

Palmer College of Chiropractic, Florida Campus



Intake Questionnaire

Please print all information in pen. All blanks must be filled in to allow us to serve you quickly and efficiently. Some sections may not apply to you, if that is the case check the N/A box for **“Not Applicable”** or **Section not applicable**. Your accurate responses will give us a better understanding of you and your health. From this information, we can provide you the best care possible. **Thank You for your cooperation.**

Date: _____ Date of birth: _____ Email Address: _____

Patient Name: _____

Address: _____

City, State, Zip Code: _____

Phone: Home () _____ Work: () _____ Mobile: () _____

Employer's name: _____ **Section N/A**

Address, City, State, Zip: _____

How were you referred to the Palmer College Clinic: Patient/Friend Physician Advertisement
 Student Palmer's Reputation Community Event Sporting Event Other: _____

Primary Doctor's Name: _____

Address: _____

City, State, Zip Code: _____

Phone: () _____ Fax: () _____

Do you want a medical report sent to this physician? No Yes

Are you or will you be a Palmer College student? No Yes

Are you an alumnus of Palmer College? No Yes

Are you an employee of Palmer College No Yes

Have you previously been a patient in any of our clinics? No Yes; if yes: date of last visit: _____

Do you have insurance? No Yes; if yes with whom? _____

Do you have Medicare (or an affiliate) coverage? No Yes; affiliates name: _____

Do you have Medicaid coverage? No Yes (if applicable)

Chiropractic Physician's use only:

All information contained in this questionnaire was thoroughly reviewed on (date): _____/_____/_____

Physicians signature + PIN: _____

(Continued on next page)

Revised: 6/20/2011

HISTORY OF PRESENT COMPLAINT

Age: _____; Male Female; Race: _____; Dominate hand: Rt or Lf

(A,O) What has brought you to our clinic today?:

What do you want to happen as a result of this visit? _____

(H) Which area of pain is worse: Head Neck Upper back Arm Lower back Hip Leg N/A

(E) How long have you had this problem? _____ **(E)** Since? _____/_____/_____ N/A

(If you have had this problem before please tell us how long you've had this episode)

(List the date the current episode started)

(B) Briefly, please give details of how this pain/problem(s) started: N/A

(D) My current pain/problem came on: gradually over time; specify time period: _____ quickly N/A

(D) If you have had this pain/problem before what was the date of the first episode? _____ N/A

◆ How many episodes have you had per year? _____ per month? _____

(C.) What time of day is your current pain/problem worse? Morning Late in the day The middle of the night As day progresses N/A

(F) My current pain/problem now seems to be: Getting better ◆ Staying the same Getting worse ◆ N/A

◆ If your current pain/problem is getting better or worse please explain in more detail: N/A

(F) My current pain/problem pattern is:

- A single continuous attack
 - Attacks of pain and pain free intervals
 - Continuous / Constant
 - Continuous pain with attacks of severe pain
 - Other: _____
- _____
- N/A

(G) I experience this pain/problem:

- The entire day
- Most of the day (16-20 hours)
- A good part of the day (8-15 hours)
- A fair amount of the day (2-7 hours)
- A small amount of the day (1 hour or less)
- Less than once per day
- N/A

(E) How long does your current pain/problem attack last: _____Seconds _____Minutes _____Hours N/A

