CHIROPRACTIC

Pamer Chiropractic Health Center, Inc...

Patient Information

Full Name: ____ Date: ______________

Address: _____________________________ City: ________________ State: ___ Zip: ______

Date of Birth: __________ Age: ____ ❑ Male ❑ Female Email: ______________________________

Home Phone: ___________________ Cell Phone: __________________ May we text you? ❑ Yes ❑ No

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

Employer: _________________________ Occupation: ________________________________

Emergency Contact Name: ______________________________ Relationship: _________________

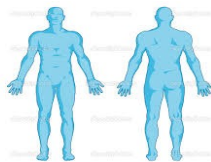
Phone #: ___________________ Whom may we thank for referring you? ________________________

Patient Condition

Reason for visit: ____

When did your symptoms appear? _________________ Is this condition progressively getting worse? ❑ Yes ❑ No

Front Back



Please mark an 'X' on the picture where you continue to have pain, numbness, or tingling.

Type of pain of pain (mark all that apply): ❑ Sharp ❑ Numbness ❑ Burning ❑ Stiffness ❑ Dull ❑ Throbbing ❑ Tingling ❑ Swelling ❑ Cramping ❑ Aching ❑ Shooting

Rate the severity of your pain on a scale of 1 to 10: ____ How often do you have this pain? ___________________

Is it constant or does it come and go?_________ Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

What type of treatment(s) have you had for your current complaints/symptoms? (i.e. chiropractic care, medications, therapies, surgeries, vitamins): ____

Have you noticed anything that makes it better? (i.e. ice pack, heat, different postures/positions): ____________________
____

Have you noticed anything that makes it worse? (i.e. movement, different postures/positions): ___________________
____

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) ____________________________

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

List any accidents and/or falls: ____

List any broken bones and/or dislocations: ____

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

Operations:

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

Other not listed above with dates: ____

Please check all of the following symptoms which you now have or have had withing the last 6 months.

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
- ❑ Skin Eruptions

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:
- ❑ 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: ___________________________

____
____
____
____
____
____
____
____

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.

_______________________________ Print Patient Name

_______________________________ Signature of Patient or Patient Representative

_______________ 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 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 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 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.
- 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, contact: **Pamer Chiropractic Health Center, Inc. / 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.

Print Patient Name	Signature of Patient or Patient Representative	Date

Individual Privacy Rights

The U.S. Department of Health and Human Services (HHS) established, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), that when paying by cash, it is my right to withhold any personal information about myself and my health status from any person, family, agency, association or organization including the Federal, State and Local government and/or their agencies, along with any insurance companies and/or third party payers.

I understand and accept that Pamer Chiropractic Health Center, Inc., is a chiropractic office which provides healthcare on a preventative, maintenance and a quality of life basis that will have knowledge about me and my health status. Therefore, I request that any of my health records, including my past health history, current health records and/or my future health status, NOT be shared by Pamer Chiropractic Health Center, Inc., with any person, family, agency, association or organization; specifically Federal, State and Local governments and/or their agencies including Medicare and Medicaid as well as any insurance companies and/or third party payers.

Should I choose a healthcare provider that does share health information about me and/or my health status, I request that Pamer Chiropractic Health Center, Inc., NOT disclose any information about me to them.

Should I choose financial assistance or reimbursement for any healthcare services, such as those Pamer Chiropractic Health Center, Inc., provides it's patients, from any third party payer, insurance company or federal agency including Medicare and Medicaid, I request that Pamer Chiropractic Health Center, Inc., NOT disclose any information about me to them.

Should I ever change my mind about my request for privacy, I will notify Pamer Chiropractic Health Center, Inc., in writing and detail how I would desire future disclosure of information about me.

Print Patient Name	Signature of Patient or Patient Representative	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 family members being seen in the same adjusting room at the same time. It can, also, mean patients can be in rooms next to other patients 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, if requested.

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 Patient Name	Signature of Patient or Patient Representative	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 Patient 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