INNER STRENGTH
CHIROPRACTIC

1522 State Street unit A, Santa Barbarba, CA • (805) ON-LEVEL • ISChiro.com

Your Personal Health History

Name: _____ Today's Date: ____/____/____
Preferred Name: _____ Address: _____
Birth Date: ____/____/____ Age: _____ City & State: _____ Zip: _____
Height: _____ Weight: _____ Phone Number:_____

Occupation: _____ E-Mail: _____
Work City& State: _____ Employer: _____

Are You A Student? Y N
If Yes, Please Circle One: Full Time or Part Time

Gender: M F Other_____ Gender Assigned at Birth_____
Preferred Pronouns_____ Marital Status: S M W D Other_____
Spouse or Partner's Name & Age: _____
Names & Ages of Children: _____
_____
Are Your Spouse/Partner and/or Children Under Chiropractic Care? Y N
For What Reason?_____
How Did You Hear About Us? _____
Have you ever been to a chiropractor before? _____ If so, when? _____

Past Health History

How Much Birth Trauma Did You Experience? (Please circle all that apply)

Long Delivery?	Difficult Delivery?	Induced Labor?	Hospital birth?
Forceps Used?	Vacuum Extraction?	Caesarian Section?	Breech/cephalic presentation?
Mother given drugs?	Vaccines within first 3 years of life?		

Circle any conditions you currently have or previously had.

AIDS/HIV	Emphysema	Gout	Mononucleosis	Thyroid Problems
Arthritis	Cataracts	Heart Disease	Pinched Nerve	Tonsillitis
Asthma	Chemical Dependency	Hepatitis	Pneumonia	Scarlet Fever
Anemia	Chicken Pox	Liver Disease	Polio	Tumors or Growths
Anorexia	Cold/Flu	Measles	Pacemaker	Typhoid Fever
Appendicitis	Goiter	Herpes	Parkinson's Disease	Ulcers
Bulimia	Gonorrhea	High Cholesterol	Psychiatric Care	Vaginal Infections
Cancer	Epilepsy	Kidney Disease	Rheumatoid Arthritis	Vision Problems
Bleeding	Fibromyalgia	Migraines	Rheumatic Fever	Viral Infections
Breast Lump	Glaucoma	Multiple Sclerosis	Prostate Problem	Tuberculosis
Bronchitis	Hearing Problems	Mumps	Stroke	Whooping Cough
Diabetes	Hernia	Osteoporosis	Suicide Attempt	
Ear Infections	Herniated Disc	Miscarriage	Tooth Problems	

Other _____

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The majority of our patients have been involved in dozens of impacts that could cause vertebral subluxations (spinal misalignments).

1. When was your most recent Auto, Motorcycle, or Bicycle Accident, even as a passenger? Date: _____
Circle: Major / Minor Impact What body part(s) did you injure? _____ Treatment: Medical / Chiropractic

2. When was the accident before that? Date: _____
Circle: Major / Minor Impact What body part(s) did you injure? _____ Treatment: Medical / Chiropractic

Most people have a slip, strain, twist or fall playing sports, at home or at work, whether it was reported or not.

1. When was your most recent injury? Date: _____
Describe: _____
_____
What body part(s) did you injure? _____ Treatment: Medical / Chiropractic

2. When was your most recent injury before that? Date: _____
Describe: _____
_____
What body part(s) did you injure? _____ Treatment: Medical / Chiropractic

3. When was your most recent injury before that? Date: _____
Describe: _____
_____
What body part(s) did you injure? _____ Treatment: Medical / Chiropractic

Please list any surgeries, traumas, fractures, etc. that have not been mentioned above.

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

What Side Effects Have You Experienced From Drugs and/or Surgery?

Exercise	Work Activity	Habits
None Moderate Daily Extreme Sports Weight Lifting Other: _____	Sitting _____ Hrs/Day Standing _____ Hrs/Day Light. labor _____ Hrs/Day Heavy. Labor _____ Hrs/Day Other _____ _____	Smoking Packs/Day _____ Alcohol Drinks/Week _____ Coffee/Caffeine Cups/Day _____ High Stress Level Reason Occupational Physical Mental Emotional _____ Other _____

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Medications & Supplements

Please list all **current** medications, vitamins, and other dietary supplements:

_____

_____

_____

Please list all **past** medications, vitamins, and other dietary supplements:

_____

_____

_____

Do you experience any sleeping problems? (including nightmares)? Y N
What is your sleeping posture: Side Stomach Back
Are you a spiritual person? Y N
What percentage of your food is: Organic?____ Conventional? ____ GMO? ____ Processed/Packaged? ____
What percentage of your produce is from:
Farmer's Market?____ Health Food Store? ____ Grocery Store (eg. Vons, Albertson's, Ralph's)? ____
What percentage is: Frozen?____ Canned? ____ Powder, Capsule, or Drink? ____
How often do you eat meat? _____
What kind of meat do you typically eat? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Family	○	○	○	○	○
Mother's Family	○	○	○	○	○

Current Health Condition

What is the reason for your visit today?

