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: _____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(If applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ *Ambulance* ☐ *Private transportation*

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

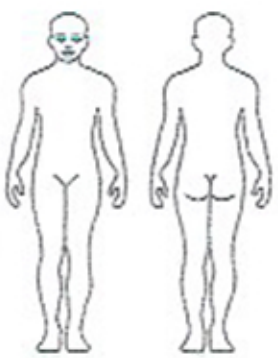
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

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 and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.