(C.) Is your pain/problem worse at night? No Yes N/A

(C.) Does your pain/problem improve with bed rest? No Yes N/A

(C.) Does the current pain/problem awaken you after falling asleep? No Yes N/A

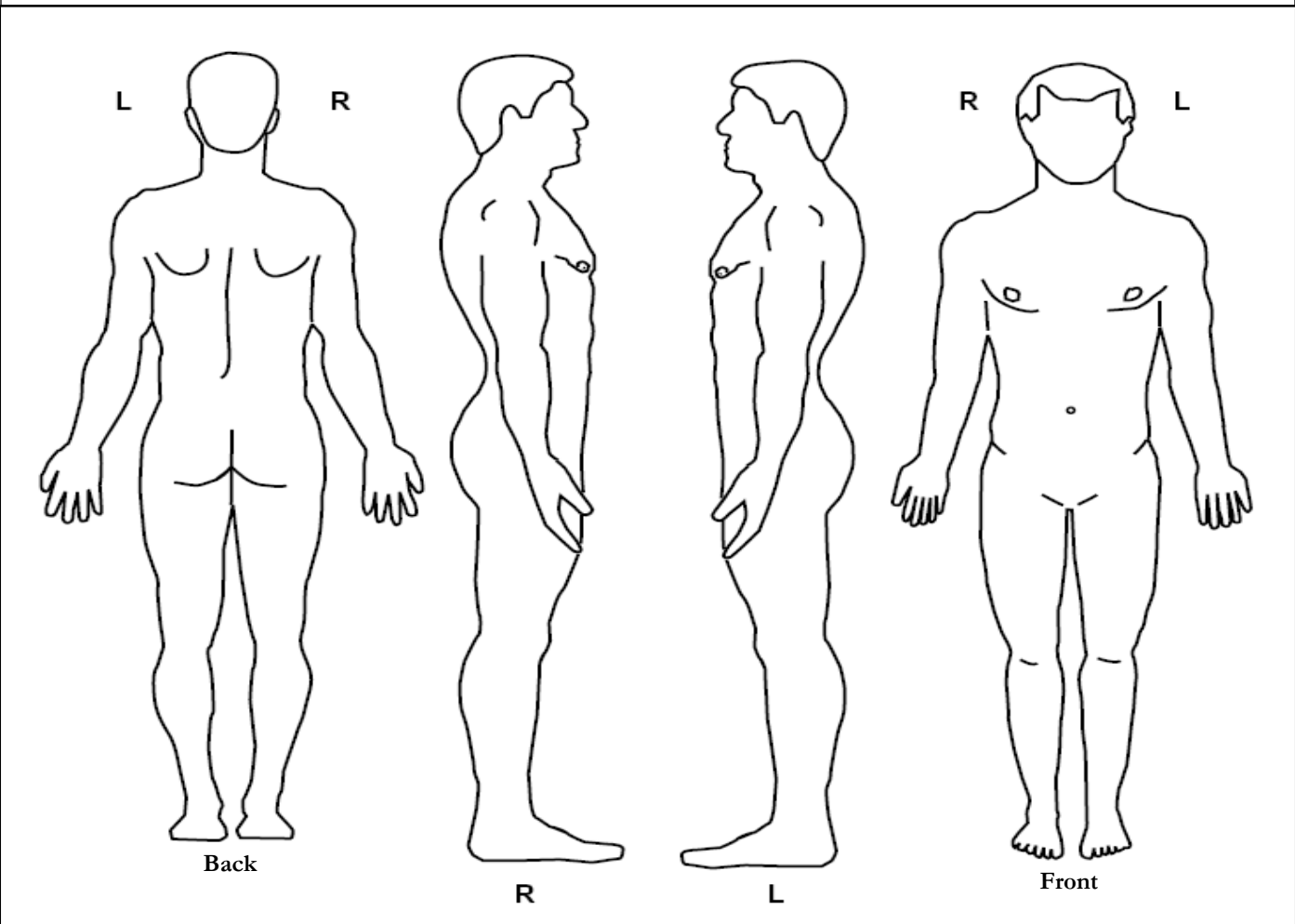
(C.) Is the following statement **true** regarding your pain/problem? **"no body position relieves my pain/problem"**: No Yes N/A

(C.) Do you notice any other symptoms, areas of weakness or sensations? No Yes; if yes, what? _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensations. Include all affected areas. You may draw on the face as well. Pay attention to right and left sides.

