

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 #_____ Male___ Female___ Date of Birth_____

Street Address_____ City_____ State_____ Zip_____

Occupation_____ Cell Phone _____

Email Address_____ Marital Status_____

Personal contact in case of emergency_____ Phone_____

How did you learn about us? Sign___ Website (palmettospinalcenter.com) ____

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

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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 to avoid filling out the remainder of this page

Insurance Information

Name of Insured_____

Relationship to patient, if different than self_____

Date of Birth_____ Insurance Company_____

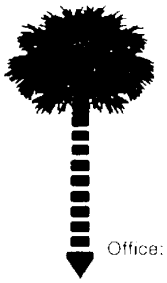
Policy/ID #_____ Group #_____

Secondary Coverage Information

Name of Insured_____

Insurance Company_____

Policy/ID #_____ Group #_____



PALMETTO SPINAL CENTER, L.L.C.
Health History

Welcome to our practice. We need to know your past or present illnesses/conditions to maximize your level of care. Please fill this form out completely and in print.

Date_____ Patient Name_____

Chief Complaint (reason 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 lessen?_____

Office:

PALMETTO SPINAL CENTER, L.L.C.
Pain Diagram

Patient Name_____ Date_____

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.

1	2	3	4	5	6	7	8	9	10
Barely Noticeable				uncomfortable					unbearable

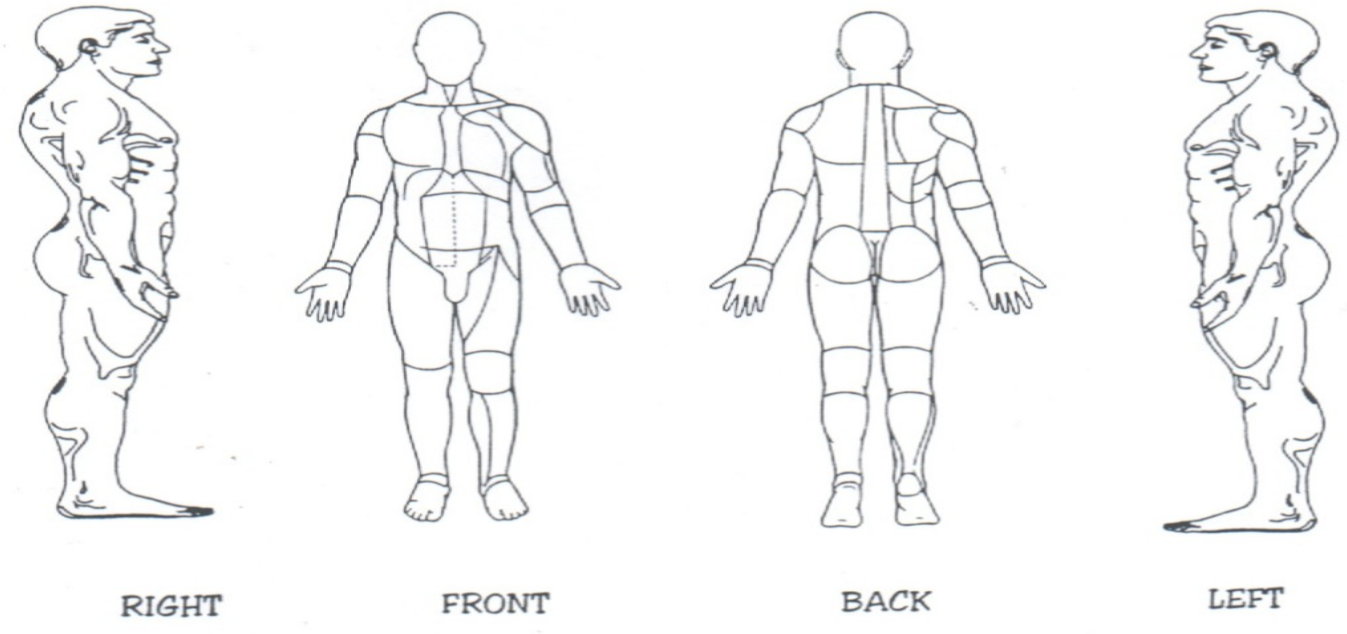
Rate your pain when it is at its worst.

1	2	3	4	5	6	7	8	9	10
Barely Noticeable				uncomfortable					unbearable

Rate your pain when it is at its least.

1	2	3	4	5	6	7	8	9	10
Barely Noticeable				uncomfortable					unbearable

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



Office:

PALMETTO SPINAL CENTER, L.L.C.
Health History

Health History: Please circle if you currently have or previously had any of the following.

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***	***Enlarged Glands***
Diabetes	***Hernia***	***Polio***	***Chronic Cough***
Eye Disease	***Hearing Loss***	***Chest Pain***	***Constipation***
Kidney Stones	***Irregular Periods***	***Joint Swelling***	***Muscle Weakness***
Dizziness	***Numbness***	***Radiating Pain***	***Tremors***

***Others*_____

Previous Hospitalizations/Surgeries Year

_____ _____

_____ _____

_____ _____

Medications

Please list all prescribed medications you are currently taking.

_____

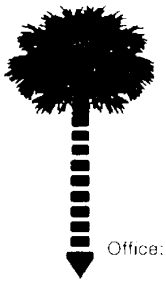
_____

_____

Alcohol use: How many alcoholic beverages do you average per week _____

Tobacco/Vape use: Never___ Rarely___ Daily___

Other drug use type: _____



PALMETTO SPINAL CENTER, L.L.C.

Disclosure Consent of Information/Appointment Reminder Authorization & Informed Consent

Our Privacy Pledge

We are very concerned with protecting you 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.

_____ _____

Patient/ Authorized Rep. Signature Date