NEW PATIENT QUESTIONNAIRE

PALMER CHIROPRACTIC CLINIC, INC.

PATIENT INFORMATION

Name: _____ Social Security #_____
First Middle Last

Marital Status: (circle one) Single / Married / Separated / Divorced / Widowed Birth Date: _____ / _____ / _____

Address: (ex. P.O.Boxes) _____ Cell phone _____

Physical Address: _____ Home phone_____
Street City Zip

Email: _____

Would you like to receive our FREE monthly E-Newsletter? YES or NO *(We will never share/sell your email address)*

GENERAL

List name, address, and phone number of two relatives not living with you in case of an emergency at our office.

1)_____

2)_____

How did you hear about our office? _____

Number & Ages of Children: _____

Females: Pregnant? **Y / N** If yes, due date _____ OBGYN/location _____

REASON FOR OFFICE VISIT

Please describe your main complaint(s) / reason for office visit?

_____

_____

What other health care have you received for this problem? _____

_____Date of Accident. Or ***Beginning of Complaint***: _____

Location of Accident: _____

How did it occur? ____Auto Collision ____On-the-job (work comp) ***If either is YES, please notify receptionist before continuing.***

Other _____

Please describe the circumstances: _____

Have you lost time from work? **Y / N** Dates:

EMPLOYMENT / BILLING INFORMATION

Employed by: (***parent's name*** & ***employer*** *if patient is school-aged OR under 18*): _____

Occupation: _____

Business address _____ Phone: _____
Street City Zip

Spouse name: _____ SSN: _____ Employer: _____

Who is responsible for this account? _____

Please indicate which type of insurance you have: Group _____ (insurance provided by employer)

Worker's Comp _____ Accident Policy _____ Auto _____ Other _____ Medicare _____ Medicare Supplement _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. ***However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand by signing below it authorizes the attending physician to release any information concerning my examination or treatment to the insurance company.***

Signature_____Date_____

(If patient is a minor, signature of parent or legal guardian.)

(please continue on reverse)

PALMER CHIROPRACTIC CLINIC, INC.

OFFICE POLICIES

X-RAY POLICY

I understand that this chiropractic office takes x-rays as deemed necessary by the treating physician. These x-rays are meant to determine specific spinal subluxations (misalignments) and further detail as needed. I understand that the fee I pay for these services is for the examination and interpretation only. As is the standard in any other facility, the x-ray films themselves remain property of this clinic. If I am transferring to another facility, I may request my x-rays be loaned out. They will be mailed directly to the doctor/hospital of referral.

_____ ***Please initial***

ACCOUNTS RECEIVABLE STATEMENT

Payments are due at the time service(s) are rendered. Cash, check, and major credit cards are accepted. A monthly $35.00 charge will be added to those accounts with balances *past due* after 60 days, unless prior payment arrangements have been made.

I understand that in the case of default on my part, and if it is necessary for this office or its agents to employ legal and/or collection counsel, I hereby agree that I am responsible for collection charges/fees incurred which will be added to my account.

Out of respect of our doctor's and staff's time, there will be a $35.00 fee for a missed appointment. In order to avoid this fee, please notify our office if you will not be able to make your scheduled appointment. This fee will only be waived in certain situations as deemed necessary by this office. Your understanding of this notice is acknowledged by the scheduling of your appointments.