_____

Besides visiting our office today, what other steps are you taking to maximize your health and wellness?

_____

If you are here for Pain or a Problem, when did it start?

_____

What words describe your condition or pain? _____
If you have pain, what does it rate on a scale of 1-10? _____
Is there anything that makes your condition or pain better? _____
Is there anything that makes your condition or pain worse? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with your: Work Sleep Daily Routine Other _____
Is this condition getting: Worse Better The Same
What type of care have you already received for your condition?
Chiropractic Massage Medication Surgery Other _____
Name of Doctor(s) who have cared for you: _____

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Other Current Health Concerns (Please circle all that apply):

Neck Pain or Stiffness	Low Back Pain	Nervousness	Ringing / Buzzing in Ears
Headache	Hip or Groin Pain	Tension	Cold or Fever
Shoulder Pain	Leg Pain R L	Irritability	Fainting
Upper or Mid-Back Pain	Pins & Needles: Legs R L	Depression	Loss of Balance
Chest Pains	Numbness in Toes	Fatigue	Diarrhea
Rib Problems	High or Low Blood Pressure	Cold Sweats	Constipation
Arm or Hand Pain R L	Allergies	Face Flushed	Upset Stomach
Pins & Needles: Arms R L	Dizziness	Shortness of Breath	Other_____
Numbness in Fingers	Sleeping Problems	Memory Loss	_____

What are three challenges you are currently facing in your life (Health-related or otherwise)?

_____

_____

_____

What are three things in your life that make you happy?

_____

_____

_____

What Benefits of Chiropractic Care Would You Like to Achieve? (Please check all that apply)

- o Relieve My Pain Quickly
- o Recovery From Injury or Disease
- o Help My Body Resist Injury or Disease
- o Avoid Drugs and/or Surgery
- o Improve My Spine & Nervous System Health
- o Live a Longer, Healthier, Happier Life
- o Live a More Vitalistic, Holistic Life
- o Improve My Performance in Physical Activities
- o Remain Active Longer

For Office Use

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Terms of Acceptance & Informed Consent to Chiropractic Care

Please discuss any questions or concerns with the doctor before signing this consent.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

The Nature of the Chiropractic Adjustment

The doctor will use their hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may feel a sense of movement.

The Material Risks Inherent with the Chiropractic Adjustment

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 strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination. Stroke has been the subject of disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as "rare".

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

- Heat ~ risk of 1st and 2nd degree burns, hemorrhage
- Cryotherapy (cold packs) ~ risk of skin reactions
- Trigger Point Therapy ~ risk of bruising, release of emboli
- Massage ~ risk of deep vein thrombosis

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered over-the-counter analgesics and rest
- Medical care with prescription drugs
- Hospitalization
- Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest in impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self-discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

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I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by Dr Jacob Martin, his staff, and/or associates.

Patient Acknowledgement of Privacy

I acknowledge that I have read and fully understand the Notice of Privacy Practices of Inner Strength Chiropractic. I understand that I may request a copy of this notice at any time. I further understand that this Notice may be modified with no prior notification to me.

_____ _____

Name of Patient Date

_____ _____

Signature of Patient Signature of Parent or Guardian

(for office use)

VIC_____

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Office Fees and Financial Policy

Fees:

Initial Examination & Consultation	
(Includes first adjustment, if indicated by exam)	
Individual	95.
Entire Family	150.
Chiropractic Adjustment	60.
Periodic Re-Examination	100.
Physical Therapy (per 15 minutes)	30.
Manual Therapy (per half hour)	75.

Discounts:

(Discounts do not apply to the Initial Exam fee)

Children	
Birth – 12 years	50%
12 – 18 years	25%
College Students	
Full-time	50%
Part-time	25%
Senior Citizens	15%
Divinitree Yoga Students	25%
Current & Former Military Service	25%

We offer additional discounts for choosing health crisis care, correction & stabilization care, or lifestyle care, based on your individual health needs.

Financial Policy

We are committed to guiding you to heal your mind, body, spirit, & planet. You will be expected to pay for your chiropractic care at the time the service is rendered unless you make other arrangements in advance. These arrangements are designed to be the most cost effective way to keep you and your family as healthy as possible, and will be discussed with you on your second visit.

Please Check One:

☐ **Insurance:** If you have insurance that covers chiropractic, please let us know today, and we will contact your insurance company, if possible, between your initial examination and your second visit, in order to determine what your benefits are. We will provide you with a superbill that can be submitted to your insurance for you to receive reimbursement quickly. We have found it is best for record keeping if we issue your superbills approximately once per month. Just send your superbills to your insurance company, and they will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

☐ **No Insurance:** If you do not have health insurance, or choose not to use your health insurance, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. These receipts do not include insurance documentation.

If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

I have read and I understand the above policies. I have selected the documentation option that applies to me.

_____

Name

_____

Signature Date