



Date: _____

PATIENT DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Phone Number: _____ Work Number: _____ Occupation: _____
Employer: _____
Employer's Address: _____
Social Security Number: _____ Age: _____ Date of Birth: _____
Gender: M F Race (optional): _____
E-mail Address: _____

Please check the appropriate box: Single Divorced Married Widowed
Number of Children and Ages: _____

Spouse's Name: _____
Spouse's Employer : _____
Spouse's Work Phone: _____
Other Nearest Relative or Contact Person: _____ Phone: _____

Have you received chiropractic care in the past? Yes No
If yes, please give the date and the name of the chiropractor, as well as the reason for the previous care: _____
Name of your Medical Doctor: _____

Name of your health insurance company: _____
Insurance policy number: _____
Complete if applicable to your current health condition:
Personal Injury Auto Accident Workers Compensation
If you have consulted an attorney, regarding the above, please provide your attorney's name and address:
Name: _____ Phone: _____
Address: _____



Dear Patient:

Welcome to the Palmer Clinics. For our records and for your convenience, please check the appropriate box for the following questions. Thank you.

1. Are you a Medicare patient? Yes No
If so, please state your secondary insurance carrier: _____
2. Are you a Medicaid patient? Yes No in Iowa in Illinois
3. Are you filing for a Workers Compensation case? Yes No
4. Are you filing for a personal injury case? Yes No
5. Are you a minor (under the age of 18)? Yes No
Please state the name of your parent or legal guardian: _____
-

*** Questions 6-12 should be completed ONLY if patient is associated with Palmer College:**

6. Employee of Palmer College Employee Spouse Employee Dependant Child
If you're a Palmer Employee, please state your department _____
Please state your name _____
7. Palmer Alumni Alumni Spouse Alumni Dependant Child
Please state the alumni's name _____
8. Employed by one of Palmer's contractors: (i.e. ARAMARK, PerMar, etc.)
Please state organization _____
9. Prospective Student Prospective Student Spouse Prospective Student Dependant Child
If you're a prospective student, please present your prospective student card to the front desk.
Please state the prospective student's name _____
10. Graduate/Undergraduate Student at Palmer Student Spouse Dependant Child
If you're a graduate or undergraduate student, please state your starting date _____ and
anticipated graduation date _____
Please state the student's name _____
11. Palmer D.C. Student Student Spouse Student Dependant Child Student Parent
If you're a D.C. student, please state your starting date _____ and your anticipated graduation
date _____
Please state the D.C. student's name _____
12. Palmer C.T. Student Student Spouse Student Dependant Child
If you're a C.T. student, please state your starting date _____ and your anticipated graduation
date _____
Please state the C.T. student's name _____



Personal Health History: Please indicate whether you have/had any of the following

Are you currently under the care of a healthcare provider or any other doctor? Yes No

If yes, for what condition(s) _____

Provider's Name _____ Phone _____

Name of Previous Chiropractor _____

Date of Last: Chiropractic Exam _____ Spinal X-ray _____ Cholesterol _____
 Prostate/PSA _____ Mammogram _____ Pap Smear _____
 Stool check for blood _____ Colon _____
 MRI _____ CT-Scan _____

Place an "X" to indicate if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Liver Trouble/Hepatitis | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shoulder/Arm Problems | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Unexplained Fatigue |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Jaw Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Throat Problems | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Chronic Cough/Cold |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Mid Back/Rib Pain | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Diabetes Type I or II |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hypertension/High Blood Pressure |
| <input type="checkbox"/> Wrist/Elbow/Hand Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Hip/leg Problems | <input type="checkbox"/> Sciatica | |

Other, please specify: _____

Are you pregnant? Yes No Due Date _____

Any of the following? (include number) Pregnancies _____ Live Births _____ Miscarriages _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Have you ever:	Description	Date
Lost Consciousness	_____	_____
Used a Cane/Crutch	_____	_____
Had Mental/Emotional Disorders	_____	_____
Been treated for Spine/Nerve Disorder	_____	_____

_____ Patient Initials

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Family History

Relation	Living	Deceased	Age (now or at death)	Serious Illnesses/Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

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Social History

WORK ACTIVITY: Sitting Standing Light Labor Heavy Labor
What job did you do during most of your life? _____

DIET/NUTRITION:
Are you on any special diet? Yes No If yes, for what reason? _____

Is your weight a concern for you emotionally or physically? Yes No

Have you gained or lost over 10 pounds in the past six months without wanting to? Yes No

My diet emphasizes fruits, vegetables, whole grains, lean meats or other protein sources, and is low in saturated fats, sugars, and salt. Rate your diet on a scale of 0 to 10:

☺ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ☹

How many eight ounce glasses of water do you drink a day? _____

How many caffeine drinks do you drink a day? (soda, coffee, etc.) Cans _____ Cups _____ None _____

HABITS: Tobacco Use: Now? Yes No Amount/Weekly _____ How long? _____ Years/Months
(Smoking/Smokeless) In the past? Yes No Amount/Weekly _____ How long? _____ Years/Months

Alcohol Use: Now? Yes No Amount/Weekly _____ How long? _____ Years/Months
In the past? Yes No Amount/Weekly _____ How long? _____ Years/Months

Do you have any concerns about your sexual health? Yes No

Are you or have you ever been a victim of domestic or sexual abuse? Yes No

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Review

Rate each of these areas on a scale of 0 to 10:

- Stress Level ☺ No Stress ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ☹ Very Stressed
- Exercise ☺ High Intensity Exercise ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ☹ No Exercise at All
- Activity ☺ Normal Daily Activity ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ☹ Stuck in Bed
- Sleep ☺ Wake-up Fully Rested ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ☹ No Sleep / Poor Sleep
- Appetite ☺ Normal Appetite ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ☹ Eat Nothing
- Mood ☺ Happy, Relaxed ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ☹ Depressed, Nervous

In addition, talk to your doctor about other areas which may be affecting your health, such as worries about finances, social support, and alcohol, tobacco and/or drug use.

While we will work closely with you to resolve your chief complaint, as health professionals we are also concerned about your overall wellness. On future visits we will discuss issues with you that may impact your overall health.

All of the answers I have given are correct to the best of my knowledge, and I agree to continue with my chiropractic evaluation at the Palmer Clinics at this time.

Patient's Signature

Date

Signature of Parent or Legal Guardian

Relationship

