARE YOU INTERESTED IN?

- Chiropractic
- Prenatal Chiropractic
- Pediatric Chiropractic
- Massage Therapy
- Cupping
- Acupuncture/Dry Needling
- Cold Laser Therapy
- Nutritional Consulting
- Spinal Decompression
- Essential Oil Counseling

WHOM MAY WE THANK FOR REFERRING YOU?

\_\_\_\_\_

## ACCIDENT INFORMATION

Is this condition due to an accident?  YES  NO

Date of accident: \_\_\_\_\_

Type of accident:  Auto  Work  Home  Other

Adjuster Name: \_\_\_\_\_

Adjuster Phone: \_\_\_\_\_

Company Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

## PATIENT CONDITION

Reason for visit: \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  YES  NO  UNKNOWN

What have you tried to make it better? (ice, heat, meds, etc.) \_\_\_\_\_

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): \_\_\_\_\_

Type of pain:  SHARP  DULL  THROBBING  NUMBNESS  ACHING  
 SHOOTING  BURNING  TINGLING CRAMPS  STIFFNESS  SWELLING  
 OTHER: \_\_\_\_\_

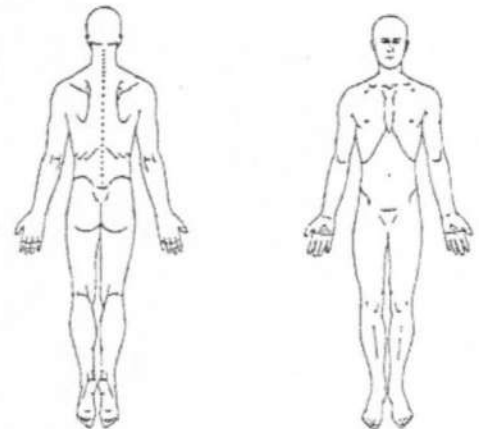
How often do you have this pain? \_\_\_\_\_

Is it constant or does it come & go? \_\_\_\_\_

Does it interfere with your:  WORK  SLEEP  DAILY ROUTINE  RECREATION

Activities or movements that are painful to perform: \_\_\_\_\_

SITTING  STANDING  WALKING  BENDING  LYING DOWN



PLEASE TURN OVER

# HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy Chiropractic  
None Other: \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_

Date of Last: Physical Exam: \_\_\_\_\_ Spinal Exam: \_\_\_\_\_ Blood Test: \_\_\_\_\_ Urine

Test: \_\_\_\_\_

Spinal X-Ray: \_\_\_\_\_ Chest X-Ray: \_\_\_\_\_ Dental X-Ray: \_\_\_\_\_ MRI/CT/Bone

Scan: \_\_\_\_\_

Mark "Yes" or "No" to indicated if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Alcoholism	<input type="checkbox"/> YES <input type="checkbox"/> NO	Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Migraine Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergy Shots	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Miscarriage	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatoid Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Food Intolerances	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mononucleosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Appendicitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Multiple Sclerosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Goiter	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gout	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Parkinson's Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tonsillitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breast Lump	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herniated Disk	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pinched Nerve	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tumors/Growths	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemical Dependency	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO	Polio	<input type="checkbox"/> YES <input type="checkbox"/> NO	Typhoid Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chicken Pox	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Prostate Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcer	<input type="checkbox"/> YES <input type="checkbox"/> NO

**ARE YOU PREGNANT?** Yes No Due Date: \_\_\_\_\_ LMP: \_\_\_\_\_

<b>Exercise</b>	<b>Work Activity</b>	<b>Habits</b>	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day: _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week: _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day: _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason: _____

**Please List All Past Injuries and Surgeries**

DESCRIPTION

DATE

Falls \_\_\_\_\_

Head Injuries \_\_\_\_\_

Broken Bones \_\_\_\_\_

Dislocations \_\_\_\_\_

Surgeries \_\_\_\_\_

Other \_\_\_\_\_

**MEDICATIONS**

**ALLERGIES**

**VITAMINS/HERBS/MINERALS**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**CREDIT CARD AUTHORIZATION (OPTIONAL)**

For my convenience, I hereby authorize Inwood Chiropractic Center to charge this card for any services or fees rendered or obtained, unless otherwise stated at time of service.

