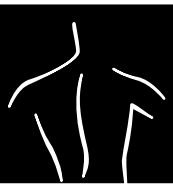
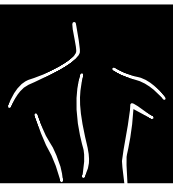


# Palmer Chiropractic

*Your health is our concern*



Name _____ Email Address _____ Preferred: Cell / Hm # / Wk #

Address _____ City_____ Zip Code_____

Home Ph _____ Work Ph _____ Cell Ph _____

Date of Birth _____ Age _____ Sex M F Marital Status S M D W

Social Security # _____ Spouse's Name _____

Number of Children _____ Occupation _____

Employer's Name & Address _____

Insurance Yes _____ No _____ Name _____

Are Your Injuries Due to an On-The-Job Injury? Yes _____ No _____ Auto Accident? Yes _____ No_____

Do You Plan on Turning it in to Workman's Compensation? Yes _____ No _____ Accident Date _____

Are You Now or Have You Ever Been Disabled (Service or Work) Yes _____ No _____ Dates _____

Referred By _____ Past Chiropractic Care Yes _____ No _____

Chiropractor's Name _____ Date of Last Visit _____

List Your Major Health Complaints & Areas of Pain: _____

_____

Please check all of the following symptoms and signs which you have or have had within the last 6 months. An understanding of your health status will facilitate treatment.

GENERAL SYMPTOMS
_____ Fever
_____ Chills
_____ Night Sweats
_____ Fainting
_____ Loss of Sleep
_____ Fatigue
_____ Nervousness
_____ Loss of Weight
_____ Numbness or Pain in arms, legs, hands
_____ Allergies (What)
_____ Headache
_____ Dizziness
_____ Tremors
_____ Convulsions
_____ Skin Eruptions/Problems
_____ Painful Menses

DIGESTIVE PROBLEMS
_____ Nausea, Stomach Upset
_____ Heart Burn
_____ Constipation
_____ Diarrhea
_____ Vomiting
_____ Pain Over Stomach
_____ Difficulty Swallowing

CARDIO-VASCULAR
_____ Rapid Heart
_____ Slow Heart
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Pain Over Heart
_____ Previous Heart Trouble
_____ Strokes

EYE, EAR, NOSE, THROAT
_____ Frequent Colds
_____ Sinus Problems
_____ Difficulty Breathing
_____ Wheezing
_____ Asthma
_____ Pain in Eyes
_____ Earache
_____ Ear Noises
_____ Nose Bleeds
_____ Sore Throat
_____ Chronic Cough

MUSCLE & JOINTS
_____ Stiff Neck
_____ Backache
_____ Swollen Joints
_____ Painful Tail Bone
_____ Pain Between Shoulders

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?

_____ Polio
_____ Anemia
_____ Sciatica
_____ Diabetes
_____ Rheumatism
_____ Lumbago
_____ Eczema
_____ Mumps
_____ Pneumonia
_____ Typhoid
_____ Appendicitis
_____ Alcoholism
_____ Epilepsy
_____ Goiter
_____ Mental Disorders
_____ Heart Disease
_____ Malaria
_____ Chickenpox
_____ Pleurisy
_____ Flu
_____ Measles
_____ Cancer
_____ Arthritis

# OPERATIONS

Date

| | | |
|---|---|---|
| _____ Appendectomy | _____ Heart Surgery | _____ Stomach Surgery |
| _____ Back Operations | _____ Hernia Repair | _____ Thyroid Operation |
| _____ Female Organs | _____ Lung Surgery | _____ Tonsillectomy |
| _____ Gall Bladder | _____ Rectal Surgery | Other _____ |

Major Falls or Accidents: (Childhood & Adult) _____

_____

Broken Bones or Dislocations: _____

_____

Were You Ever Knocked Unconscious? Yes _____ No _____

Have You Ever Had a Lapse of Memory? _____

Have You Ever Had X-Ray Pictures Made of Your Spine? _____

If So, By Whom? _____

For What Aliments Were These Pictures Made? _____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

Are You Presently Taking Any Medication - Prescription or OTC ? _____

If So, What Drugs? _____

Who Is Your Family Medical Doctor? _____

When Did You Last See Him/Her? _____

Why? _____

What Treatment Was Given (Drugs, Surgery, Therapy, Etc?) _____

Have You Consulted A Specialist? _____ Who? _____

Why? _____ What Treatment Did You Receive? _____

It is understood and agreed the amount paid to Palmer Chiropractic for X-Ray is for examination only, and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I understand that if my insurance company covers services and the check(s) is sent to the patient, it is the patient's responsibility to bring the check and explanation of benefits to this office. I understand and agree that if my insurance or Medicare fails to provide payment for services rendered that it is my responsibility to pay for these services. I understand that my insurance is a quote of benefits and not a guarantee of benefits. There is no guarantee until the Explanation of Benefits is received from the insurance company which takes approximately 30 days. Co-pays and/or deductibles that are left unpaid for more than 30 days will incur an 18% interest rate annually.

