Welcome to

Inner Sanctum Chiropractic

Date Completed: _____

General Patient Information

Name:_____Sex:_____Age:_____Date of Birth:_____

Address: _____

City: _____ State:_____Zip:_____

Email: _____Profession:_____

Primary Complaint

What has brought you in today?_____

Where is it located? _____Does it radiate anywhere?_____

How long has it been going on for?_____

When did it start? _____

What were you doing when you noticed it began causing problems?_____

On a scale of 1-10, 10 being worst imaginable pain, where do you rank this pain?_____

Do you have any numbness, tingling, or sharp shooting pains?_____

Has anything made it better? (heat, ice, mediation, rest, positions, etc)

_____

Has anything made it worse? (activity, positions, rest, etc)

_____

What are your treatment goals?

_____

_____

Personal Health History

Height:_____Weight:_____Blood Type (if known):_____

Are you taking any medications or supplements? Please list

_____

_____

_____

Any known allergies (including food, medication, and seasonal)?

_____

Have you had any major traumas/accidents/injuries?

_____

_____

_____

Have you had any surgeries?

_____

_____

_____

Major Diagnoses or symptoms? Please Circle Answers (lines below for more room)

Acne	Fainting	Numbness, tingling, weakness
Addiction	Fibrocystic Breasts	Ovarian cysts
ADD/ADHD	Fibromyalgia	Pain with urination
Anemia	Fractures or Broken Bones	Parasitic Infection
Appendicitis	Gallbladder problems	Pneumonia
Arthritis (OA or RA)	Heart Disease	Polycystic Ovarian Syndrome
Autoimmune Conditions	Hepatitis	Sciatica
Bloating	Herpes Simplex, Fever Blister, Cold Sores	Scoliosis
Bruising	High Blood Pressure	Seizures/ Epilepsy
Cancer (specify)	High Cholesterol	Shoulder/ Arm/ Hand pain
Chest pain	Hysterectomy	Stomach Pain
Chronic bronchitis or recurrent lung conditions	Insomnia	Surgeries (List Below)
Chronic Fatigue or Pain	Kidney Problems	Thyroid Problems
Chronic headaches	Lower Limb (leg) pain	Traumas, accidents
Cold hands or feet	Liver Problems	Ulcers
Colitis	Loss of Balance	Vertigo
Constipation	Low Back Pain	Vision Changes
Diabetes (Type, insulin dependent?)	Menstrual Disorder	Weight Gain/ Loss (unintentional)
Difficult Breathing	Mid Back Pain	
Ear Infection	Mood Swings, Depression, Anxiety	
Eating Disorder	Muscle Spasms	
Endometriosis	Nausea/ Dizziness	

_____

_____

_____

Do you have any children? If so, how many and how old are they?

_____

Females only:

Age at onset of first cycle? _____Last menstrual cycle? _____

Are you taking hormonal birth control? (if so, what kind and how long have you been taking it)

_____

Are you pregnant? _____ Number of past pregnancies? _____

Have all pregnancies been carried to term? _____

How were they delivered? (vaginal or C-section) _____

Lifestyle:

How often do you consume the following? Please Circle Answers

Soda/ coke	Daily	Weekly	Monthly	Never
White flour/Bread	Daily	Weekly	Monthly	Never
Fried Foods	Daily	Weekly	Monthly	Never
Coffee	Daily	Weekly	Monthly	Never
Packaged Foods	Daily	Weekly	Monthly	Never
Sweets	Daily	Weekly	Monthly	Never
Beer/wine	Daily	Weekly	Monthly	Never
Alcohol	Daily	Weekly	Monthly	Never
Tobacco/smoking	Daily	Weekly	Monthly	Never
Vaping	Daily	Weekly	Monthly	Never

Are you vegetarian/vegan?_____

Do you have any food allergies?_____

How often do you exercise and what types?_____

How active is your job? ◯ Very Active ◯ Somewhat Active ◯ Mostly Sitting

How many hours of sleep do you get per night?_____

Do you wake up during the night? _____

Do you have difficulty falling asleep?_____

Do you feel well rested upon waking? _____

Family Health History

	Mom	Dad	Siblings	Children	Mom's Parents	Dad's Parents
Autoimmune Conditions						
Cancer						
Diabetes						
Epilepsy						
Heart Conditions						
Hormonal Conditions						
Kidney Conditions						
Liver Conditions						
Mental Health Conditions						
Neurological Conditions						
Stomach Conditions						
Thyroid Conditions						
Other						

Please use the lines below for any explanations or additional conditions we missed.

_____
_____
_____
_____
_____

Working with Us

How did you hear about us?_____

What are your expectations for Dr. Luster as your healthcare provider?

_____
_____
_____

What are your long-term goals for working with us?

_____
_____

Do you have a Primary Healthcare Provider? Please list here.

_____

Have you seen anyone else about these concerns? If so, whom?

_____

Have you received chiropractic care before?

_____

What healthy activities do you engage in regularly?

_____
_____
_____

What self-destructive activities do you engage in regularly?

_____
_____
_____

What 3 things do you love to do most?

_____
_____
_____

If there is any additional information you feel we need to know, please write it here.

_____
_____
_____
_____
_____

In an emergency, who should we contact? Please include name and phone number.

_____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, may provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: Sprain/Strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance in one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, your spinal health, and the appropriateness of chiropractic care. These procedures will assist us in determining if chiropractic care is needed or if further evaluations or testing is needed. In addition, they will help us determine if there is any reason to modify your care and/or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and to the chiropractic care (to include spinal adjustments) following my assessment.

Print Name Here_____

Sign Name Here_____Date_____

If This Health information is for a minor/ child, please fill out and sign below.

Written Consent for a Child

Name of Practice Member who is a Child_____

I Authorize Dr. Taylor Luster and any/all Inner Sanctum Chiropractic Staff to perform Diagnostic procedures, evaluation, and rendering of chiropractic care (to include spinal adjustments) to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Inner Sanctum Chiropractic.

Guardian's Name_____

Guardian Relationship to minor/child_____

Guardian Signature

_____Date_____

Witness Signature (office staff)

_____Date_____

Informed Consent for Acupuncture

Please read this information carefully, and ask your practitioner if there is anything that you do not understand. While acupuncture has proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

• Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive.

• Minor bleeding or bruising can occur from acupuncture.

• In less than 3% of patients, symptoms may become worse before they improve for 1-2days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.

• Fainting can occur in certain patients, particularly at the first treatment.

Is there anything your practitioner needs to know? Apart from the usual medical details, it is important that you let your practitioner know:

• If you have ever experienced a fit, faint, or other odd detached sensations;

• If you have a pacemaker or any other electrical implants;

• If you are pregnant;

• If you have a bleeding disorder;

• If you are taking anti-coagulants (blood thinners) or any other medication;

• If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understand the above information, and I consent to acupuncture treatments at ISC. I also understand that I can refuse treatment at any time. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions.

Print Name Here_____

Sign Name Here_____Date_____

Media Release Form

I, _____, grant permission to _***Inner Sanctum Chiropractic***_, hereinafter known as the “Media” to use my image (photographs and/or videos) and/or written reviews for use in Media publications including: Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____ - I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Name (please print): _____

Signature: _____ Date: _____

Signature of parent or legal guardian: _____
(if under 20 years of age)

ISC Staff Signature: _____

Email Consent Form

Practice Member Name: _____
Email:_____

Inner Sanctum Chiropractic will be abbreviated to 'ISC' for the remainder of this document.

Risk of Using Email

Transmitting Practice Member information by email has a number of risks that Practice Members should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Emails can easily be misaddressed.
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect email transmitted through their system.
- Email can be intercepted, altered, forwarded or used without authorization.
- Email can be used to introduce viruses into computer systems
- Email can be used as evidence in court.
- Emails may be not secure, including at ISC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the Use of Email

ISC cannot guarantee but will use reasonable means to maintain security and confidentiality of email information. ISC is not liable for improper disclosure of confidential information that is not caused by ISC's intentional misconduct. Practice Members must acknowledge and consent to the following conditions:

- **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular time.**
- Email must be concise. The Practice Member should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- **All pertinent health information will be printed and filed in the Practice Member's medical record.**
- ISC staff may receive and read messages
- ISC will not forward Practice Member identifiable emails outside of ISC healthcare providers without the Practice Member's prior written consent, except as authorized or required by law.
- The Practice Member should not use email for communication regarding sensitive medical information.
- ISC is not liable for breaches of confidentiality caused by Practice Member or any third party.
- It is the Practice Member's responsibility to follow up and/or schedule an appointment.

Instructions

To communicate by email, the Practice Member shall:

- Avoid use of employer's computer.
- Put the Practice Member's name in the body of the email.
- Key in the topic (e.g., medical question, billing question) in the subject line.
- Inform the provider of changes in his/her email address.
- Acknowledge any email received from the Provider.
- Take precautions to preserve the confidentiality of email.

Practice Member Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between ISC and me, and consent to the conditions and instructions that ISC may impose to communicate with Practice Member by email.

Practice Member Signature: _____Date: _____

HIPPA
Patient Privacy Notification

This notice describes our policy for how medical information about you may be used and disclosed, how you may get access to this information, and how your privacy is being protected.
In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- limited access to facilities where information is stored;
- policies and procedures for handling information;
- requirements for third parties to contractually comply with privacy laws; and
- all medical files and records (including email, regular mail, phone messages, and faxes) are kept on permanent file.

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information:

- about your financial transactions with us (billing transactions);
- from your medical history, treatment notes, test results, and any letters, faxes, emails or phone conversations to/from other health care practitioners;
- from health care providers, insurance companies, Workers Comp and your employer, and other third part administrators (*e.g.*, requests for medical records, claim payment information).

You may update personal information we have collected about you that identifies you.
We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please contact us during regular business hours.
Please sign below indicating that you have read our privacy policy.

Printed Name _____
Signature _____ Date_____

Cancellation Policy

Our cancellation policy is in order to provide you with the most flexibility in scheduling possible.

We require a 48-hour notice for scheduled and rescheduled appointments.

The first missed appointment will be waived.

Any additional no call-no shows will result in a 50% charge to the payment on file.

This looks like:

$30 for each $60 Open Bay appointment.

$75 for each $150 specialized private 45-minute appointment

$50 for each $100 specialized private 30-minute appointment

Multiple cancelled or rescheduled appointments could result in dismissal.

I understand the cancellation policy and agree to the terms listed above.

Practice Member Name _____

Practice Member Signature _____

Date _____