Palmer Chiropractic Center

Patient Information and History

PATIENT INFORMATION

Date_____ Home Phone_____

Name_____
LAST NAME *FIRST NAME* *INITIAL*

Address_____

_____

Sex M F Age_____Birthdate_____

SS#_____Marital Status_____

Occupation_____

Employer_____

Cell Phone:_____
○ (check if primary contact #)

Tobacco Use:
○ Never ○ Current every day ○ Current sometimes ○ Former

Spouse's Name_____
Does your spouse have permission to access your medical records? ○ Yes_____ ○ No_____
Initial Initial

Whom may we thank for referring you?_____
○ Provider ○ Friend ○Family ○Previous patient ○ Other

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____Work Phone_____

INSURANCE

Do you have Medicare? Yes No

Primary Insurance Co._____

Secondary Insurance Co._____

Is patient covered by any additional insurance? Yes No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Palmer Chiropractic Center, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance as well as interest of 1.5% per month, attorney's fees, collection agency fees and costs associated with the collection of overdue balances. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Patient / Guardian Signature

_____ _____
Relationship Date

How you heard of us: ○Walk-in ○Referral ○Phone Book

○Website ○Google search ○Facebook ○Other_____

Is condition due to an accident? Yes No

Date of accident_____ In which state?_____

Type of accident Auto Work Home Other_____

PATIENT CONDITION

Reason for visit_____ When did your symptoms appear?_____

Is this condition getting progressively worse? Yes No Unknown How often do you have this pain?_____

Is your pain? Constant or does it? Come and go Does it interfere with your? Work Sleep Daily Routine Recreation

Activities that are painful to perform? Sitting Standing Walking Bending Lying Down

Indicate on the diagram the type of pain using the symbols below.

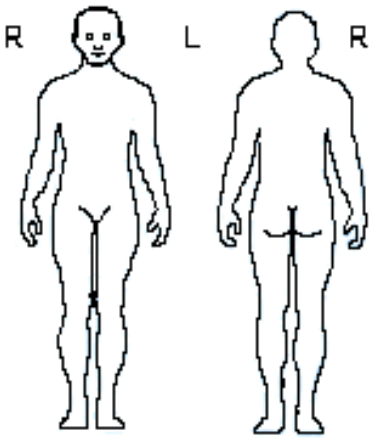
Ache : ZZZ

Burning : BBB

Numb : XXX

Pins & Needles : = = =

Stabbing : ///



List each area of pain (IE. Neck or Back)	How severe is your pain today? 0 = No Pain 10 = Intolerable
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Information and History (continued)

Print Name:_____

Primary Care Physician _____ **Specialist** _____ **Type**_____

Patient Height: ' " **Patient Weight:_____lbs.**

Date of Last: (If none, write N/A)

Physical Exam_____ Spinal X-Ray_____ Spinal Exam_____

Blood Test_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI/CT-Scan/Bone Scan_____ Bone Density_____

Circle any treatments have you already received for the condition you are being seen for today?

(Medications) (Surgery) (Physical Therapy) (Chiropractic) (Injections) Other _____

Please circle symptoms you currently have:

Dizziness/Loss of Balance Loss of Memory Ringing/Buzzing in Ears Depression Nausea

Visual/Sensory Disturbance Lightheadedness Loss of Concentration Headaches Burning Eyes

Have you ever suffered from:

□ Dizziness	□ Arthritis	□ Digestive Disorders
□ Backaches	□ Headaches	□ Nervousness
□ Heart Trouble	□ Numbness	□ Sinus Trouble
□ Diabetes	□ Asthma	□ Anemia
□ Hernia	□ Neuritis	□ Cancer
□ Disc Bulge/Herniation	□ Pinched Nerve	□Whiplash

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN

EXERCISE

None Daily

Moderate Heavy

WORK ACTIVITY

Sitting Light Labor

Standing Heavy Labor

LIFESTYLE

Smoking Packs/Day_____ Coffee/Caffeine (Cups/Day_____)

Alcohol Drinks/Week____ High Stress Level (Reason_____)

INJURIES/SURGERIES YOU HAVE HAD

(If none, write N/A) (Description) (Date)

Falls _____ _____

Head Injuries _____ _____

Broken Bones _____ _____

Dislocations _____ _____

Surgeries _____ _____

Please list below anything you are currently taking.

MEDICATIONS (start date) **VITAMINS/HERBS**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: ○ If none check_____

I authorize the release of my medical records to: _____ _____ _____ _____

Name Relation Name Relation

I have read, understood, and agree to the foregoing. I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of this clinic responsible for any errors or omissions that I may have made in the completion of this form. I understand that the doctor will be relying on the above information and all other information that I supply in his treatment of me. I hereby give permission to the doctor and whomever he may designate as his assistants to administer treatment and/or therapy, and perform such procedures as he may deem necessary in the diagnosis and/or treatment of my condition. I certify that no guarantee has been made as to the results that may be obtained.

Patient / Guardian Signature_____ Date_____