(C.) Please circle the quality of your current pain/problem (circle all that apply):

- A. Electric B. Sharp C. Stabbing D. Knife-like E. Piercing F. Shooting G. Achy H. Gripping I. Heavy J. Cramp-like
- K. Burning L. Deep M. Superficial N. Stiffness (AM >1/2 hour or PM or Both) O. Spasm P. Tearing
- Q. Other: (describe) _____



(F) Please indicate your current pain level by circling a number below. If you have multiple areas of pain label the circle (i.e.: low back pain, neck pain, etc). 0 = No pain; 1-3 = mild pain (nagging annoying, interfering little with daily activities); 4-6 = moderate pain (interferes significantly with daily activities); 7-10 = disabling pain (unable to perform daily activities). "Pain acceptable" means at what number is the pain at an acceptable level for you.

Right now: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Pain at its worst: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Pain at its best: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Pain on average: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Pain acceptable: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

- The center of my pain is easily identified: No Yes
- The boundaries of my pain are easily identified? No Yes

For low back problems only: N/A:

Have you experienced any locking or catching or giving away of your low back while moving? No Yes

(I) I feel the pain more in my leg(s) than in my lower back? No Yes N/A

(I) I feel the pain more in my arm(s) and/or hand(s) than in my neck? No Yes N/A

CURRENT PAIN/PROBLEM PROFILE *CONT.*

(J) List activities of your daily living that are adversely affected by your pain or condition: **Section N/A**
Examples: work inside and outside your home, self care, sitting, standing, traveling, lifting, exercise, sports, etc

(L) Have you ever had any past episodes of similar pain or injury? No Yes; (if "yes" please describe): **N/A**

(L, M, N, O) List all other physicians with whom you have consulted in the past year for **this problem**, when you were seen, what were you told about your pain/problem, what were you told could be done to help you, what tests were performed, medications? **Section N/A**

(L, M) Have you ever had surgery on your neck or back? No (go to next section) Yes; if yes, how many times? _____

•What type of surgery(s) was/were performed? Disectomy Laminectomy Fusion IDET
 Unknown Other: _____ What spinal level? _____

•What was the date of your most recent surgery? _____

•Did you improve from your spine surgery procedure(s)? No Yes

•Did you undergo post-surgical rehabilitation?: No Yes, if yes for how long? _____

Do you have numbness in the groin or anal area? No Yes; if yes for how long: _____

Have you noticed any progressive muscle weakness especially in your arms/legs? No Yes; if yes how long: _____

Have you ever had any fractures (including compression) of the spine? No Yes; if yes what spinal level? _____

Have you ever had an adverse (bad) reaction to or following chiropractic care? N/A No Yes; if yes explain: _____

Have you ever had spinal pain greater than 4 weeks? No Yes; if yes explain: _____

Do you have or have you had headaches early in the morning that sometimes wake you up? No Yes; if yes explain: _____

Do you have any of the following symptoms: Band-like trunk pain Vague non-specific lower limb symptoms Decreased mobility No

(B) Was this from a work-related injury? No Yes - Is it under workers compensation? No Yes

Are you planning to apply for disability or worker's compensation? No Yes

(B) Was this from an automobile accident? No Yes - other accident/trauma?: _____

Is there a lawsuit or litigation pending or being contemplated in relationship to your pain or problem? No Yes

Have you missed any work/school because of this problem? N/A No Yes, how much?: _____

CURRENT PAIN/PROBLEM PROFILE CONT.

