PALMER CHIROPRACTIC LIFE CENTER

PATIENT QUESTIONAIRE

TODAY'S DATE: _____

Name: _____
Address: _____ Apt/Suite #: _____
City: _____ State: _____ Zip Code: _____
Home Phone _____ Cell Phone: _____Work Phone: _____
Email Address: _____
Gender: M / F Date of Birth: _____ Height: _____ Weight: _____

Race: (Circle One) American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer
Ethnicity: (Circle One) Hispanic or Latino / Not Hispanic or Latino / Decline to Answer
Preferred Language: _____
Marital Status (Circle One): Single / Married / Divorced / Separated / Widowed
Spouses Name: _____ Number of Children: _____

Have you ever been to a chiropractor before? (Circle one) Y or N
If Yes: Name: _____

MAJOR COMPLAINTS – Please check off areas of concern and complete the chart.

X		0-10 Pain Scale	**R**ight **L**eft **B**oth	**C**onstant **F**requent **O**ccasional	**X**		0-10 Pain Scale	**R**ight **L**eft **B**oth	**C**onstant **F**requent **O**ccasional
	Headache					Shoulder Pain			
	Neck Pain/Stiffness					Elbow Pain			
	Upper Back Pain					Wrist Pain			
	Mid Back Pain					Hip Pain			
	Low Back Pain					Knee Pain			
	Pins & Needles in Arm					Ankle Pain			
	Pins & Needles in Leg					Foot Pain			

- Others:_____
  _____
  _____

What caused this condition(s)?_____

When did this condition begin? _____

Have you had a complaint in this area before? (Circle One) Y or N

If yes, please explain: _____

What makes this condition better? _____

What makes this condition worse? _____

Employment Information:

Regular Work Status: (Circle One) Full Time / Part Time / Homemaker / Unemployed

Employers Name: _____ Employer Phone #: _____

Employer Address: _____

Employer City: _____ State: _____ Zip Code: _____

Occupation: _____ Supervisor Name: _____

Supervisor Phone/Extension: _____

Physical Work Duties: (Circle One) Sedentary / Light / Medium / Heavy Labor

Explain:_____
_____
_____

Have you missed any work due to your injuries? (Circle One) Y or N _____

Personal Health History

Name of Family Physician or Physician Seen: _____

Physician Phone: _____ Physician City: _____ State: _____

Have you had any of the following? (Circle all that apply)

Traumas / Recent weight loss / Surgeries / Allergies / Serious Illness (i.e. diabetes, arthritis, cancer, osteoporosis, high blood pressure, thyroid disorder, etc.)

If any apply, please explain (be specific):

_____
_____
_____

Are you taking any medications? (Please include regularly used over the counter medicines)

Medication Name	Dosage (i.e. 5mg)	Frequency (i.e. once a day)

Do you have any allergies to any medications? (Please be specific)

Medication Name	Reaction	Onset Date	Additional Comment

Do you take Blood Thinners? (Circle One) Yes or No

Have you ever:

Broken Bones? Y or N. Year? _____ Explain: _____

Been Hospitalized? Y or N. Year? _____ Explain: _____

Been in an Auto Accident? Y or N. Year? _____ Injuries? _____

Had Major Sprains/Strains? Y or N. Year? _____ Explain: _____

Had Surgery? Y or N. Year? _____ Explain: _____

Had a Stroke? Y or N. Year? _____

Smoked Cigarettes? Y or N. If yes, what date did you start? _____

How often? _____ Have you quit? Y or N. If yes, what date? _____

Consumed Alcohol? Y or N. If yes, How much? _____ How often? _____

Heart Conditions: (that may interact with certain therapy procedures)

Do you have a pacemaker or heart arrhythmia? (Circle One) Y or N

Do you have a defibrillator? (Circle One) Y or N

Females only:

Are you pregnant, or have you had any signs of pregnancy? (Circle One) Y or N

Are you planning to get pregnant in the next 12 months? (Circle One) Y or N

Insurance Information:

How do you plan on paying for care? (Circle One)

Personal Insurance / Flex Spending Account / Self Pay (Cash)

Primary Insurance:

Insurance Name: _____ Phone: _____

Insurance Address: _____ Apt/Suite #: _____

Insurance City: _____ State: _____ Zip Code: _____

ID/Policy #: _____ Group #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Relationship: _____ Gender: (Circle One) M or F

Insured's Address: (If different from patient's) _____

Insured's City: _____ State: _____ Zip Code:_____

Secondary Insurance:

Insurance Name: _____ Phone: _____

Insurance Address: _____ Apt/Suite #: _____

Insurance City: _____ State: _____ Zip Code: _____

ID/Policy #: _____ Group #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Relationship: _____ Gender: (Circle One) M or F

Insured's Address: (If different from patient's) _____

Insured's City: _____ State: _____ Zip Code:_____

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES PALMER CHIROPRACTIC LIFE CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- ❖ I give permission to Palmer Chiropractic Life Center to request/view copies of my medical records including but not limited to imaging reports, hospital records, notes from other treating physicians, and lab tests.
- ❖ Palmer Chiropractic may send information or records regarding my examination, treatment and diagnoses to my insurance company or attorney's office.
- ❖ I give Palmer Chiropractic Life Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for the conversations.
- ❖ By signing this form, you are giving Palmer Chiropractic Life Center permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Palmer Chiropractic Life Center. The written notice must contain the following information:

- Your name and date of birth; a clear statement of your intent to revoke this authorization; the date of your request and your signature.
- The revocation is not effective until it is received by the Privacy Official.
- This authorization is requested by Palmer Chiropractic Life Center for its own use/disclosure of protected health information.

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Palmer Chiropractic Life Center will not refuse to provide treatment.

You have the right to inspect or copy the protected health information to be used/disclosed.

_____ _____

Date Signature of Patient

_____

Printed Name of Patient

PALMER CHIROPRACTIC LIFE CENTER
DR. T SHANE PALMER
DR. KIMBERLY MIRRA

100 Dover Street
New Castle, DE 19720
(302) 656-1390

191 Christiana Road, Suite 1
New Castle, DE 19720
(302) 328-2656 / Fax (302) 328-5870

MEDICAL RECORDS AND DOCTOR'S LIEN

I do hereby authorize Palmer Chiropractic Life Center to furnish my insurance company with a full report of examination, diagnosis, prognosis, and records in regards to my treatment.

I hereby authorize and direct my insurance company to pay directly to Palmer Chiropractic such sums as may be due and owing them for medical services rendered to me. I fully understand that I am directly responsible to the said doctor for all co-payments and medical bills submitted by the said doctor for service rendered to me and that this agreement is solely for the said doctor's protection and in consideration for their awaiting payment.

Date	Patient Signature (Or Parent/Guardian if under 18 years old)
Date	Signature of Personal Representative