Effective October 2010

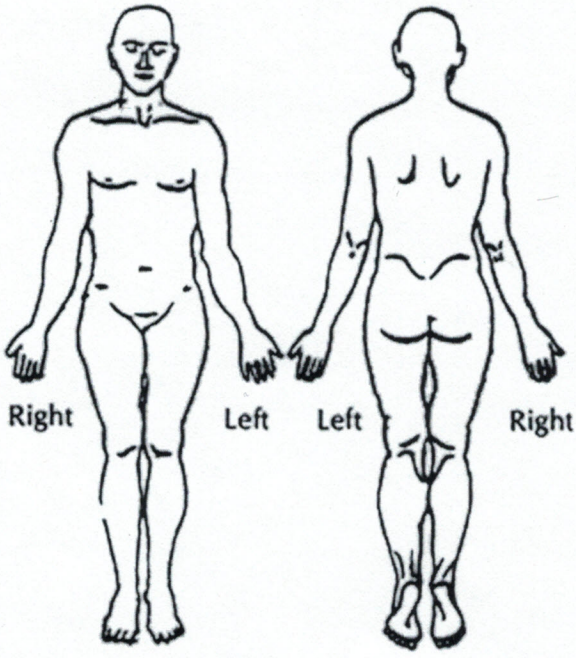
Signed _____ **Date**_____

HEALTH QUESTIONAIRE

Name _____ Date _____

In order to best provide an accurate diagnosis and treatment of your problem, some background information is necessary. All information will be kept confidential.

PLEASE MARK ON DIAGRAM YOUR → → → AREAS OF DISCOMFORT / PAIN:



Height _____ Weight _____
Have you recently gained or lost more than 10 lbs.? Y / N
Do you feel you are in overall good health? Y / N
Are you diabetic? Y / N
If yes, Type 1 or Type 2? _____
Do you wear contacts or glasses? _____
If yes, approximate date of last eye exam?
_____
Do you smoke? Y / N # of cigarettes/ packs per day? __
Do you use recreational drugs? _____
Do you drink caffeine? _____ coffee, tea, or soda? _____ How many per day? _____
Do you drink alcohol? _____
Do you get adequate sleep at night? Y or N _____
Do you feel you are under a lot of stress? Y or N _____
List any vitamins, supplements, or over-the-counter medications and reason for taking _____
_____
_____
List your current prescription medications and reason for taking *(if you carry a list we can make a copy for you)*
_____
_____
_____
Who is your primary care physician? _____ Where are they located? (city/hospital) _____
Abnormal childhood illness / diseases? _____
_____
List of surgeries and approximate dates _____
_____
_____
_____
Previous accidents or complications? _____
_____
_____
Other current disease or diagnosis you are being treated for? _____
_____
_____ **(please continue on reverse)**

REVIEW OF BODY SYSTEMS

PLEASE MARK
(C) for CURRENT and
(P) for PAST health history:

MUSCULO-SKELETAL
___ low back problems
___ spinal disc problems
___ neck problems
___ pain between shoulders
___ arm problems
___ leg problems
___ swollen joints
___ painful joints
___ stiff joints
___ sore muscles
___ weak muscles
___ broken bones
___ jaw pain / problems

NERVOUS SYSTEM
___ numbness
___ paralysis
___ dizziness
___ fainting
___ headaches
___ muscle jerking
___ convulsions
___ seizures
___ forgetfulness
___ confusion
___ depression

GASTRO-INTESTINAL
___ poor appetite
___ excessive hunger
___ difficulty chewing
___ difficulty swallowing
___ excessive thirst
___ nausea
___ vomiting food
___ vomiting blood
___ acid-reflux
___ abdominal pain
___ diarrhea
___ constipation
___ black stools
___ bloody stools
___ white stools
___ hemorrhoids
___ liver trouble
___ gall bladder trouble
___ weight trouble

FAMILY HISTORY
___ history of cancer?
___ history of diabetes?

CARDIO-RESP. / VASCULAR
___ chest pain
___ difficulty breathing
___ asthma
___ persistent cough
___ persistent phlegm
___ coughing blood
___ rapid heartbeat
___ blood pressure problems
___ high cholesterol
___ heart problems
___ lung problems
___ varicose veins

EYE/EAR/NOSE/THROAT
___ eye strain
___ eye inflammation
___ vision trouble
___ ear pain
___ ear noises
___ hearing loss
___ ear discharge
___ nose pain
___ nose bleeding
___ allergies *(circle which applies)*
chronic? seasonal? other?
___ nasal congestion
___ sore gums
___ sore mouth
___ dental problems
___ sore throat
___ hoarseness
___ difficult speech

GENITO-URINARY
___ bladder trouble
___ painful urine
___ excessive urine
___ discolored urine
___ other urine trouble?
___ sexual dysfunction
(pain, difficulty, or other)
___ kidney trouble

FEMALES ONLY
___ vaginal discharge
___ vaginal bleeding
(other than normal menses)
___ vaginal pain
___ breast pain
___ breast lumps
___ other?

