



Thank you for choosing Palmer Chiropractic Clinic for your wellness needs. As a new patient to our practice, we would like to welcome you and provide you with important information.

Enclosed you will find new patient forms that should be completed prior to your appointment. Completing these forms in advance will ensure completeness and timely processing in our office.

In addition to the new patient forms, please bring with you the following items:

- Photo ID
- Insurance Card(s)
- Any Test Results (MRI, CT Scan, X-Rays)
- Form of payment, payments are due at the time of service

Please arrive at your scheduled appointment time. This scheduled time is 15-minutes before your actual appointment, allowing us time to process your paperwork.

Should you need to reschedule your appointment at any time, you may do so by calling our office at 405-375-5497. For your convenience, there is a 24-hour answering machine.

Once again, WELCOME to Palmer Chiropractic Clinic where commitment to your health and well-being is our priority!

See you soon!

NEW PATIENT QUESTIONNAIRE



PATIENT INFORMATION

Name: _____ Nickname: _____
First Middle Last
Marital Status: (circle one) Single / Married / Separated / Divorced / Widowed Birth Date: ____ / ____ / ____
Home Address: _____ Home phone _____
P.O Box or Street City Zip Cell phone _____
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? (MRI / Xray?) _____
Date of Accident OR *Beginning of Complaint*: (ex. 2 weeks/ off & on for years?) _____
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)



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 \$45.00 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 \$45.00 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

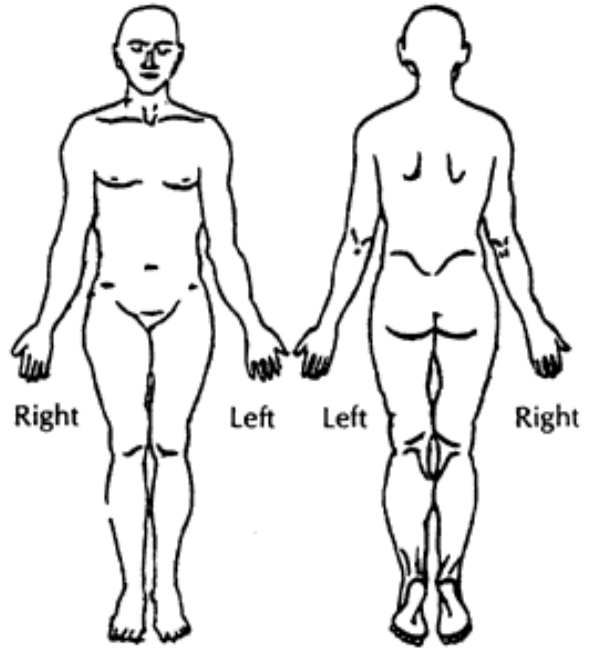
Signed _____ Date _____

HEALTH QUESTIONNAIRE

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 (✓)
if applicable to your
CURRENT or 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)



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 through 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 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