Signature _____ Date _____

# AUTHORIZATION FORM

**Patient Name_____**

**RELEASE OF INFORMATION**
I hereby authorize ***Palmer Chiropractic*** to release medical and financial data to my insurance carriers and attorney.
**INITIALS_____**

**RESPONSIBILITY OF BILL**
The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. ***Palmer Chiropractic*** cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or precertification procedures. I also understand that if I suspend or terminate my care and treatment, the fees for services rendered me will be immediately due and payable. In the event that of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection.
**INITIALS_____**

**AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER**
I hereby authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to ***Palmer Chiropractic*** professional services rendered. NO OTHER THIRD PARTY, including attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. **INITIALS_____**

**CONSENT FOR TREATMENT OF MINOR CHILD**
Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of ***Palmer Chiropractic***. The undersigned states that he/she is the patient's legal guardian. **INITIALS_____**

**SUBROGATION AND RIGHTS OF REIMBURSEMENT AGREEMENT**
If I, or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party. I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which I or my covered dependents are injured as a result of the acts of a third party. I will do whatever is reasonably needed to secure the Carriers rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement. **INITIALS_____**

**BOUNCED CHECK FEES**
I understand that the fee for any bounced check or return check for insufficient funds, closed accounts or any other ancillary concerns will be an additional $35.00 charge and will be required to be paid by credit card, money order, or cash. **INITIALS_____**
Please check the following boxes to inform us that you are in compliance with our office standards of operation. Any questions or concerns please feel free to talk with us.
□ Permission to use you as a source of testimonial letters
□ Permission to use or take photos for marketing or website
□ Permission to call you for updates regarding your care or finances

Permission can always be revoked, but this must be done in writing

Sign _____ Date _____

# PALMER CHIROPRACTIC

## 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 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 operation**
- **The practice reserves the right to change the privacy policy as allowed by law**
- **The patient 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 you to confirm appointments? YES NO**

**May we leave a message on your answering machine at home or on your cell? YES NO**

**May we leave a message at your employment? 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 PLEASE**

**Signature:_____**

**Date:_____**

**Witness:_____Date:_____**

## *Oswestry Disability Index*

**Section 1 – Pain Intensity**

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

**Section 2 – Personal Care (washing, dressing, etc.)**

- ❑ I can look after myself normally.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

**Section 3 - Lifting**

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

**Section 4 – Walking**

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

**Section 5 – Sitting**

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

**Section 6 – Standing**

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

**Section 7 – Sleeping**

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

**Section 8 – Sex life (if applicable)**

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

**Section 9 – Social Life**

- ❑ My social life is normal and cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

**Section 10 – Traveling**

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

**Section 11 - Previous Treatment**

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

# QUADRUPLE VISUAL ANALOGUE SCALE

**INSTRUCTIONS: Please put a mark on the line that best describes the question being asked.**
**NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.**

**EXAMPLE:**

| | headache | neck | low back | |
|---|---|---|---|---|
| **no pain** | ——————— | ——————— | ——————— | **worst possible pain** |

##########################################################################################################

**1. What is your pain RIGHT NOW?**

**no pain** _____ **worst possible pain**

**2. What is your TYPICAL or AVERAGE pain?**

**no pain** _____ **worst possible pain**

**3. What is your pain level AT ITS BEST?**

**no pain** _____ **worst possible pain**

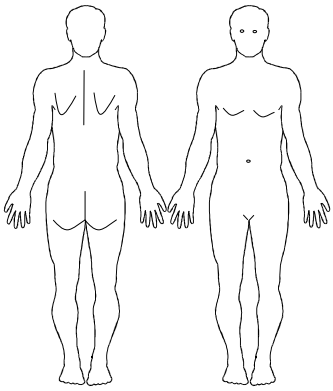
**What percentage of your awake hours is your pain at its best? _____%**

**4. What is your pain level AT ITS WORST?**

**no pain** _____ **worst possible pain**

**What percentage of your awake hours is your pain at its worst? _____%**

**Mark the diagram as follows:**
**A - Ache**
**B - Burning**
**N - Numbness**
**P - Pins & Needles**
**S - Stabbing**
**O - Other - Describe**



**NAME** _____ **AGE**_____ **DATE**_____ **SCORE**_____

**SCORE**: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)