Palmer CHIROPRACTIC
a family wellness clinic

Patient Information

Name: _____ Date of Birth: _____/_____/_____

Mailing Address: Street: _____
City: _____
State, Zip: _____

Phone Number: Primary: (_____) _____-_____ Secondary: (_____) _____-_____
*E-Mail Address: _____

*We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.

I authorize contact in the following manner: (check all that apply)

☐Cell ☐Via text/ email communication ☐Home ☐Work

☐Leave message with detailed information ☐Leave message with call back number only

Occupation: _____ Employer: _____ Regular work status: FT PT

Sex: Male Female **Weight:** _____lbs **Height:** _____ft _____in.
Marital Status: Single Married Divorced Widowed

Spouse's Name: _____ Number of children: _____
Emergency Contact: _____ Relationship: _____

Who is responsible for your bill? Self Spouse Employer Parent Insurance (Auto or Work Related)

Who may we thank for referring you to our office? _____

Thank you for choosing Palmer Chiropractic in recovering and optimizing your health. We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. You were given a copy of our office and financial policies; please read them, agree to, and sign prior to any treatment.

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of Chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctors to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signed _____(Patient or Guardian) Date _____

Name:_____ Date:____/____/____

Current Complaint	How Intense? (0-none 10-worst)	How Frequent? (100%, 75%, …)	What does it feel like?
1._____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	_____
2._____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	_____
3._____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	_____

Goals For My Care:

Choose the reason that best describes your reason for consulting our office:

_____ I have a specific concern and require only help with this
_____ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
_____ I want to be healthier five years from now than I am today
_____ Other, please explain: _____

When did this concern begin? _____

_____

Does this concern interfere with: WORK SLEEP DAILY ROUTINE OTHER ACTIVITIES
Explain: _____

_____

_____

Has this concern occurred before? YES NO briefly explain: _____

_____

Have you seen another doctor for this? YES NO Doctor's name _____
Type of treatment: _____

List any previous accidents, injuries (i.e.: car accident, sports injuries…) or surgeries: _____

_____

List any major illness or broken bones: _____

_____

Are you currently under any other doctor's care? YES NO Who and for what reason: _____

_____

List current medications and/or supplements: (name, amounts, frequency, length of use, reason for use)

_____

_____

Health Habits:

□Take Nutritional Supplements
□Exercise Regularly
□Drink Alcohol
□Tobacco use _____ pk/day for _____ days
□Drink Water _____ glasses/day
□Coffee _____ cups/day
□Aspirin, Ibuprofen… How often? _____

Sleep Habits:

□Stomach
□Back
□Side

Have you had x-rays taken within the last 3 years? YES NO What areas? _____

WOMEN ONLY: Is there ANY possibility you may be pregnant? YES NO

Date of first day of last menstrual cycle: (day and month) _____