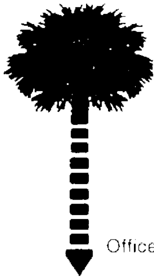


PALMETTO SPINAL CENTER, L.L.C.
Patient Information

Thank you for choosing our practice. In order to serve you properly, we need the following information that will be kept confidential. Please print.

Date_______________ Patient Name____

Social Security #____________________Date of Birth___________ Marital Status___________

Address______________________________ City_________________ State______ Zip_______

Cell Phone____________________________ Home Phone______________________________

Email Address__________________________________ Occupation______________________

Emergency Contact Person_______________________________ Phone____________________

How did you learn about us? Sign ___ Website (drerikyounginer.com) ____

Insurance Directory ___ Referral ___ (Whom may we thank?)________________________

==

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits to the Palmetto Spinal Center, L.L.C. pertaining to my treatment here.

X_____________________________________ ____________________________

Signature of patient or parent if minor Date

****Please show us your insurance card and avoid filling out the remainder of this page****

Insurance Information

Name of Insured____

Relationship to patient, if different than you_________________________

Date of Birth______________ Insurance Company_____________________________

Policy/ID #_______________________________ Group #_______________________

Secondary Coverage Information

Name of Insured____

Insurance Company____

Policy/ID #_______________________________ Group #_______________________

Health History

Date__________________ Patient Name____

Chief Complaint (reason for seeking care) _______________________________________

____

Chief Complaint History:

Onset (when exactly did this begin) ____

Quality (describe the type of pain) ____

Severity (rate this pain on a scale of 1-10; one is barely noticeable and ten is unbearable) ______

Timing (time of day the pain is most noticed) ____

Duration (how long this pain lasts when noticed ____

What makes the pain worse? ____

What makes the pain lessen? ____

If you have another condition affecting you, please provide this additional information in the following section.

Second Complaint History:

Location (where is the pain/problem ____

Onset (when exactly did this begin ____

Quality (describe the type of pain ____

Severity (rate this pain on a scale of 1-10; one is barely noticeable and ten is unbearable _______

Timing (time of day the pain is most noticed ____

Duration (how long this pain lasts when noticed ____

What makes the pain worse? ____

What makes the pain better? ____

Pain Diagram

The following diagrams are for you to better explain the type of pain(s) you are currently experiencing and the location(s). Using a scale of 1-10, circle the severity of your chief complaint. Place the letter of the corresponding pain you are describing in the actual area of the drawings.

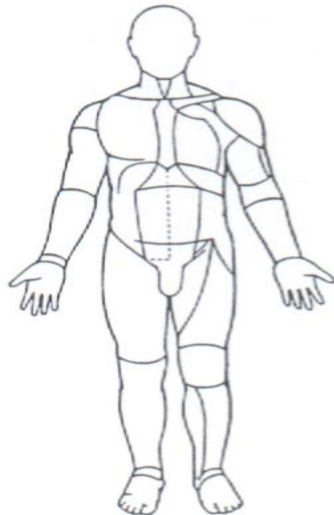
Rate your pain at this moment.

Rate your pain when it is at its worst.

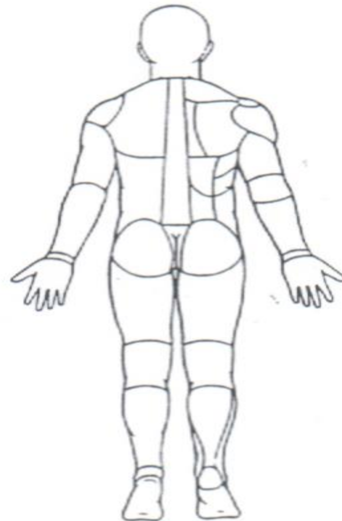
Rate your pain when it is at its least.

Burning- **B** Numbness- **N** Pins & Needles- **P** Aching- **A** Stabbing- **S**

RIGHT



FRONT



BACK

LEFT

Please indicate if you have or have had any of the following by circling:

Allergies	***Dizziness***	***HIV +***	***Psoriasis***
Anemia	***Digestive Pain***	***Hypertension***	***Psychosis***
Arthritis	***Eczema***	***Hypotension***	***Rheumatism***
Asthma	***Epilepsy***	***Kidney Disease***	***Stroke***
Back Pain	***Fibromyalgia***	***Lupus***	***Thyroid Disease***
Bladder Infections	***Glaucoma***	***Migraines***	***Tuberculosis***
Cancer___________	***Heart Disease/Attack***	***Multiple Sclerosis***	***Ulcer***
Concussion	***Hemorrhoids***	***Muscular Dystrophy***	***Venereal Disease***
COPD	***Hepatitis***	***Neuritis***	***Other______________***
Diabetes	***Hernia***	***Polio***	***Other______________***

Previous Hospitalizations/Surgeries Year

____ ______

____ _______

____ _______

Medications

Please list all prescribed medications you are currently taking.

