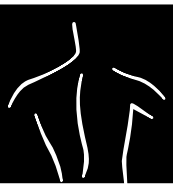

Palmer Chiropractic

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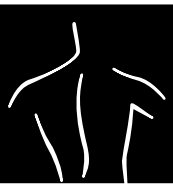


Name: First _____ Middle _____ Last_____

Address _____ City_____ Zip Code_____

Primary Ph _____ 2nd Ph _____ Email _____

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 _____

Oswestry 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)

I, the undersigned, have filled out this form by myself.
No other person has answered the questions for me.

Name _____

Signature _____

Date _____

Palmer Chiropractic in Richmond Hill, GA

Palmer Chiropractic

Your health is our concern

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:

no pain 0 _____Neck_____Low Back_____ **10 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 LEAST?

no pain _____ **worst possible pain**

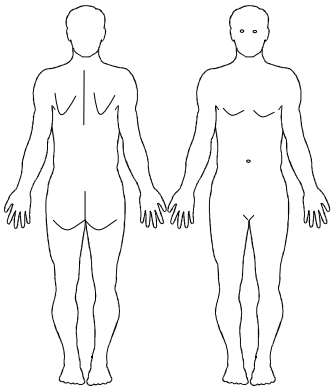
What percentage of your awake hours is your pain at its least? _____%

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? _____%

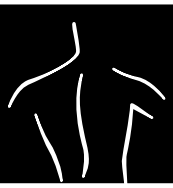
Mark the diagram as follows:
A - Ache
B - Burning
N - Numbness
P - Pins & Needles
S - Stabbing
O - Other - Describe



I, the undersigned, have filled out this form by myself.
No other person has made annotations for me.

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

SIGNATURE _____ **DATE** _____



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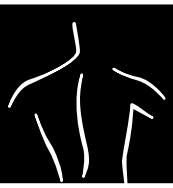


What is worst problem?

Where does it hurt? (circle one) Neck Midback Low Back Pelvis

When in your life did this problem start? _____

How many episodes have you had since this started? _____

How long has this episode been going on? _____

Describe in detail what it feels like? _____

Does the pain radiate? If yes circle where: Head Shoulder Blade Buttocks Arm Leg Hand Foot Fingers Toes

What makes it worse? _____

What makes it better? _____

What is the frequency of the pain? _____

How many hours of pain per day? 1 2 3 4 5 6 7 8 9 10 11 12 13+ (circle one)

Is the pain? (circle one) Staying the same / Getting Better / Getting Worse

---

What is second worst problem?

Where does it hurt? (circle one) Neck Midback Low Back Pelvis

When in your life did this problem start? _____

How many episodes have you had since this started? _____

How long has this episode been going on? _____

Describe in detail what it feels like? _____

Does the pain radiate? If yes circle where: Head Shoulder Blade Buttocks Arm Leg Hand Foot Fingers Toes

What makes it worse? _____

What makes it better? _____

What is the frequency of the pain? _____

How many hours of pain per day? 1 2 3 4 5 6 7 8 9 10 11 12 13+ (circle one)

Is the pain? (circle one) Staying the same / Getting Better / Getting Worse

Patient Signature: _____

Date: _____

Palmer Chiropractic
11400 Ford Ave
Richmond Hill, Georgia 31324
PH: 912-756-3433

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Palmer Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

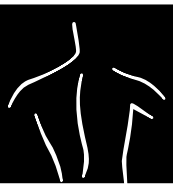
Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date



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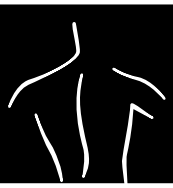

Patient Name_____

CONSENT FOR TREATMENT

I hereby give my consent to the performance of diagnostic tests including x-ray, examination procedures, chiropractic adjustments and management of my condition(s). Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks**: **-Temporary soreness or increased symptoms or pain**. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. **-Dizziness, nausea, flushing,** these symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. **-Fractures**, when patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. **-Disc herniation or prolapsed**, spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. **-Stroke**, a certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke. I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. **INITIALS**_____

Dr Palmer has my consent to **Manually Adjust** my**:**

Cervicals / neck **INTIALS**_____ Thoracis /midback **INITIALS**_____

Lumbars / low back **INTIALS** _____ Pelvis / hips **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**_____

RELEASE OF INFORMATION

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

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

Sign _____ **Date** _____