Patient Information (Please Print)

Name_____ Date _____ SSN_____

Address _____ City _____ State_____ Zip _____

Birth Date _____ Age _____ Home Phone _____

Work Phone _____ Cell Phone _____ Email_____

(circle) Male Female Minor Married Single Number of children _____

Employer _____ Occupation _____

Business City _____

Spouse's or Parent's name _____ Emergency Contact _____Phone_____

Reason for Visit _____

If you are here for symptom care what are your symptoms:

_____

When did the symptoms start? : _____

How did the symptoms start? : _____

Where specifically are the symptoms located? : _____

Is the symptom getting worse with time? : Y N

What makes the symptom: Better? : _____ Worse? : _____

Which activities are difficult to perform? : sitting walking bending lying down _____

What treatment have you already tried? : Medication _____ Physical Rehab _____

Surgery _____ Other _____

What other doctors have you seen for this symptom? : _____

Health History (circle those that apply)

AIDS/HIV	Anemia	Abdominal surgery	Arthritis	Diabetes
Bleeding Disorder	Cancer	Depression	Osteoporosis	Epilepsy
Irregular Heart beats		Pacemaker	Prostate problems	Stroke
Prosthesis	Thyroid Problem	Other _____		

HOW DID YOU HEAR ABOUT US?_____

List all medications you are taking _____

Do you smoke: Y N ____ packs per day How much alcohol do you drink a week? _____

Please list any surgeries you have had and when:

_____

_____

_____

_____

If you are here for wellness care to prevent sickness, what else do you do for health and wellness: _____

How often do you exercise? _____ a week

How many times a day do you eat a meal? _____

Our purpose is not just to get you healthy but to keep you healthy. Does this align with your own thoughts? Y N please explain: _____

What is your definition of health:

_____

_____

Assignment and Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Palmer Care Chiropractic, any insurance benefits otherwise payable to me. I understand that I am responsible for all charges. If the doctors are participating providers for my insurance, I understand that I am responsible for any co-payments, deductibles, or other charges in accordance with my plan. I also understand that should my account be placed with an agency or attorney for collection, then I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest at 1.5% per month (18% annual), and all court costs.

Signature of Patient (Or Parent)_____Date_____

FAMILY HEALTH AND WELLNESS ANALYSIS

(place an X in those boxes that correspond)

	Self	Spouse	Sister	Brother	Son	Daughter	Mother	Father
ADD								
Ear Infections								
Headaches								
Sinus Trouble								
Allergies								
Commonly Have Colds								
Asthma								
Heart Problems								
Breathing Problems								
Digestive Problems								
Constipation								
Carpal Tunnel Syndrome								
Weakness In Hands or Feet								
Dizziness								
Chest Pains								
Decreased Vision								
Pain or Stiffness in Neck								
Common Fevers								
Fatigue								
Acid Reflux								
Menstrual Problems								
Pregnant								
Infertility								

	Self	Spouse	Sister	Brother	Son	Daughter	Mother	Father
IBS								
Crohn's Disease								
Heartburn								
Shoulder Dysfunctions								
Elbow Pain								
Wrist Pain								
Hip Pain								
Knee Pain								
Ankle/ Foot Pain								
Plantar Fascitis								
TMJ Syndrome								
Other								

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Palmer Care Chiropractic we may use or disclose personal and health related Information about you in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted be alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your projected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us.

We may also mail information to you regarding your health care status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

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We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

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: Dr. Scott Allen

If you would like further information about our privacy policies and practices please contact: Dr. Scott Allen

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of June 27, 2005. This notice, and any alterations or amendments made here to will expire seven years after the date of the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____

(Name:Printed) (Signature)

_____

(Date)

If you are a minor, or if you are being represented by another party.

_____

_____ (Personal Rep)

(Rep Signature)

_____

(Description of authority to act)

INFORMED CONSENT TO TREATMENT

The primary treatment used by doctors of chiropractic is spinal manipulations or adjustments. We will use this procedure in your treatment program.

The nature of Chiropractic manipulation/adjustment: We will use our hands to manipulate or loosen and reposition the joints of your spine. Often with this procedure, you will hear a popping noise associated with the loosening and repositioning. We may also use a mechanical adjusting instrument, called an Activator.

The material risks inherent to Chiropractic manipulation/adjustment: As with any health care procedure, there are certain complications that may arise from chiropractic manipulation. These complications may include aggravation of degenerative or injured spinal discs, rib fractures, ligament sprains, muscle strains, nerve injury or spinal cord compression. Manipulation of the neck has been associated with injury to arteries in the neck leading to or contributing to stroke. Local soreness and/or stiffness is typical in the early phases of treatment.

Probability of those risks occurring: Fractures are rare occurrences and generally result from underlying bone weakness which we check for during your history, examination and x-rays. The exact incidence of stroke is uncertain, but it is generally believed to occur in less than one per million treatments. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include: -over the counter medications and rest
-Medical care which may include anti-inflammatory drugs, muscle relaxants, and pain medications
-Surgery

Material risks inherent to your other treatment options: The common analgesics and anti-inflammatory drugs have been shown to cause damage to the stomach and intestines, and possibility to the kidneys. Approximately 1 in 150 patients taking anti-inflammatory drugs for extended time periods require hospitalization for stomach ulceration. There are about 16,500 deaths in the U.S. each year from these complications, which is more common than deaths from either Hodgkin's disease or cervical cancer. The risks are similar for both prescription anti-inflammatories as well as over-the-counter medications.

Spine surgery may be a consideration for some cases. It, however, is reserved for those cases where extensive conservative treatment has been tried. Spinal surgery is associated with a minor complication rate of between 9 per 100 and 15 per 100 cases depending on the area of the spine involved. More serious complications of the nervous system may occur in 1 per 400 cases, and death has been reported in approximately 1 per 1500 cases.

While spinal manipulation is associated with complications in a smaller number of cases, it has a complication rate of several thousand times less than other typical treatment options.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read _____ or had read to me ____ the above explanation of chiropractic manipulation or adjustments and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is the best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date:_____ Print Name: _____
Signature: _____
Guardian Signature: _____
Witness Name: _____
Witness Signature: _____

HEALTH CARE EDUCATION OPTIONS:

_____ / / Tues _____am Partner's name: _____

_____ / / Thurs _____pm