

CONFIDENTIAL PATIENT INFORMATION

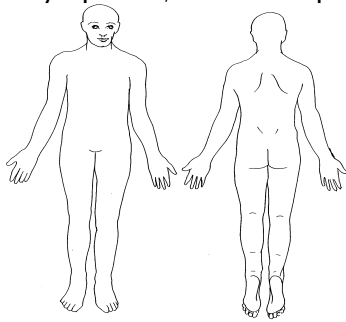
Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Home Phone: (____) _____
 Work Phone: (____) _____
 Cell Phone: (____) _____
 Email: _____@_____._____
 Social Security Number: _____

Date of Birth: _____ Age:
 Occupation: _____
 Employer: _____
 Marital Status: **M S D W** Spouse's Name: _____
 Emergency Contact: _____
 Phone: (____) _____
 Who may we thank for referring us to you?

 Date of Complaint/Accident: ____/____/____

Chief Complaint: _____

Place a letter on the drawing below on areas causing you symptoms/decreased performance



A = Ache **B** = Burning **S** = Stabbing
N = Numbness **P** = Pain **D** = Discomfort

PAIN SCALE

0	1	2	3	4	5	6	7	8	9	10
None		Little			Medium			Severe		

Describe your past health history:

Prior Illness: _____

 Past Hospitalizations : _____

 Surgeries: _____

 Medications: _____

Is this visit related to a(n):

- Work injury
- Athlete's Peak Performance Care
- Sports or Recreational Injury
- Car Accident/Motor Vehicle Accident
- Other: _____
- Do you anticipate litigation for this injury?

I am interested in the following:

- Chiropractic Wellness Care
- Personal Training
- Private Soccer Coaching
- Custom Orthotics
- Ergonomics/Workspace Eval
- Massage
- Diet/Weight Loss
- Vitamins/Support
- Pediatric Wellness Car

TODAY'S DATE: _____



135 West Pine Avenue, Longwood, FL 32750
 407.682.8444 www.palmerwellnesscenter.com

Patient Review of Systems

Please check the “**Current**” box for all conditions that you are now experiencing and mark the “**Ever**” symptom(s) experienced at any time in your life. Please do not write in the spaces marked “**Doctor’s Notes Only.**”

Doctor’s Notes Only

Please do not write in
this space.

Doctor’s Notes Only

Please do not write in
this space.

General

	Current	Ever
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Change in routine	<input type="checkbox"/>	<input type="checkbox"/>

Head

Headache	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>

Eyes

Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>

Ears

Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infection	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Drainage	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>

Nose

Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>

Mouth

Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>

Lungs

	Current	Ever
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Vascular

Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>
Cold feet or hands	<input type="checkbox"/>	<input type="checkbox"/>
Discolored foot/hand	<input type="checkbox"/>	<input type="checkbox"/>
Hot feet or hands	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>

G–I System

Gas	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>

G–U System

Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>
Increased urination	<input type="checkbox"/>	<input type="checkbox"/>
Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>
Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>
Genital infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Notes Only
Please do not write in
this space.

Doctor's Notes Only
Please do not write in
this space.

Neck

- Masses
- Swelling
- Stiffness
- Psychologic
- Excessive stress
- Depression
- Anxiety
- Mood swings

Skin

- Rash
- Bruising
- Hair loss
- Warts
- Brittle nails
- Changes in moles
- Itching
- Peeling

Neurologic

- Seizures/epilepsy
- Strokes
- Tingling sensation
- Numbness
- Weakness
- Difficulty walking
- Poor coordination

Muscle/Bone

- Joint pain
- Stiffness
- Muscle ache
- Arthritis
- Deformity
- Bone pain
- Fractures
- Dislocations

Conditions

- Hypertension
- Diabetes
- Thyroid condition
- Heart condition
- Rheumatoid arthritis
- Rheumatic fever
- Glaucoma
- Alcoholism
- Cancer/tumor
- Polio
- Parkinson's
- Multiple Sclerosis
- Gout
- Anemia
- Osteoporosis
- Osteoarthritis

Medication

Please bring a list of
prescription medications.

Please bring a list of non-
prescription medications.