(M) Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your **current complaint, problem or injury** (Check one of each): Section N/A

| Treatments | Which Type | Helpful | No Help | Not Used |
|---|------------|--------------------------|--------------------------|--------------------------|
| Anti-inflammatory (NSAIDs) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle Relaxants <i>i.e. Flexeril, Norflex, Parafon Forte, Robaxin, Soma, Valium, Zanaflex etc.</i> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Narcotic Pain Medications | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hot packs | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ice | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ultrasound | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TENS Unit | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle Stimulation | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical Therapy | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Back/Neck exercises | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bed rest | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chiropractor | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epidural block/injection | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Facet block injection | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SI joint block injection | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Trigger Point injection | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Acupuncture | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Massage | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Traction/VAX-D | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brace/Collar | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical activity | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychologist/Psychiatrist | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Family practitioner (<i>MD, Osteopath</i>) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Orthopedist | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurologist | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spine surgeon | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain clinic | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dentist | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gynecologist | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CURRENT PAIN/PROBLEM PROFILE CONT.

| (J, K) Which of the following activities changes the nature of your pain/problem | | <input type="checkbox"/> Section N/A | | |
|---|--------------------------|--------------------------------------|--------------------------|--|
| Activity | Aggravates Pain | Relieves Pain | Neither | |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Leaning forward (brushing teeth, vacuuming, ironing, doing dishes etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lying on your side with knee's bent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lying on your back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lying on your stomach | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Rising from sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Changing positions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Coughing/sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Physical activity (AC) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lifting/straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Standing from a sitting position | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bowel movements | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Turning head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Looking up (neck extension) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Looking down (neck flexion) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Moving neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Going up stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Going down stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

*** Now go back and **CIRCLE** the box to indicate the **most aggravating activity** and the **most relieving activity**.

(R, Q, AC, RC) **GENERAL MEDICAL HISTORY**

Bladder Control (urine): No problem Can't empty bladder Loss of urine (accidents)

Bowel Control: No problem Constipation Loss of control (accidents)

Have you experienced any (Check all that apply):

- Dizziness Loss of consciousness Visual disturbances Difficulty speaking
- Difficulty swallowing Difficulty walking Nausea/vomiting Numbness on face or body
- Headache or neck pain unlike anything you have experienced before None of these

GENERAL MEDICAL HISTORY CONT.

- (R.)** Check all conditions below that you have or have had in the past. If **NONE**, check here
- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Colon problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Cancer: type: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cirrhosis (Liver disease) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Degenerative arthritis | <input type="checkbox"/> Frequent pneumonia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Duodenal problems | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anemia (low blood count) | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Sexual difficulty | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Allergies | <input type="checkbox"/> Pregnant?? | <input type="checkbox"/> Headache type: _____ |

Any abnormalities in recent blood test and/or urine tests? Last blood test: _____ No Yes; if yes, when and what: _____

Are you under a doctor's care for any other medical condition? No Yes; if yes please explain: _____

Menopause: N/A No Yes; if yes, when did it begin?: _____

Have you seen your primary care physician in the past year? No Yes; if yes when _____

(S) Have you had any accidents, injuries, falls or other trauma? _____

(V) SURGICAL HISTORY (Please check all surgeries you have had; if none check here)

- | | | |
|--|--|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Appendix / Intestine | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Heart / Pacemaker IV filter | <input type="checkbox"/> Hernia / Colon / Rectum | <input type="checkbox"/> Ears |
| <input type="checkbox"/> Angioplasty / Stent | <input type="checkbox"/> Hysterectomy / C-section / Female | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Kidneys / Bladder / Urinary | <input type="checkbox"/> Throat / Tonsils |
| <input type="checkbox"/> Gall bladder / Stomach | <input type="checkbox"/> Prostate | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Shoulders / Arms / hands | <input type="checkbox"/> Hips / Knees / Legs / Feet | _____ |

(T) List any hospitalizations, include date and the reason: _____

Have you ever used: Immuno-suppression : No Yes; Corticosteroids No Yes; Glucocorticoids (Cortizone Prednisone, Decadron, Medrol etc.): No Yes; Blood thinners: No Yes (i.e. Warfarin, Coumadin, Plavix, etc.)
 Estrogen: No Yes

Do you have any allergies other than to medications (such as to latex, shellfish, etc.)? No Yes; if yes describe: _____

