Pamer Chiropractic Health Center
Patient Information

Full Name: ______________________________ Date: ______________

Address: ______________________________ City: ______________ State: _____ Zip: _________

Date of Birth: ____________ Age: ______ ❑ Male ❑ Female Email: ______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Employer: ______________________________ Occupation: ______________________________

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Spouse's Name: ______________________________

Emergency Contact Name/#: ______________________________ Referred by: ______________________________

Children's Names/Dates of Birth: ______________________________
____

______________________________ ______________________________

List the major health concerns/issues that interfere with the healthy lifestyle you choose for yourself (for example: sickness, illness, stress, overweight, habitual practices, work, etc.):______________________________

____

Current complaints and symptoms and how do they interfere with your normal living and work? ______________________________

____

What type of treatment(s) have you had for your current complaints/symptoms? (for example: chiropractic care, medications, therapies, vitamins, etc.):______________________________

To improve your health and well being, are you interested in? (check all that apply): ❑ chiropractic spinal adjustment ❑ weight loss ❑ nutritional consulting ❑ specific exercise program ❑ other (specify)______________________________

What hereditary or genetic issues could affect your health? ______________________________

How committed are you to reaching and maintaining your health goals? Circle on a scale of 1 to 10 your level of commitment:
Least 1 2 3 4 5 6 7 8 9 10 Most

To better understand the best approach to lifetime wellness, indicate your current and past health status. Please check mark if you have had any of the following:

❑ Polio	❑ Small Pox	❑ Rheumatic Fever	❑ Sciatica
❑ Alcoholism	❑ Appendicitis	❑ Malaria	❑ Typhoid Fever
❑ Pneumonia	❑ Measles	❑ Whooping Cough	❑ Pleurisy
❑ Lumbago	❑ Chicken Pox	❑ Anemia	❑ Mental Disorders
❑ Scarlet Fever	❑ Goiter	❑ Cancer	❑ Tuberculosis
❑ Diabetes	❑ Diphtheria	❑ Rheumatism	❑ Arthritis
❑ Venerial Infection	❑ Heart Disease	❑ Mumps	❑ Epilepsy

Operations:

Date ____________ Tonsillectomy	Date ____________ Appendectomy	Date ____________ Hernia
Date ____________ Gall Bladder	Date ____________ Female Organs	Date ____________ Thyroid
Date ____________ Back Operations	Date ____________ Rectal Surgery	Date ____________ Stomach

Other not listed above with dates: ______________________________

Please check all of the following symptoms and signs which you now have or have had withing the last 6 months.
An understanding of you health status will help facilitate care.

GENERAL SYMPTOMS:
❑ Headache
❑ Fever
❑ Chills
❑ Night Sweats
❑ Fainting
❑ Dizziness
❑ Convulsions
❑ Loss of Sleep
❑ Fatigue
❑ Nervousness
❑ Weight Loss
❑ Numbness or Pain in Arms, Legs or Hands
❑ Allergies
❑ Wheezing
❑ Neuralgia

MUSCLES & JOINTS:
❑ Weakness
❑ Twitching
❑ Stiff Neck
❑ Backache
❑ Swollen Joints
❑ Tremors
❑ Foot Trouble
❑ Painful Tailbone
❑ Pain Between Shoulders
❑ Hernia
❑ Spinal Curvature

GASTRO-INTESTINAL:
❑ Poor Appetite
❑ Poor Digestion
❑ Excessive Hunger
❑ Belching or Gas
❑ Nausea
❑ Vomiting
❑ Vomiting Blood
❑ Stomach Pain
❑ Constipation
❑ Diarrhea
❑ Colon Trouble
❑ Hemorrhoids (Piles)
❑ Liver Trouble
❑ Jaundice
❑ Gall Bladder Trouble
❑ Irregular Bowel Movement

CARDIO-VASCULAR:
❑ Rapid Heartbeat
❑ Slow Heartbeat
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Pain Over Heart
❑ Previous Heart Trouble
❑ Swelling of the Ankles
❑ Poor Circulation
❑ Varicose Veins
❑ Stroke

EYE, EAR, THROAT, NOSE:
❑ Poor Vision
❑ Crossed Eyes
❑ Pain in Eyes
❑ Deafness
❑ Earache
❑ Ear Noises
❑ Nasal Obstruction
❑ Sore Throat
❑ Hoarseness
❑ Hay Fever
❑ Asthma
❑ Frequent Colds
❑ Enlarged Thyroid
❑ Tonsillitis
❑ Sinus Trouble

SKIN OR ALLERGIES:
❑ Skin Eruptions
❑ Itching
❑ Bruising Easily
❑ Dryness
❑ Boils
❑ Sensitive Skin
❑ Hives or Allergies
❑ Eczema

RESPIRATORY:
❑ Chronic Cough
❑ Spitting Blood
❑ Spitting Phlegm
❑ Chest Pain
❑ Difficulty Breathing

