INWOOD CHIROPRACTIC
AND WELLNESS 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: _____

Adjsuter Phone: _____

Company Name: _____

Claim Number: _____

PATIENT CONDITION

Reason for visit:_____

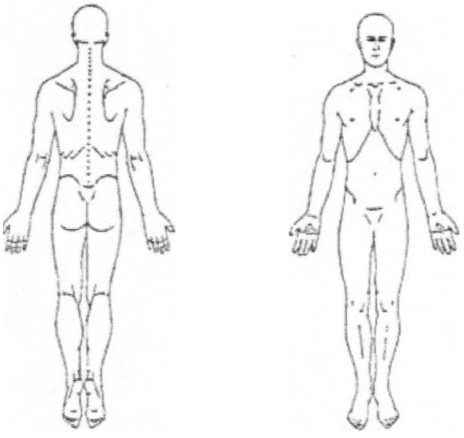
When did your symptoms appear? _____

Is this condition getting progressively worse? □ YES □ NO □ UNKNOWN

What have you tried to make it better? Other:_____

□ Ice □ Massage □ Stretching □ Heat □ PT □ Injections □ Nothing
□ Meds:_____

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

ARE YOU PREGNANT? ☐Yes ☐No Due Date: LMP:

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine Drinks
- ☐ High Stress Level

Packs/Day:_____
Drinks/Week:_____
Cups/Day:_____
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_____

INWOOD CHIROPRACTIC
AND WELLNESS CENTER

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, ifthe 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

INWOOD CHIROPRACTIC
AND WELLNESS CENTER

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.

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 _____

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 _____

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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

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