____

____

Social Activities

Use of alcohol: How many alcoholic beverages do you consume on average per week: _____

Use of tobacco products: Never____ Rarely____ Moderately____ Daily____

Use of illegal drugs: Never____ Type ____

Please circle 'Yes" to any current presence you are noticing of the following signs and symptoms.

Status
Fever……….Yes
Fatigue……..Yes
Headaches.…Yes

Eyes
Eye disease……………Yes
Blurred/double vision…Yes

Ears/Nose/Throat
Hearing loss or ringing…Yes
Earaches………………...Yes
Nose bleeds……………..…Yes
Mouth sores………….…Yes
Bleeding gums………..…Yes
Foul taste……………….Yes
Sore throat……………...Yes
Swollen glands…………Yes

Cardiovascular
Chest pain…………...Yes
Palpitations………….Yes
Shortness of breath….Yes
Hands/feet swelling…Yes
Cold extremities…….Yes

Lymphatic
Enlarged glands……Yes
Swollen veins………Yes
Bleeding tendency….Yes
Easy to bruise………Yes

Respiratory
Chronic coughing… .Yes
Productive cough…. .Yes
Shortness of breath…Yes
Wheezing…………..Yes

Gastrointestinal
Loss of appetite…Yes
Painful BM…...…Yes
Constipation…….Yes
Nausea………..…Yes
Diarrhea………....Yes
Blood in Stool…..Yes
Abdominal Pain…Yes

Genitourinary
Frequent urination…..…Yes
Burning urination……....Yes
Blood in urine…………Yes
Incontinence…………...Yes
Kidney stones……….…Yes
Male-testicular pain........Yes
Female-irregular period..Yes
Female-# of births…...…Yes
Female-#miscarriages.....Yes

Musculoskeletal
Joint pain………..…..Yes
Joint swelling…….…Yes
Stiffness in joint(s)…Yes
Muscle weakness…...Yes
Cramping…………...Yes

Skin
Rash… …………………Yes
Skin color change………Yes
Change in hair or nails.…Yes
Lumps…………….…….Yes

Neurological
Dizziness…….…Yes
Numbness………Yes
Radiating Pain.…Yes
Paralysis……..….Yes
Tremors……..….Yes

Psychiatric
Memory loss…..Yes
Confusion……..Yes
Nervousness…..Yes
Depression…....Yes
Hyperactivity.…Yes

Endocrine
Hormone problem…Yes
Excessive thirst……Yes
Heat intolerance..…Yes
Cold intolerance..…Yes
Dry skin………...…Yes

I have completed these forms regarding my past and current health status accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any change in my medical condition.

X____ ______________________
Signature of Patient or Minor's Parent/Guardian Date

Disclosure Consent of Health Information/Appointment Reminder Authorization & Informed Consent

We are very concerned with protecting your privacy. While law requires us to give you this disclosure, please know that we always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

-Disclosure of your health information to another health care provider/facility if it is necessary to refer you for the diagnosis, assessment, or treatment of your health condition.
- Disclosure of your health information and billing records to another party if they are potentially responsible for the payment of your services.
-We may need to use your health information within our practice for quality control or other operational purposes.

We may need to use your name, address, or phone number to contact you with appointment reminders, information regarding your treatment, or other health related information that may interest you. If this contact is made by phone and you are not present, a message will be left. Information we use/disclose based on the authorization you are giving may be subject to re-disclosure by anyone having access to the reminder or other information and may no longer be protected by the federal privacy rules. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (Section 164.524). A more complete notice providing a detailed description of how your health information may be used or disclosed is available. You have the right to review that notice before you sign this consent form (Section 164.520). We reserve the right to change our privacy practices as described in that notice. If we make changes to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or discourses

You have the right to request we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your health information, please let us know in writing. If we agree with your restrictions, the restriction is binding on us.

Your right to refuse or revoke your authorization

You have the right to refuse to give us this authorization. If you don't give us authorization, it won't affect treatment provided to you or the methods used to obtain reimbursement for your care. You may revoke your consent to us at any time; however, your revocation must be in writing. We won't be able to honor your revocation request if we have already released your health information before we received your revocation. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Informed Consent

Chiropractic care is by nature one of the safest forms of all healthcare. However, no discipline of healthcare is without its risks. We want to inform you that while uncommon, there are possible risks associated with chiropractic adjusting. These include no positive change rendered, soreness, and the chance of symptoms worsening. There are more severe outcomes which medical research has routinely shown as extremely rare including sprain/strains, disc injuries, and stroke. Again, the risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

By signing, I am indicating that I have read and agree to all items of the consent policy. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend for this consent to apply to all my present and future chiropractic care. This authorization is effective as of today's date and expires seven years from my last date of service.

______________________________	______________________________
Printed Name	Authorized Palmetto Spinal Center Rep.
X______________________________	______________________________
Patient/ Authorized Rep. Signature	Date