PAMER CHIROPRACTIC LIFE CENTER EAST
DAVID C. PAMER, D.C.
MEGAN PAMER, D.C.

265 N. MCELROY RD.
MANSFIELD, OH 44905
(419) 589-9898

PATIENT INFORMATION---Please Print

GENERAL INFORMATION

Patient Last Name _____ First Name _____
Address _____ Care of _____
(Parent or financially responsible person)
City _____ State _____ Zip Code _____ Phone (Home) _____
Driver's License # _____ No. Children _____ Phone (Work) _____
Email Address _____ Cell Phone _____

Sex M F	Married Single Widowed Divorced	Age	Date of Birth / /	Social Security Number -- --

Employer's Name _____
Address _____
City _____ State _____ Zip Code_____
Phone _____ Occupation _____

Spouse's Name _____ Spouse's Employer _____
Spouse's Date of Birth _____

EMPLOYED
Full Time Part Time
Retired Not Employed

STUDENT
Full Time Part Time
Non-Student

REFERRED BY: _____

INSURANCE INFORMATION

Primary Insurance Company Name _____	***Complete only if patient is not the insured***
Insured's Name _____ ID/Membership # _____ Policy/Group # _____ Provider Customer Service Phone _____	Patient's Relationship to Insured _____ Insured's Date of Birth _____/_____/_____ Insured's Employer _____
Secondary Insurance Company Name _____	***Complete only if patient is not the insured***
Insured's Name _____ ID/Membership # _____ Policy/Group # _____ Provider Customer Service Phone _____	Patient's Relationship to Insured _____ Insured's Date of Birth _____/_____/_____ Insured's Employer _____

Are you seeing the Doctor today due to a:
(If yes, please inform the front desk)
Work-Related Injury? Yes___ No ___ Date of Injury _____

Auto Accident? Yes ___ No ___ Date of Injury _____

RELEASE AND ASSIGNMENT

Pamer Chiropractic Life Center East conforms to the current HIPAA guidelines. You may request a copy of our HIPAA Policy at the front desk. Please sign below to indicate you have been made aware of its availability.
Patient's Signature _____ Date _____

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor.
Patient's Signature _____ Date _____

I understand that Pamer Chiropractic will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.
Patient's Signature _____ Date _____

POLICIES

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. X-rays are the property of this office and are used for treatment purposes. A copy of your x-rays may be requested for a fee. Fees are determined and based upon total number of x-rays as outlined by the Department of Health.

3. Method of payment you plan to use to take care of today's charges? (Please check one choice)

☐ CASH ☐ CHECK ☐ VISA/MASTERCARD/DISCOVER

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Pamer Chiropractic Life Center East will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Pamer Chiropractic Life Center East will be credited to my account upon receipt. **However**, I clearly understand and agree that all my services rendered me are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to account balance. I authorize Pamer Chiropractic Life Center East to obtain a credit report if deemed necessary.

Please Note:
This will be our only notice to you. Due to our efforts to keep costs down and control our outstanding accounts, all accounts over 30 days past due are subject to collection agency procedures and additional costs.

Patient Signature_____ Date_____

Guardian Signature Authorizing Care_____ Date_____

EMERGENCY CONTACT INFORMATION: *[Please list someone OUTSIDE OF YOUR HOME---Thank you!!]*

In case of emergency, please notify_____

Relationship_____

Address _____
_____
_____

Phone # _____

PATIENT HISTORY/EXAMINATION FORM

_____Complete ALL questions below _____

1. What are your **major complaint(s)/illnesses?**_____
_____

2. What are your **minor complaint(s)/illnesses?**_____
_____

3. How **long** have you been experiencing your major complaint? □ Days □ Weeks □ Months □ Years

Mechanism of Injury

4. What was the **cause** of your major complaint that brought you into the office today (how did it happen)?
_____
_____

5. **When** did you first experience your major complaint? _____

6. What have you done **prior** to coming to this office to treat your major and minor complaints?
_____
_____

7. When do you **notice** your complaint or complaints the most? □ AM □ PM □ BOTH

8. How long does it last? _____Minutes _____Hours

9. What makes it feel **worse**? □ Sitting □ Standing □ Lying □ Activity □ Other_____

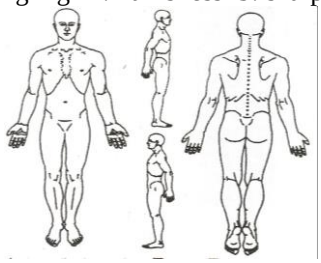
10. What makes it feel **better**? □ Sitting □ Standing □ Lying □ Activity □ Drugs □ Other_____

11. What best describes the character and quality of your major illness or pain?

A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain

12. Have you ever had this problem in the past? □ Yes □ No

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters: A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain



14. On the scale below, please **circle** the **severity and intensity** of your **main complaint** (at its' worst):

None		**Slight**		**Mild**		**Moderate**			**Severe**
1	2	3	4	5	6	7	8	9	10

15. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

Occasional			**Intermittent**			**Frequent**			**Constant**
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

16. Does your pain radiate? _____Y _____N Where does it radiate to? _____

Signature _____ Date _____

Patient History
Please check (x) all present and past symptoms.

HEAD:
___Headache
___Sinus
___Entire head
___Back of head
___Forehead
___Temples
___Migraine
___Loss of memory
___Light-headed
___Fainting
___Light bothers eyes
___Blurred vision
___Double vision
___Loss of vision
___Loss of balance
___Loss of taste
___Loss of hearing
___Dizziness
___Pain in ears
___Ringing or noises in ears

NECK:
___Pain in neck
___Sharp
___Dull
___Ache
___Neck pain with movement
___Forward
___Backward
___Turning (L) (R)
___Bending (L) (R)
___Pinched nerve in neck
___Neck feels out of place
___Muscle spasms in neck
___Grinding sounds in neck
___Popping sounds in neck

SHOULDERS:
___Pain in joint (L) (R)
___Pain across shoulders
___Arthritis (L) (R)
___Can't raise arm
___Above shoulder level
___Over head
___Tension in shoulders
___Pinched nerve in shoulder (L) (R)
___Muscle spasms in shoulder

ARMS AND HANDS:
___Pain in arm
___Tennis elbow
___Pain in hands/fingers (L) (R)
___Pins and needles sensation (L)(R)
___Numbness (L) (R)
___Hands cold
___Loss of grip strength
___Sore/swollen joints in fingers

MIDBACK:
___Mid-back pain
___Pain between shoulder blades
___Sharp stabbing
___Dull ache
___Muscle spasms

CHEST:
___Chest pain
___Shortness of breath
___Rib pain
___Breast pain
___Irregular heartbeat

ABDOMEN:
___Nervous stomach
___Foods can't eat_____
___Nausea
___Gas
___Constipation
___Diarrhea
___Hemorrhoids

LOW BACK:
___Lower back pain
___Sharp
___Dull
___Ache
Location:
___Upper lumbar
___Lower lumbar
___Hip
___Low back pain is worse when
___Working
___Lifting
___Stooping
___Standing
___Sitting
___Bending
___Coughing
___Lying down
___Walking
___Pain relieved when_____
___Slipped disc
___Low back feels out of place
___Muscle spasms

HIPS, LEGS & FEET:
___Pain in buttocks (L) (R)
___Pain in hip joint (L) (R)
___Pain down leg (L) (R)
___Knee pain (L) (R)
___Outside
___Inside
___Leg cramps
___Feet cramps
___Pins and needles in legs
___Numbness in legs/feet
___Swelling in legs/feet

WOMEN ONLY:
___Menstrual pain
___Cramping
___Irregularity
___Cycle ___Days
___Birth control _____type
___Hysterectomy
___Tumors/Cancer_____
___Discharge
___Menopause
___Abortions
___Are you pregnant

MEN ONLY:
___Urinary frequency
___Difficulty urination
___Night urination
___Prostate swelling

GENERAL:
___Nervousness
___Irritable
___Depressed
___Fatigue
___Run-down feeling
___Normal sleep _____hrs
___Loss of sleep
___Loss of weight _____lbs
___Weight gain _____ lbs
___Coffee _____cups/day
___Tea _____cups/day
___Cigarettes _____pack/day
___Diabetes
___Hypoglycemia

OTHER _____
_____

Medications: _____
_____
_____
_____

Signature: _____ **Date:** _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion.

Adjustment: A Chiropractic Adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

_____ _____
Signature Date

FEMALES ONLY:

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period _____.

_____ _____
Signature Date

CONSENT TO EVALUATE AND ADJUST A MINOR:

I _____ being the legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care. If you agree sign below.

_____ _____
Signature Date

INFORMED CONSENT FOR TREATMENT

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I _____ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine, exercises and traction. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

- Soreness: It is common to experience muscle soreness during treatment
- Uncomfortableness: Temporary symptoms (dizziness, nausea) can occur, but are rare.
- Fractures/Joint Injury: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
- C.V.A.: Cerebral vascular accidents from chiropractic adjustments are extremely rare.

Treatment Results
I understand there are benefits associated with treatment including decreased pain, improved mobility and function and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatment Available
Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing, which may include Associates, interns, preceptors, Chiropractic Assistants, etc and hereby provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

OFFICE USE ONLY:
Patient Status At Time Of Consent:

( ) Of Legal Age
( ) Oriented x3
( ) Coherent/Lucid
( ) Proficient English
( ) Assisted by Interpreter
( ) Medicated, but Unimpaired
( ) Denies Use of Alcohol or Recreational Drugs Prior to Consent
( ) Unable to Give Legal Consent
( ) Consent Given Via Legal Guardian

I certify that this form accurately reflects the patient's status during the informed consent process.

_____ _____
Doctor/Staff Signature Date

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