- Drug allergies
- Recreational drug use

Medical

- Surgery—any area
- Hospitalization
- Prior prescriptions
- Psychiatric care
- Substance abuse

Social

- Consume alcohol
- Consume coffee
- Consume tea
- Consume sodas
- Smoker
- Aerobic exercise
- Sleep

**Please bring in a list
of vitamins you take.**

- Herbs
- Hobbies
- Water intake/day
- Allergies

Ob Gyn

Date

- Age period began _____
- Last breast exam _____
- Last PAP date _____
- Pregnancy—present _____
- Pregnancy—past _____
- Mastectomy
- Lump in breast
- Nipple discharge
- Hysterectomy
- PMS
- Irregular periods
- Hot flashes
- Menstrual cramps

Signature _____ Date _____

Patient Name _____ File # _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice, while it is in effect. This Notice takes effect: **04-15-03**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician/dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We may from time to time contact you by mail or phone to update you on information that may be pertinent to your dental health unless you state in writing otherwise.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities, if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.



Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards, or letters), birthday cards, or recall cards and missed appointment notification.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. **(You must make a request in writing to obtain access to your health information).** You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for duplication of your records and x-rays.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing).** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. **(Your request must be in writing, and it must explain why the information should be amended).** We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), your are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file you complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

- I agree with this Notice of Privacy Practices and all that is held within.
- Individual Refused to Sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other: Please specify: _____

Patient Signature

Date

Print Name

OP 5021 3/2/03

135 West Pine Avenue
Longwood, FL 32750
407.682.8444

com



ASSIGNMENT OF BENEFITS / PAYMENT

I hereby assign from any and all Group insurance policies which provide medical benefits or, all benefits, rights, title and interest to **Palmer Chiropractic & Sports Medicine** as Assignee, for services rendered unto me both by reason of accident or illness. This is to act as an limited assignment of my rights and benefits to the extent of the Assignees services provided and in no way should be construed as a delegation of any duties under said insurance policy by the Assignor to Assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action in tort or contract and proceeds from such causes of action, that I might have or that might exist in my favor against such insurance company and authorize Assignee to prosecute said cause of action either in my name or Assignee=s name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize said insurance company to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. I further agree to pay any applicable deductible or co-payment not covered by my insurance. In the event that I do not have insurance coverage, I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

CASH PAYMENT I understand that I am not utilizing insurance for payment. I remain personally responsible for payment of services rendered. If and when insurance is presented, I will follow the guidelines as outlined in this assignment pertaining to insurance.

RELEASE OF INFORMATION

I hereby authorize Assignee and/or his office to disclose/release any information concerning my illness / injuries protected by the Federal HIPPA to a requesting party with a properly executed medical records release.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT _____

DATE _____

Print Name: _____



Palmer Chiropractic & Sports Medicine is proud of the excellent healthcare we provide our patients/athletes. We use low force, gentle, Chiropractic techniques to provide quality Chiropractic/Wellness Healthcare. Athletes demand a lot from their body; they are often challenging patients requiring expertise not only in neurological/orthopedic issues but also knowledge of their particular sport. Dr. Palmer, Doctor of Chiropractic, Certified Athletic Trainer,(NATA) and Certified Strength and Conditioning Specialist (NSCA), is a leading Chiropractor in her field having over ten years experience in sports healthcare working with amateur, elite, and professional athletes, in sports ranging from collegiate hockey to professional women's soccer. An athlete herself, she understands the frustration of limiting injuries. As a Healthcare team, Dr. Palmer and her staff look forward to returning you to the activities you enjoy, preventing them from reoccurrence, and improving the quality of your health. Please feel free to address any questions/concerns with Dr Palmer, she is happy to answer any questions regarding your healthcare and the healthcare of your family!

Informed Consent

I (the patient/guardian) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy (ultrasound, massage, traction) and diagnostic X-rays, on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future work at Palmer Chiropractic & Sports Medicine. On field care may consist of minor first aid, injury assessment, and /or emergency first responder care in conjunction with on field athletic trainers, emergency medical technicians, paramedics, and other health care staff.. In the event of emergency the parent/guardian will be notified as soon as possible.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Emergency Contact Name _____ Phone _____



Office Policy

Your appointment is reserved especially for you. Kindly give at least 24 hours notice if you cannot keep your scheduled appointment. Patients who do not give at least 24 hours notice will be charged a \$25 missed appointment fee.

I have read and understand the Cancellation Policy. _____
Please initial.

(Print full name.)

I give/do not give (please circle your choice) permission to Palmer Chiropractic & Sports Medicine to call and leave a voice mail on the phone number listed on my patient information sheet or with whoever answers the phone. You have also received the Notice of Privacy Practice by HIPPA. The best number to reach me at is _____ or email address _____

Signature Date

I would like an appointment reminder call _____ Yes or _____ No

Effective date June 11, 2007