Valley Chiropractic & Wellness
Dr. Adam R. Idsinga, D.C.
663 N. Main St.
Spanish Fork, UT 84660
(801)894-9633

Date: _____

Name: _____ Sex: (F) (M) SS#: _____
DOB: _____ Age: _____ Phone #: _____
Address: _____
Street Apt # City State Zip
Profession: _____ Employer: _____
Marital Status: (S) (M) (W) (D) Spouses Name: _____ SS#: _____
Spouses Employer: _____ DOB: _____
Referred By: _____ Previous Chiropractic Care: (Y) (N)
What brought you in? ( ) Vehicle Crash ( ) Work Injury ( ) Sports Injury ( ) Other

Area of Complaint: _____
Symptoms Are: ( ) Improving ( ) Returned ( ) Worsening ( ) New Injury

Symptoms Described As: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness/Tingling
( ) Aches/Soreness ( ) Shooting ( ) Burning ( ) Cramping ( ) Stiffness

Activities Affected: ( ) Household ( ) Personal Care ( ) Lifting ( ) Work
( )Sleep ( )Walking ( ) Standing ( ) Sitting ( ) Laying ( ) Driving ( ) Concentrating
( ) Social Life ( ) School ( ) Exercise ( ) Recreation ( ) All

Rate your pain 1-10? /10 When did the pain begin? _____
List Treatment you've received for this condition: _____
Previous Accidents/Injuries: _____
Previous Surgeries/Hospitalizations: _____
Medications: _____
Supplements: _____
Women ONLY: Could you be pregnant? ( ) Yes ( ) No LMP _____

Check all that apply:

Past	Present		Past	Present		Past	Present	
___	___	HIV/AIDS	___	___	Diabetes	___	___	Stroke
___	___	Birth Control	___	___	Steroid use	___	___	Hypertension
___	___	Dizziness	___	___	Urinary issues	___	___	Cancer/Tumor
___	___	Aneurysm	___	___	Weight Changes	___	___	Seizures
___	___	Visual Changes	___	___	Head Aches	___	___	Neck Pain
___	___	Upper Back Pain	___	___	Mid Back Pain	___	___	Low Back Pain
___	___	Shoulder Pain	___	___	Elbow Pain	___	___	Hand Pain
___	___	Hip Pain	___	___	Knee Pain	___	___	Foot Pain
___	___	Arthritis	___	___	Osteoporosis	___	___	Trauma
___	___	Alcohol Use	___	___	Tobacco Use	___	___	Drug Use

Family History: ( ) Cancer ( ) Diabetes ( ) Hypertension ( ) Heart Disease ( ) Stroke

Additional Notes/Information: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- • ☐Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- • ☐The practice reserves the right to change the privacy policy as allowed by law.
- • ☐The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- • ☐The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- • ☐The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ( ) YES ( ) NO
May we leave a message on your answering machine at home or on your cell phone? ( ) YES ( ) NO
May we discuss your medical condition with any member of your family? ( ) YES ( ) NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINT NAME)

Signature: _____ Date: _____
Witness: _____ Date: _____

PATIENT NAME _____

DATE _____ Doctor _____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

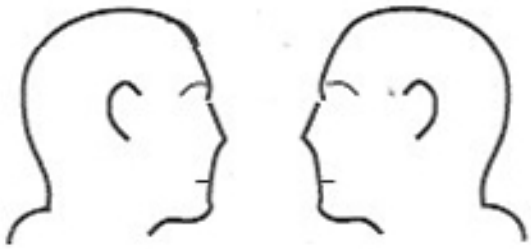
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

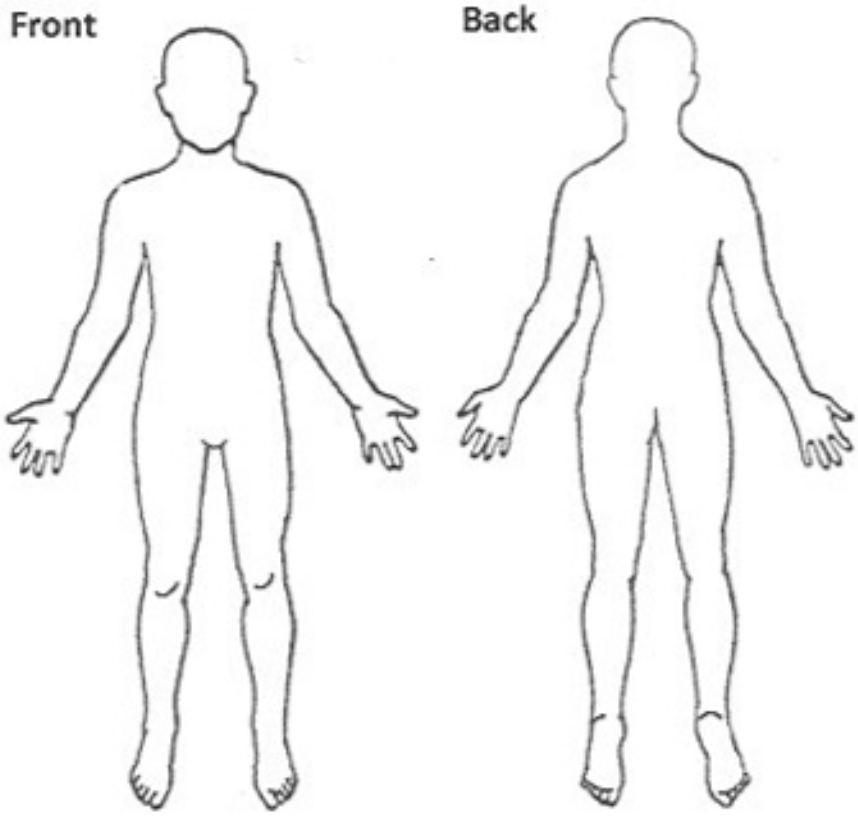
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE			EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**