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Signature: \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:**

Name : \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**Cancellation Policy:**

Inwood Chiropractic Center kindly asks that you give us **24 hours' notice** if you need to cancel or change your scheduled appointment time. This 24-hour notice allows us to offer that time to another patient. If we do not receive sufficient notice or you do not show for that appointment, you will be charged a cancellation fee. **We may provide a courtesy reminder text/email 2 days prior to your appointment, but it is the responsibility of the patient to give sufficient notice.** It is our desire to provide you with the highest quality of care and attention that we are able to offer.

We appreciate your understanding in this matter.

I understand that I am asked to provide 24 hours' notice if I need to cancel or reschedule my appointment, and that I will be charged \$20 for office visits and \$35 for massage appointments if I do not give such notice.

\_\_\_\_\_  
Printed Name of Patient

I understand that if I have repeated cancellation occurrences of 5 or more appointments (within the 24 hrs.) I will be charged the FULL price of my scheduled service.

\_\_\_\_\_  
Signature of Patient

We understand that unexpected situations may occur, therefore the 1st occurrence will be waived.

\_\_\_\_\_  
Date

**Again, we make every effort to give a courtesy email or text reminder. However, each patient is still responsible for any and all appointments made.**

Preferred reminder: Cell \_\_\_\_\_ Mobile provider (Sprint, AT&T, T-Mobile, Verizon, etc.)

Email \_\_\_\_\_

**INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, and physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Name and Address of Office or Clinic**

Inwood Chiropractic Center  
7979 Inwood Rd, Ste 123  
Dallas, TX 75209

**Name(s) of Doctor(s) Treating this Patient**

Tim Nawrocki, DC  
Caley Cummins-Nawrocki, DC  
Brent Smarinsky, DC  
Annah Graves-Lanham, DC

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_ [Name of Individual], consent to Inwood Chiropractic Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relation to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operation of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or the Practice has acted in reliance on this consent.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT'S REPRESENTATIVE  
(IF MINOR OR PHYSICALLY INCAPACITATED)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS TO PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TRANSLATED BY

\_\_\_\_\_  
DATE

**CONFIDENTIAL COMMUNICATION REQUEST  
(HIPAA form)**

From time to time in caring for our patients, it may become necessary to contact you by telephone or email. Often our patients are not available when we call them and we would like to be able to leave detailed messages (i.e. X-ray results). In order to protect your privacy, we need your written permission to leave detailed messages for you.

However, it should be noted that our current notice of privacy does allow us to text or email you with a courtesy reminder regarding any upcoming appointment(s).

**Please read the following choices and tell us whether or not we can leave messages regarding your medical information, such as X-ray results, and with whom we may leave it.**

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Choose one of the following:

**I DO CONSENT** for your staff to leave detailed messages as follows:

I, \_\_\_\_\_, give **INWOOD CHIROPRACTIC CENTER** and their staff my permission to leave telephone messages regarding my medical care with the following options: **(Initial each one that we are able to use).**

- My home phone answering machine Initials \_\_\_\_\_
- My cell or mobile voice mail Initials \_\_\_\_\_
- My email Initials \_\_\_\_\_
- My spouse (name) \_\_\_\_\_ Initials \_\_\_\_\_
- Other (name) \_\_\_\_\_ Initials \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**I DO NOT CONSENT** for your staff to leave detailed messages. Instead, please leave your name and call back number.

I, \_\_\_\_\_, wish to be contacted personally and I **DO NOT AUTHORIZE** detailed messages regarding my medical care be left on an answering machine, voice mail or with others.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Inwood Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

**FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT**

The Practice has made a good-faith effort to obtain an acknowledgement of \_\_\_\_\_'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons: (check all that apply)

- Patient unavailable
- Patient physically unable
- Patient unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner: (check all that apply)

- Personally       Mail       Phone Follow-up
- Other: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Physician

Inwood Chiropractic Center

\_\_\_\_\_  
Name of Practice