GENITO-URINARY:
❑ Frequent Urination
❑ Painful Urination
❑ Blood in Urine
❑ Kidney Infection
❑ Bed Wetting
❑ Inability to Control Urine
❑ Prostrate Trouble

FOR WOMEN ONLY:
❑ Painful Periods
❑ Excessive Flow
❑ Irregular Cycles
❑ Hot Flashes
❑ Cramps and/or Backaches
❑ Miscarriage
❑ Vaginal Discharge
❑ Pregnant at this time

HABITS:
❑ Smoking #____ packs per day
❑ Drinking Alcohol
❑ Coffee #____ cups per day

EXERCISE:
❑ None
❑ Moderate
❑ Daily

Additional Comments: ________________

List any accidents or falls with dates: ____________________

Broken bones or dislocations with dates: ____________________

I hereby authorize Pamer Chiropractic Health Center and it's doctors to administer care to myself and my family as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: ____ Date: ____________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

In the course of your care as a patient with Pamer Chiropractic Health Center, we may use or disclose personal and health related information about you in the following ways:

- It may be used as a means of communication among health professionals who contribute to your care for further diagnosis and treatment.
- It may be used to obtain payment from a third party, such as an insurance company or Medicare and Medicaid.
- It may be used as a means to contact you regarding appointment reminders, information about alternatives to your present care and other health related information that may be of interest to you.

The physical record of your health is the property of the healthcare provider, or the facility that compiled it. However, the underlying information belongs to or is available to you. The ability to:

- Inspect and obtain a copy of your health record, except in limited circumstances you may be charged a reasonable fee for copying.
- Revoke your authorization to use and disclose health information except to the extent that action has already been taken. This will not affect the care provided to you or the reimbursement avenues associated with your care.
- Request communications of your health information by alternative means or at alternative locations if we are providing health care to you based on orders provided by other health professionals. Any use of your health information will be only disclosed upon your written authorization. Information that we use or disclose based on this privacy may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.
- If we provide health care services to you in an emergency.
- Obtain a copy of the Notice of Privacy Practices upon request.

Our responsibilities at Pamer Chiropractic Health Center are:

- Maintain the privacy of your health information.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Abide by the terms of our Notice of Privacy Policies.

We reserve the right to change our practices at any time and to make new provisions effective for all protected health information we maintain. You will be provided a copy of our new Notice of Privacy Practices if any information changes.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Andrew T. Pamer, D.C.

If you would like further information about our privacy policies and practices, please contact:

Pamer Chiropractic Health Center
66 Swartz Road
Akron, OH 44319
#(330)724-9331

I acknowledge that Pamer Chiropractic Health Center “Notice of Privacy Practices” has been provided to me.

____ ______________________

Signature of Patient or Patient Representative Date

I, hereby authorize Pamer Chiropractic Health Center to use the following protected health information and/or disclose the information to Pamer Chiropractic Health Center:

- Names
- Dates of birth
- Testimonials
- Photographs and/or articles of individual accomplishments

For the following purposes:

- To display on bulletin board or patient testimonial books in the office; to send you information by phone, text, fax, mail or email (for example: newsletters, special programs, etc.) to use portions/all of your testimonial in the media (for example: newspapers, radios, flyers, etc.).
- To share with the Preferred Chiropractic Doctors Company (if applicable) for purposes of enrollment or other vital aspects of their program.
- To contact you by phone, text, fax, mail or email for missed appointments or any other patient issues regarding your health.

I understand this information, I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Andrew T. Pamer, D.C. at 66 Swartz Road, Akron, OH 44319. I understand that a revocation is not effective to the extent that Pamer Chiropractic Health Center has relied on the use or disclosure of the protected health information. Pamer Chiropractic Health Center will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure.

Your Signature indicates your authorization of this activity.

____________________	____________________	_______________
Print Name	Signature	Date

Patient Authorization regarding chiropractic care being provided in an “open adjusting” environment.

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” can involve several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is the environment used for taking patient histories, performing examinations and presenting reports of findings. These procedures can be completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as “incidental disclosure” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters, in the event that you or someone else would not agree with us, we are providing disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to do your patient history, have a chiropractic examination, be present with a report of findings or be adjusted in a “open adjusting” environment, other arrangements will be made for you. Your decision will have no adverse effect on your care at Pamer Chiropractic Health Center or your relationship with our staff.

Your signature indicates your authorization of this activity.

____________________	____________________	_______________
Print Name	Signature	Date

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for change in our procedures to be

completed.

Terms of Acceptance

When a patient seeks chiropractic health care and the doctor feels such health care will be beneficial, it is essential for both to be working towards the same objective.

Chiropractic has only one goal, it is important that each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and the interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____ have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis for myself and/or my family and grant permission for any minor children to be evaluated and receive chiropractic care being their parent or legal guardian.

____ ________________________
Signature of Patient or Patient Representative Date