Please indicate whether you have had any of the following tests or studies and write when/where the most recent was:

| Test | Yes | No | Where/When | Test | Yes | No | Where/When |
|--------------------|--------------------------|--------------------------|------------|--------------|--------------------------|--------------------------|------------|
| X-ray's | <input type="checkbox"/> | <input type="checkbox"/> | | Myelogram | <input type="checkbox"/> | <input type="checkbox"/> | |
| CT Scan | <input type="checkbox"/> | <input type="checkbox"/> | | Discogram | <input type="checkbox"/> | <input type="checkbox"/> | |
| EMG / NCV | <input type="checkbox"/> | <input type="checkbox"/> | | MRI | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bone scan | <input type="checkbox"/> | <input type="checkbox"/> | | Bone density | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthroscopy | <input type="checkbox"/> | <input type="checkbox"/> | | Stress Test | <input type="checkbox"/> | <input type="checkbox"/> | |
| EKG | <input type="checkbox"/> | <input type="checkbox"/> | | Angiogram | <input type="checkbox"/> | <input type="checkbox"/> | |
| Doppler ultrasound | <input type="checkbox"/> | <input type="checkbox"/> | | Biopsy | <input type="checkbox"/> | <input type="checkbox"/> | |
| Echocardiogram | <input type="checkbox"/> | <input type="checkbox"/> | | Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | |

SOCIAL HISTORY

(AC, Q) Smoking:
 Do you now or have you ever smoked? Yes No
 If YES, please complete the following:
 I smoke _____ packs per day
 And I have smoked for _____ years.
or
 I did smoke _____ packs per day
 for _____ years, but I quit smoking _____
 years ago.
 Do you use any smokeless tobacco product? Yes No
 Do you smoke cigars? No Yes; freq: _____

(Q) Alcohol Consumption:
 Do you drink: *(check all that apply)*
 Beer?
 Wine?
 "Hard" drinks?
 Frequency of drinking:
 Never
 Rarely
 Socially (how often : _____)
 Daily
 Do you have a history of heavy drinking?
 Yes No

Effects of your problem/complaint on your lifestyle. Check all that apply: *Section N/A*
 I describe my home setting as supportive of me during this time.
 I describe my work setting as supportive of me during this time.

Exercise:
 How active are you?: *(Check all that apply)*
 I get a cardiovascular workout 3 or more times/week
 I walk daily but do not workout
 I exercise or walk less than 3 times/week
 I am not generally active
 I am on a sports team; specify: _____
 Other: _____

Customs: Any customs or religious beliefs or wishes that might affect care?
 No Yes; if "yes" explain:

My pain has affected my interaction with my family and friends.
 The changes in my lifestyle because of my problem have been difficult for me.

Please indicate your current work status. *Section N/A*
 Working full time
 Working part time
 Seeking employment
 Not working by choice (retired, homemaker, student, etc.)
 Physically unable to work **because** of your current problem
 Physically unable to work **not because** of your current problem

Before having your current problem, did you normally work:
 Full time Part time Neither

What is your usual occupation?

Do you like your work situation?
 No Yes Not applicable

Please check the type of occupation below that applies to the majority of your work habits:
 Heavy labor Light labor Professional Student Unemployed
 Sedentary (sitting or very little physical activity) Section not applicable

Does your job require you to : lift _____ pounds bend prolonged sitting drive a truck or fork lift
 (Check all that apply) prolonged standing twisting/turning prolonged walking driving
 use a computer reach over head lift over head section N/A
 Other: _____

Have you ever used drugs intravenously? No Yes; if yes for how long and what type: _____

Do you use recreational or performance enhancing drugs? in the past but quit No Yes ♦
 ♦ If yes, specify marijuana cocaine speed hallucinogens narcotics steroids other: _____
 ♦ How much/day _____ When did you quit: _____

Have you ever received treatment for a drug or alcohol problems? No Yes ♦
 ♦ If yes specify when and where: _____

(P) FAMILY HISTORY

I do not know the medical history of my biological parents or other family members. (Go on the next section)

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following: None of these
Check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Kyphosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Spine problems |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Other: _____ |

(w) REVIEW OF SYSTEMS

Do you currently have or have had any of the following problems. Please check an answer "Yes" or "No" to every item; do not skip any.

