

**PATIENT DEMOGRAPHIC INFORMATION**  
**(Pediatric 0-6 Years)**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Purpose of this appointment: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**PREVIOUS CARE INFORMATION**

Have you received chiropractic care in the past?       yes       no      If so, when? \_\_\_\_\_

If yes, please give name of the chiropractor: \_\_\_\_\_

Please describe the reason for previous care: \_\_\_\_\_

Name of your medical doctor: \_\_\_\_\_

**INSURANCE INFORMATION**

List the name of your health insurance company: \_\_\_\_\_

Social security number of person with insurance: \_\_\_\_\_

My insurance policy number is: \_\_\_\_\_

Complete if applicable to your current health condition:

Case Type:       Personal Injury       Auto Accident       Workers' Compensation

If you have consulted an attorney, please provide the following information:

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_



Dear Patient;

For our records and for your convenience, please answer yes or no to the following questions...  
Please provide a copy of any Insurance and/or Medicare card.  
Thank you, and welcome to the Palmer Clinics.

1. Are you an outpatient:  Yes  No
2. Are you a minor (under the age of 18)?  Yes  No
3. Are you a Medicare patient?  Yes  No  
If yes, please state your secondary insurance carrier:  

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4. Are you a Medicaid (Title 19) patient?  Yes  No
5. Are you filing for a Personal Injury case?  Yes  No
6. Are you filing for a Workers' Compensation case?  Yes  No
7. Are you a Palmer Alumnus?  Yes  No
8. Are you the spouse of a Palmer Alumnus?  Yes  No
9. Are you a dependent child of a Palmer Alumnus?  Yes  No
10. Are you currently a college student?  Yes  No  
If yes, please state where:  

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11. Are you a Palmer DC student?  Yes  No  
If yes, please state your starting date: \_\_\_\_\_  
As well as your graduation date: \_\_\_\_\_
12. Are you a Palmer CT student?  Yes  No  
If yes, please state your starting date: \_\_\_\_\_  
As well as your graduation date: \_\_\_\_\_
13. Are you a Palmer DC student spouse?  Yes  No
14. Are you a Palmer CT student spouse?  Yes  No
15. Are you a Palmer DC student dependent child?  Yes  No
16. Are you a Palmer CT student dependent child?  Yes  No
17. Are you a Palmer DC/CT student parent?  Yes  No
18. Are you an employee of Palmer College?  Yes  No
19. Are you the spouse of an employee of Palmer College?  Yes  No
20. Are you a dependent child of an employee of Palmer College?  Yes  No
21. Are you employed by one of Palmer's contractors?  
(i.e. ARAMARK, PerMar, etc.)  Yes  No
22. Are you the spouse or a dependent child of such a contracted employee?  Yes  No

Palmer Chiropractic Clinics

PEDIATRIC HEALTH QUESTIONNAIRE

(To be completed by legal guardian)

Age (yrs) (mos) Date of birth: Sex: M F No of Siblings:

Birth Weight: Birth Length:

Present Weight: Present Length:

Was the birth: Normal Vaginal, Forceps, Cesarean, Vacuum Extraction, Breech, Home Birth, Birthing Center, Hospital:

Pregnancy Problems:

Labor or Delivery Problems: APGAR Scores:

Congenital Defects/Anomalies:

Was there presence at birth: Meconium, Cyanosis (blue), Jaundice (yellow)

Pediatrician/Family MD: Address:

Obstetrician/Midwife: Address:

Immunization Dates: HEP B, OPV, MMR, DTP, HIB, VAR

Childhood Diseases: Measles, Chickenpox, Whooping Cough, Mumps, Other

Date and purpose of last MD visit:

Has this child been treated for any emergency? Yes No Describe:

Surgeries:

Medications:

Accidents:

- Allergies, Anemia, Arm Problems, Arthritis, Asthma, Backaches, Bed Wetting, Behavior Problems, "Growing Pains", Paralysis, Colds/Flu, Constipation, Convulsions, Diabetes, Diarrhea, Digestion Problems, Dizziness, Fainting, Orthopedic Problem, Hearing Trouble, Hyperactivity, Hypertension, Joint Problems, Leg Problems, Muscle Jerking, Neck Problems, Neuritis, Chronic Earaches, Poor Appetite, Rheumatic Fever, Ruptures / Hernias, Sinus Trouble, Sugar Levels, Tuberculosis, Walking Problems, Broken Bones, Headaches

Is there anything else we should know about this child?:

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Diet: \_\_\_\_\_

Environmental Factors: \_\_\_\_\_

**Personal Injury Only:**

Was your child injured in an automobile accident?  Yes  No

If Yes, please explain:

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Was the child riding in a car seat?  Yes  No

Was the car seat in the:  Front  Rear and was the car seat facing:  Forward  Backward

Was the child struck by an airbag?  Yes  No

Was the child in a booster seat?  Yes  No

Was the vehicle struck from the:  Rear  Front  Left Side  Right Side

List any visible bumps, bruises, cuts, etc. on the child that were caused by the accident:

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**About Your Health Care:**

Chiropractic provides three types of care. The first is **Condition-Based Care** which corrects the most recent layer of spinal and neurological conditions of the vertebral subluxation complex (VSC). This care usually reduces or eliminates the symptoms. Then begins **Health Care**, which corrects the accumulated damage that occurred when there were few symptoms. And finally, chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you will be able to begin a course of care that fits your health goals.

**I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.**

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PRINT Patient Name

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Signature of parent or legal guardian

Date

# Acceptance Agreement — Palmer Clinics

## **The Teaching Clinics:**

The Palmer Clinics are the foremost chiropractic teaching clinics in the world. Student interns, in their last year-and-a-half of 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 directly oversee your care. Your D.C., also called a “faculty clinician,” will assign a student intern to work with your case under his/her direct 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 your faculty clinician and you regarding your health care may be overheard by others in the vicinity of the conversation.

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## 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 Chiropractic Clinics are teaching clinics.
- My personal healthcare information may be overheard by others in the clinic setting and 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.

**Insurance:** The Clinics accept assignment for most insurance coverage and will be happy to pre-verify your insurance coverage. You will need to provide your insurance card for this process.

**Medicare/Medicaid:** Palmer Chiropractic Clinics will accept assignment for Medicare/Medicaid. Patients are responsible for their co-payment and payment for any services not covered by Medicare/Medicaid.

**Personal Injury:** In most cases, Palmer Chiropractic Clinics will accept assignment for payment. If Palmer Chiropractic Clinics accepts assignment for payment the patient is still legally responsible for their account balance. Patients will be required to sign a lien in the case of personal injuries. In this situation, you are asked to authorize direct payment to the clinic through your attorney or the insurance company, and permit the endorsement of co-issued checks.

**Workers' Compensation:** Work-related injury cases are accepted on assignment with permission of the employer and prior authorization from the employer's compensation insurance carrier.

**I have read the above statements and accept these conditions.**

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_