

Palmer Chiropractic Center of Lynchburg
PATIENT INFORMATION

Date _____ Home Phone _____

Name _____
LAST NAME FIRST NAME INITIAL

Address _____

Sex M F Age _____ Birthdate _____

SS# _____ Marital Status _____

benefits, 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 _____

Patient Information and History Pg 1 of 2
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 of Lynchburg, Inc. all insurance 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? _____

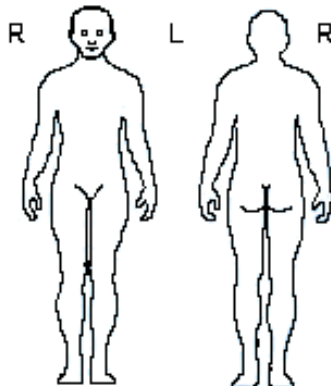
Is this condition getting progressively worse? Yes No Unknown How often do you have this pain? _____

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

Primary Care Physician _____ Specialist _____ Type _____

Patient Height: ' " Patient Weight: lbs.

Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____
(If none, write N/A) 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:

- Arthritis, Digestive Disorders, Nervousness, Sinus Trouble, Anemia, Cancer, Whiplash, etc.

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

EXERCISE

WORK ACTIVITY

LIFESTYLE

None Daily Sitting Light Labor Smoking Packs/Day Coffee/Caffeine (Cups/Day)
Moderate Heavy Standing Heavy Labor Alcohol Drinks/Week High Stress Level (Reason)

INJURIES/SURGERIES YOU HAVE HAD

Table with 3 columns: (If none, write N/A), (Description), (Date). Rows include Falls, Head Injuries, Broken Bones, Dislocations, Surgeries.

Please list below anything you are currently taking.

MEDICATIONS (start date) VITAMINS/HERBS

Table with 2 columns: MEDICATIONS (start date), VITAMINS/HERBS. Multiple rows for listing.

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 _____