General (constitutional)

- Fever yes no
- Chills yes no
- Sweats yes no
- Fatigue yes no
- Malaise (body weakness) yes no
- Unexplained weight loss yes no

Eyes

- Blurred vision yes no
- Diplopia (double vision) yes no
- Eye irritation/inflamed (AC) yes no
- Eye discharge yes no
- Vision loss yes no
- Eye pain yes no
- Photophobia (sensitivity to light) yes no

Ear/Nose/Mouth/Throat

- Earache yes no
- Ear discharge yes no
- Tinnitus (ringing in ears) yes no
- Decreased hearing yes no
- Nasal congestion yes no
- Nosebleeds yes no
- Sore throat or hoarseness yes no
- Dysphasia (difficulty speaking) yes no
- Dysphagia (difficulty swallowing) yes no

Cardiovascular

- Chest pains yes no
- Palpitations yes no
- Syncope (passing out) yes no
- Difficulty breathing on exertion yes no
- Difficulty breathing when sitting/standing yes no
- Peripheral edema (swollen ankles) yes no

Respiratory

- Hypotension yes no
- Chronic cough yes no
- Difficulty breathing yes no
- Excessive sputum yes no
- Hemoptysis (spitting up blood) yes no
- Wheezing yes no

Gastrointestinal

- Nausea yes no
- Vomiting yes no
- Digestive dysfunction yes no
- Change in bowel habits yes no
- Abdominal pain yes no
- Melena (black or tarry stool) yes no
- Bloody stool yes no
- Jaundice yes no

Psychiatric

- Depression yes no
- Anxiety yes no
- Memory loss yes no
- Mental disturbance yes no
- Suicidal thoughts yes no
- Hallucinations yes no

Genitourinary

- Unusual Discharge yes no
- Incontinence yes no
- Difficult urination yes no
- Urination blood yes no
- Urinary frequency yes no
- Amenorrhea (no menstrual cycle) yes no
- Menorrhagia (excessive menstrual flow) yes no
- Pelvic pain yes no
- Sexually transmitted disease yes no

Musculoskeletal

- Back pain yes no
- Neck pain yes no
- Shoulder pain yes no
- Wrist/hand pain yes no
- Fibromyalgia yes no
- Torticollis/stiff neck yes no
- Hip/knee pain yes no
- Arthritis yes no

Skin and/or breast (Integumentary)

- Rash yes no
- Itching yes no
- Dryness yes no
- Suspicious lesions yes no
- Skin infections yes no

Neurologic

- Intermittent paralysis/gait difficulties yes no
- Weakness yes no
- Paresthesia (prickly/tingling sensation) yes no
- Seizure yes no
- Syncope (passing out) yes no
- Tremors yes no
- Vertigo (dizziness) yes no
- Numbness yes no
- Poor balance yes no
- Incoordination yes no
- Difficulty walking yes no
- Difficulty writing yes no

Endocrine

- Cold intolerance yes no
- Heat intolerance yes no
- Polydipsia (excessive thirst) yes no
- Polyphagia (excessive eating) yes no
- Polyuria (excessive urination) yes no

Hematologic/Lymphatic

- Abnormal bruising yes no
- Abnormal bleeding yes no
- Enlarged lymph nodes yes no

Allergic/Immunologic

- Hay fever yes no
- Persistent infections yes no
- HIV exposure yes no

Page
Intentionally
Left
Blank

LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals.

We may disclose information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS:

ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. If you request copies, we will charge you our standard copying fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary or your information instead of copies.

ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, 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 other activities authorized by you, 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.

RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment, and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you 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 or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. 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 such a complaint 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. Please direct any of your questions or complaints to:

Contact: Clay McDonald, D.C., MBA, JD – Compliance Officer (563) 884-5510

Privacy Official: Shayan Sheybani D.C., MBA Email address: Shayan.Sheybani@palmer.edu (563) 884-5701

Address: Palmer Chiropractic Clinic
4705 South Clyde Morris Blvd
Port Orange, FL 32129

Palmer College of Chiropractic
1000 Brady Street
Davenport, IA 52803

Palmer Chiropractic Clinics

Consent for Purposes of Treatment, Payment and HealthCare Operations

I, _____ [Name of Individual] consent to Palmer Chiropractic Clinics' ("the Practices") use and disclosure of my Protected Health information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, clinical education, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions, However; if the Practices agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Chiropractor or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Palmer Chiropractic Clinics

**Acknowledgement of receipt of
Notice of privacy practices**

I, _____, [Patient's Name] acknowledge that I have received, reviewed, understand and agree to the Notice Of Privacy Practices of Palmer Chiropractic Clinics, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information Created, received or maintained by the Practice.

Date

Signature

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The practice has made a good-faith effort to obtain an acknowledgement of _____ [Patient's name] receipt of our Notice of privacy practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all the apply):

- Patient Unavailable
- Patient Physically Unable
- Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- Personally Mail Phone Follow Up
- Other: _____

Date

Signature

**Print Name of Chiropractor
Palmer Chiropractic Clinics**

Acceptance Agreement

The Teaching Clinics:

The Palmer Clinics are the foremost chiropractic teaching clinics in the world. Student interns, in their clinical education, study under some of the finest professional Doctors of Chiropractic in order to further develop and enhance their skills. As a patient in the Palmer Clinics, you will be assigned to a licensed and experienced Doctor of Chiropractic (D.C) who will oversee your care. Your D.C; also called a “assigned faculty clinician”, will assign one or more student interns to work with your case under his/her supervision.

In each of these clinic settings it is probable that your chiropractic care will be observed by students in training. Information about your case may be shared with students learning about the care process and with licensed chiropractors overseeing your care. In some situations, your care will occur in an open environment where others can share in this learning experience. Conversations between faculty clinicians and you regarding your health care may be overheard by others in the vicinity of the conversation.

Statement of Understanding

I, _____, was informed about the setting in which my care is to be performed and, as indicated by my signature below, acknowledge my understanding that:

- The Palmer Chiropractor Clinics are teaching clinics.
- My personal health care information may be overheard by others in the clinic setting and that my health care information may be shared with others as an educational tool for learning.
- The Chiropractic assessment and Chiropractic care provided in the Palmer Clinics may occur in an open environment where others may observe in this learning experience.

Patient Records:

Patient records, including x-rays, are the property of Palmer Clinics. These records are only released with your written permission or as required legally. As a teaching institution, data is occasionally gathered for research purposes. Patient confidentiality is always maintained.

Financial Matters:

Payment is due at the time services are provided unless prior arrangements have been made. All charges will be explained to you prior to any service being performed.

Personal Injury and Workers Compensation:

Our fee for service clinics are accepting Personal Injury (PIP) and Workers Compensation cases. Please see the Insurance coordinator for further paperwork. Preauthorization is required.

Please check here if you do not wish to have your patient information used for research purposes and educational purposes.

I have read the above statements and accept these conditions.

Print Name: _____

Signature: _____

Date: _____

Consent to Evaluation and Treatment of a Minor

I, being the lawful parent or guardian of _____, minor of the age of _____ do hereby give my consent, authorize, and request Palmer College of Chiropractic Clinics-Florida to evaluate and to administer such treatment deemed advisable, necessary, or requested on the above mentioned child.

