Gerald Palmes D.C

- **Name**_____**Address**_____
- **City**_____ **State**_____ **Zip**_____ **Home Phone** _____**Cell Phone**_____
- **E-mail** _____ **Work E-mail**_____
- **SSN** _____ **Date of Birth**_____ **Age**____ **Height**_____ **Weight**_____ **Male**_____ **Female**____

Married_____ Single_____ Divorced_____ # of Children _____ Name of Spouse or Parent_____

Employer_____Address_____

City_____ State ____ Zip _____ Work Phone _____ Occupation_____

Family Physician Name_____ Physician's location_____

Have you ever had Chiropractic care?_____ If yes, Doctor's name _____ Date of last visit_____

If you are experiencing any pain (neck, mid back, low back, etc.), health problems, symptoms, and/or complaints, please list them in order of severity

- **1.**_____ **For how long?** _____
- **2.**_____ **For how long?** _____
- **3.**_____ **For how long?** _____

Have any of these been getting **worse** or staying the **same**?_____ Describe _____

List all doctors consulted for these conditions: 1._____ 2. _____ 3. _____

Please check all medications (over the counter and/or prescribed) you are currently taking: __Aspirin/Tylenol __Pain killers __

Muscle relaxers __Insulin __ Birth control __Sleeping pills __Anti- depressants __Other

Is this work related? ____ Does your job cause you to experience any of these complaints? ____ If yes, please describe:

_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ___ If yes, describe:

_____

In the past, have you ever suffered a work injury? __ If yes, what is the date of injury? _____

Do you have an attorney representing you for this injury? ____ If yes, name of attorney: _____

Have you been involved in an auto accident in the past 12 months? ____ If yes, date of auto accident: _____

How many other passengers were in the car with you? ____ What is the name of your Auto Insurance Co.? _____

Have you had any surgeries or hospitalizations? ____ If yes please list: _____ Please list any

current or past injuries not listed above: _____

Health Insurance Co. Name _____ Policy holder name/DOB _____

Name of Spouse's Health Insurance (if applicable) _____ Policy holder name/DOB_____

Use this rating scale to rate your pain and ability to perform the following activities:

0	1	2	3	4	5	6	7	8	9	10
No Pain Completely Able to Function										Worst Pain Totally Unable to Function

1. **Family/Home Responsibilities:** Activities related to the home or family including chores and duties performed around the house. (Yard work, doing dishes, errands, favors for family members, driving children to school, etc.) _____

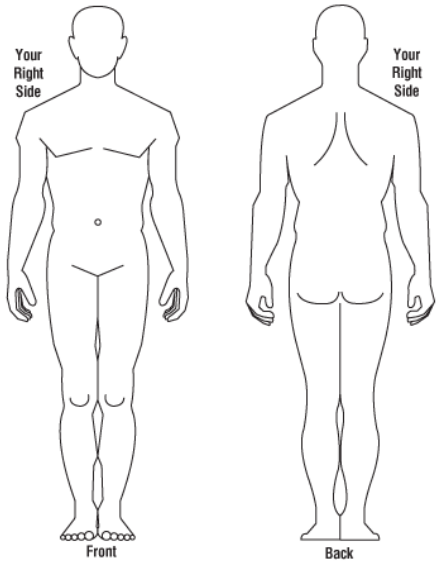
2. **Recreation/ Social Activity:** Hobbies, sports, and other similar leisure time activities. As well as Activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____

3. **Occupation:** Activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

4. **Self Care/Life Support Activity:** Activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc). As well as basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis **only**. California State Law requires we maintain your x-rays. The x-ray itself is the property of this office. They may be loaned to another facility with authorization **only**.

- **Patient's Signature** _____ **Date** _____