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:

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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? : ________________________

HOW DID YOU HEAR ABOUT US?____

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 ____		

List all medications you are taking ____

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

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:

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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 authorize the use of this signature on all insurance submissions. Patient accounts with balances over 30 days old are charged an annual interest rate of 12% (1% monthly).

Signature of Patient (Or Parent)__________________________________Date____________