CLINICAL NOTES:
(For Doctors & Staff use only)

Palmer Chiropractic Clinic, Inc.
723 S Main Street
Kingfisher, OK 73750
Tel: 405-375-5497 / Fax: 405-375-5485
www.palmerchirokf.com / palmercc@live.com

Patient Consent

For use and/or disclosure of Protected Health Information (PHI) To carry out Treatment, Payment, and Healthcare Operations

I, hereby state that by signing this Consent Form, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is provided by **Palmer Chiropractic Clinic, Inc.** and I may request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and duties of this office with respect to my protected health information.
5. I understand that, and consent to, the following appointment reminders that will be used by the Practice: **a)** a postcard mailed to me at the address provided by me; and **b)** telephoning my home, work, or mobile phone and leaving a message on my answering machine or with the individual answering the phone.
6. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
7. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
8. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
9. I understand that if I do not sign this consent or revoke consent at any time, the Practice has the right to refuse to treat me.
10. I understand and consent to the following other types of correspondence from this office: **a)** reminder post- cards may be mailed to me at the address I provided; and **b)** I may receive periodic mailings of general health information in the form of a newsletter.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of patient, parent, or guardian _____

Signature of above _____ Date _____

Please list two (2) people who are authorized to obtain your health records. (optional)

_____ relationship to patient_____

_____ relationship to patient _____

INFORMED PATIENT CONSENT

AND THE DOCTOR-PATIENT RELATIONSHIP

Chiropractic Care	It is the premise of Chiropractic that the human body possesses the inherent potential to maintain itself in a natural state of homeostasis. A state of normal homeostasis allows the body to establish normal function, express appropriate adaptation, and employ its recuperative, health sustaining powers. The relationship between the spine and the nervous system may affect the conduction of the nerve impulses over the nervous system affecting that inherent potential. Therefore, chiropractic care focuses primarily on the chiropractic adjustment for the purpose of establishing proper spinal alignment thus allowing normal nerve conduction throughout the body. The success of chiropractic care often depends on the environment, underlying causes, and the physical and spinal conditions of each individual patient.
Chiropractic Analysis	The doctor will conduct a clinical analysis for the express purpose of determining the presence of the vertebral subluxation and the effects of the vertebral subluxation complex. If such is not detected, the patient will be informed and an attempt to refer the patient to an appropriate health care provider will be made.
Clinical Results	The purpose of chiropractic care is to promote health though the correction of the vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule, degree of response, or the efficacy of the chiropractic adjustment for any given patient. However, the doctor may make recommendations for clinical management based upon known circumstances and clinical experience. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic is licensed to provide a specialized, unique, health care service. The Chiropractor is licensed in a special area of practice and is available to work with other providers in your health care regimen.
Medical Diagnosis	Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine and its effects on the nervous system, they are not internal medical or surgical specialists. Therefore, every patient should be mindful of their own symptoms and should secure other opinions should they have any concerns as to the nature of any other symptoms or their total health picture. Your Doctor of Chiropractic may express an opinion as to whether or not further consultation is necessary, but the patient is responsible for the final decision and any subsequent action.
Contra-indications To Chiropractic Care	Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as vascular accidents, fractures and disc injury. The doctor, of course, will not perform any procedures if there is awareness that such care may be contra-indicated. It is the responsibility of the patient to make it known if they are aware that they are suffering from: pathological conditions, illnesses, injuries, or deformities which may be known to the patient but have not have otherwise come to the attention of this doctor. By signing below, the patient affirms that they have been open and truthful in disclosing their health history, and gives the doctor permission and authority to examine and care for them in accordance with recognized standards and acceptable chiropractic analytical and corrective procedures.
Patient Consent For Care	***Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.*** I have read and understand the foregoing. I hereby request and authorize the doctor to render chiropractic care to me: _____ _____ *Signature of Patient, Parent, or Guardian* *Date*