Parent signature: _____ Date: _____

Printed parent name: _____

Witness signature: _____ Date: _____

Printed witness name: _____

CHILD ESCORT AUTHORITY CONSENT FORM

TO WHOM IT MAY CONCERN:

I, _____, make oath and say that I am the lawful Guardian of:
_____, (child's name) a _____ year old _____ (male/female) residing
at _____ and born on
_____ (DOB) in _____ (city), _____ (state).
_____'s (child's name) social security (or social insurance) number is:
_____ (SS#).

ESCORT'S AUTHORITY

_____ (Escort's name) of _____ (city, state) has my permission to consent to evaluations such as physical examinations, x-rays, other imaging techniques, diagnosis and treatments such as chiropractic adjustments and any other treatments or procedures that the attending chiropractic physicians, medical or emergency personnel deem necessary or prudent. I am granting the permission prior to any such health care treatment, for the purpose of providing _____ (Escort's name) with the authority and power to exercise his or her best judgment upon the advice of the chiropractic physicians, medical or emergency personnel.

In the event of my child requiring life-sustaining or emergency treatment, I authorize _____ (Escort's name) to summon any and all emergency personnel to attend, transport and treat my child and consent to physical examination (including x-rays and other imaging techniques), medical diagnosis, provision of medication or anesthetic and receipt of any other treatment that may be deemed necessary or prudent by, and provided under the supervision of, any health care professional licensed by the State of Florida.

EFFECTIVE LOCATION(S)

This consent is only valid at the following locations: **PALMER CHIROPRACTIC CLINICS, 4705 S. Clyde Morris Blvd., Port Orange, Florida 32129-4103 and 1801 S. Nova Road, Suite 322, South Daytona 32119.**

GUARDIAN CONTACT INFORMATION

_____ (Legal Guardian's name) can be reached at home or work, as follows:

- Home Phone: _____
- Work Phone: _____
- Mobile Phone: _____
- Fax Phone: _____
- Email: _____

EFFECTIVE DATE

This consent will take effect on or about _____ (M/D), 20____ and continue until _____ (M/D), 20____.

Signed this _____ the day of _____, 20____.

Clinician sign: _____ Legal guardian sign: _____

(Witness #1)

Clinician print: _____ Legal guardian
print: _____

Witness #2 sign: _____ Escort sign: _____

Witness #2 print: _____ Escort print: _____

Page
Intentionally
Left
Blank

Palmer Chiropractic Clinics 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.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of April 14, 2003, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

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.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

TREATMENT, PAYMENT, HEALTHCARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to other healthcare providers providing treatment to you.

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include clinical education, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. 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 permitted by this Notice.

DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. 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 only if authorized to do so. In the event of your incapacity or in 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.

MARKETING: We will not use your health information for marketing communications without your written authorization.

USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to 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.

PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, 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.

Rights of Patients

Each health care facility or provider shall observe the following standards:

Individual dignity

1. The individual dignity of a patient must be respected at all times and upon all occasions.
2. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's economic status or source of payment for his or her care.
3. A patient has the right to a prompt and reasonable response to a question or request.
4. A patient has the right to retain and use personal clothing or possessions as space permits, unless for him or her to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons.

Information

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient.
 2. A patient has the right to know what patient support services are available in the facility.
 3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.
 4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.
 5. A patient has the right to know what facility rules and regulations apply to patient conduct.
 6. A patient has the right to express grievances regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.
- A patient who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

Financial information and disclosure

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.
2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.
3. A health care provider or a health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services.
4. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

Access to health care

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.
3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. [456.41](#).

Experimental research

In addition to the provisions of s. [766.103](#), a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his or her care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

Responsibilities of Patients

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

-Florida Patient's Bill of Rights and Responsibilities. Florida Statutes Chapter 381(026)

Palmer Chiropractic Clinics -Florida

4705 S. Clyde Morris Blvd.
Port Orange, FL 32129 /
386-763-2718
www.palmer.edu

Palmer Chiropractic Clinics –Florida

1801 S. Nova Road
Suite 322
South Daytona, Florida 32119
386-788-3385