Palmer Chiropractic Center of Lynchburg — Patient Information and History

PATIENT INFORMATION

Date__________ Home Phone______________________

Name____
LAST NAME FIRST NAME INITIAL

Address_______________________________________

____

Sex M F Age________Birthdate______________

SS#________________________Marital Status_________

Occupation____________________________________

Employer______________________________________

Cell Phone:____________________
○ (check if primary contact #)

Tobacco Use:
○ Never ○ Current every day ○ Current sometimes ○ Former

Spouse's Name_________________________________
Does your spouse have permission to access your medical records? ○ Yes_____ ○ No______
Initial Initial

Whom may we thank for referring you?___________________________
○ Provider ○ Friend ○Family ○Previous patient ○ Other

IN CASE OF EMERGENCY, CONTACT:

Name_____________________Relationship______________

Home Phone______________Work Phone_______________

INSURANCE

Do you have Medicare? Yes No

Primary Insurance Co._________________________________

Secondary Insurance Co._______________________________

Is patient covered by any additional insurance? Yes No

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with______________________________ and assign directly to Palmer Chiropractic Center of Lynchburg, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance as well as interest of 1.5% per month, attorney's fees, collection agency fees and costs associated with the collection of overdue balances. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Patient / Guardian Signature

_________________________________ ________________
Relationship Date

How you heard of us: **○Walk-in ○Referral ○Phone Book**

○Website ○Google search ○Facebook ○Other_____________

Is condition due to an accident? Yes No

Date of accident______________ In which state?____________

Type of accident Auto Work Home Other_____________

PATIENT CONDITION

Reason for visit_____________________________________ When did your symptoms appear?________________________

Is this condition getting progressively worse? Yes No Unknown How often do you have this pain?____________________

Is your pain? Constant or does it? Come and go Does it interfere with your? Work Sleep Daily Routine Recreation

Activities that are painful to perform? Sitting Standing Walking Bending Lying Down

Indicate on the diagram the type of pain using the symbols below.

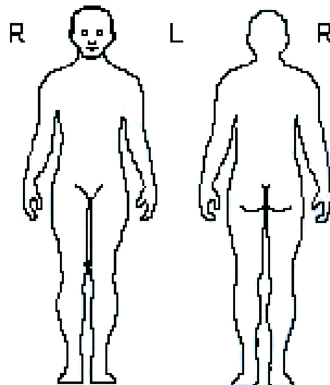
Ache : ZZZ

Burning : BBB

Numb : XXX

Pins & Needles : = = =

Stabbing : ///



List each area of pain (IE. Neck or Back)	**How severe is your pain today?** 0 = No Pain 10 = Intolerable
__________________	________
__________________	________
__________________	________
__________________	________
__________________	________

Patient Information and History (continued)

Print Name:________________________________

Primary Care Physician ____________________________ **Specialist** ________________________________ **Type**__________

Patient Height: ___'____" **Patient Weight:** __________ **lbs.**

Date of Last: (If none, write N/A)

Physical Exam_______________	Spinal X-Ray_______________	Spinal Exam_______________
Blood Test_________________	Chest X-Ray________________	Urine Test________________
Dental X-Ray_______________	MRI/CT-Scan/Bone Scan______________	Bone Density_______________

Check any treatments have you already received for the condition you are being seen for today?

(Medications) (Surgery) (Physical Therapy) (Chiropractic) (Injections) Other __________________________________

Please check symptoms you currently have:

Dizziness/Loss of Balance	Loss of Memory	Ringing/Buzzing in Ears	Depression	Nausea
Visual/Sensory Disturbance	Lightheadedness	Loss of Concentration	Headaches	Burning Eyes

Have you ever suffered from:

□ Dizziness	□ Arthritis	□ Digestive Disorders
□ Backaches	□ Headaches	□ Nervousness
□ Heart Trouble	□ Numbness	□ Sinus Trouble
□ Diabetes	□ Asthma	□ Anemia
□ Hernia	□ Neuritis	□ Cancer
□ Disc Bulge/Herniation	□ Pinched Nerve	□Whiplash

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? YES NO UNCERTAIN

EXERCISE		**WORK ACTIVITY**		**LIFESTYLE**	
None	Daily	Sitting	Light Labor	Smoking Packs/Day______	Coffee/Caffeine (Cups/Day_____)
Moderate	Heavy	Standing	Heavy Labor	Alcohol Drinks/Week____	High Stress Level (Reason________)

INJURIES/SURGERIES YOU HAVE HAD

(If none, write N/A) (Description) (Date)

Falls	____________________________________	__________
Head Injuries	____________________________________	__________
Broken Bones	____________________________________	__________
Dislocations	____________________________________	__________
Surgeries	____________________________________	__________

Please list below anything you are currently taking.

MEDICATIONS (start date)	**VITAMINS/HERBS**
____________________	_____________________
____________________	_____________________
____________________	_____________________
____________________	_____________________
____________________	_____________________

ALLERGIES: ○ If none check____

I authorize the release of
my medical records to: _________________________ _______________ _________________________ _________________
Name Relation Name Relation

I have read, understood, and agree to the foregoing. I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of this clinic responsible for any errors or omissions that I may have made in the completion of this form. I understand that the doctor will be relying on the above information and all other information that I supply in his treatment of me. I hereby give permission to the doctor and whomever he may designate as his assistants to administer treatment and/or therapy, and perform such procedures as he may deem necessary in the diagnosis and/or treatment of my condition. I certify that no guarantee has been made as to the results that may be obtained.

Patient / Guardian Signature____ Date___________________________