Patient Intake Form

PALM Health Center

1116 Belcher Rd. Dunedin, FL. 34698

(727) 733-0433

Chart #_____

Name:_____**Date:**_____

Address:_____**City:**_____**State:**_____**Zip**_____

Phone #:_____ **Cell #**_____

Email:_____(for general office emails/reminders/promotions)

Sex: Male_____ Female_____ Marital Status_____ D.O.B:_____

S.S #:_____ Employment:_____

Current Height:_____ Weight:_____Blood Pressure (if known):_____

Have you ever been adjusted or treated with a chiropractor before? Yes No

If so, when was your last treatment? _____ Who referred you here? _____

NATURE OF INJURY:

Are your present symptoms due to an: *Auto Accident *Personal Injury *Work related or * Neither

Who has the incident been reported to: * Auto Insurance *Attorney * Employer *_____

What was the date of your injury? _____ Name of Auto Ins?_____

Auto Accident Claim #_____ Adjuster's Name & #_____

Attorney Name and #:_____

Were you treated at the scene of the accident by a medic? *YES *NO

Were you admitted to the hospital due to this condition: *YES *NO By Ambulance? *YES *NO

If so, what Hospital? _____

What other doctors have you treated with-for this condition:_____

Have you had any X-rays or Mri's taken for this condition? *Yes *No

If so, when & where were these studies done and what area of the body:_____

SYMPTOMS:

List ALL of your symptoms you are experiencing TODAY: **Choose the level of severity for each symptom**

_____ 1 (very mild) 2 3 4 5 6 7 8 9 10 (remarkably severe)

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Have you missed work due to these conditions? *Yes *No If so, To:_____ _From:_____

Do you Smoke? *Yes *No Drink Alcohol? *Yes *No Exercise? *Yes *No

FAMILY HISTORY:

Mother: *Diabetes *Cancer *Other_____

Father: *Diabetes *Cancer *Other_____

Brother(s): *Diabetes *Cancer *Other_____

Sister(s): *Diabetes *Cancer *Other_____

Grandparent(s) *Diabetes *Cancer *Other_____

Do you have any medical conditions that we need to be aware of?_____

MEDICATIONS:

Are you currently taking any medications for your symptoms: *Yes *No

(If so, please list them below)

Have you ever had any surgeries related to the spine? *Yes *No

If so, where_____ when_____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT _____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE