Palank Chiropractic
Dr. Brad A. Palank

1304 Main Street
Hellertown, PA 18055

Phone: (610) 838-6891
Fax: (610) 838-6754

Today's Date________/_________/_________ How did you hear about us___________________________________

Name ____ Date of Birth____________/_____________/________________

Address ____ City _______________________ State_______ Zip___________

Phone (Home) (______)_______-____________Cell Phone (_______)________-____________E-mail________________________________

Occupation ____

Marital Status________________________________ Spouse's Name____

Emergency Contact Name____ Phone Number (_______)____________-________________

Name of primary care physician:____

Have you been treated for any health condition by a physician in the last year? _____ Yes ______ No
If yes, explain____

Describe any surgeries you had, include when they were performed____
____

List current medications____

List conditions you are taking medications for: ____

Do you smoke? ______Yes ______No What is your stress level? ______Mild _____Moderate _____Severe

---

Reason for seeking care today____

When did condition begin?____

Is this condition progressively getting better or worse?__________________________________

Have you had similar pain before? __ Yes __ No If yes, explain: ____

List any other providers seen for this condition:____

List any diagnosis and type of treatment received:____

Have you received chiropractic treatment previously? _____Yes _____ No If yes, explain:____

What are your goals regarding treatment of this condition?____
____

Mark which of the following you are interested in?

__ treatment of current complaint only

__ treatment of current complaint and strategies to help prevent future episodes of pain

Palank Chiropractic
Dr. Brad A. Palank
1304 Main Street
Hellertown, PA 18055
Phone: (610) 838-6891
Fax: (610) 838-6754

Family History: If applicable, please list any known health conditions of your immediate family

Father: ____

Mother: ____

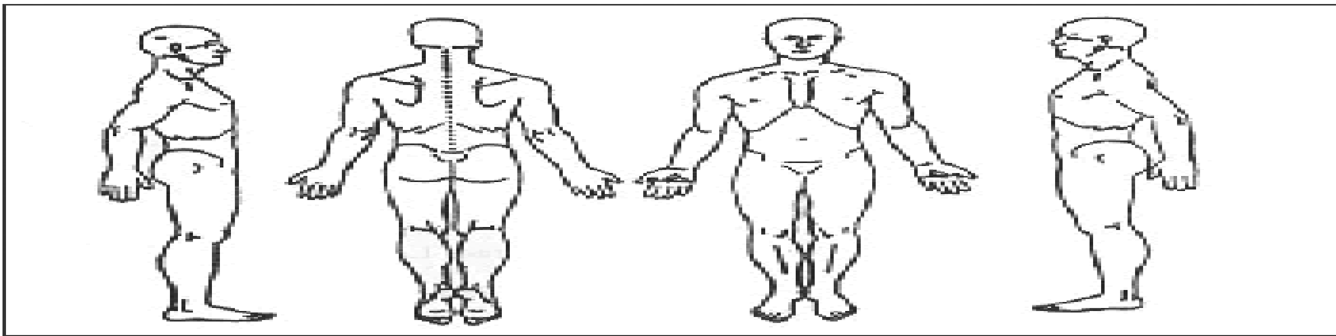
Siblings: ____

Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness === Dull Ache OOO Burning XXX Sharp/Stabbing /// Pins, Needles +++



For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
O	O	Abdominal Pain	O	O	Elbow/upper arm pain	O	O	Liver/Gall Bladder Disorder
O	O	Abnormal Weight gain/loss	O	O	Epilepsy	O	O	Loss of Bladder Control
O	O	Allergies Headache	O	O	Excessive thirst	O	O	Low back pain
O	O	Angina	O	O	Frequent Urination	O	O	Mid back pain
O	O	Ankle/foot pain	O	O	General Fatigue	O	O	Neck pain
O	O	Arthritis	O	O	Hand pain	O	O	Painful Urination
O	O	Asthma	O	O	Heart attack	O	O	Prostate Problems
O	O	Bladder Infection	O	O	Hepatitis	O	O	Shoulder pain
O	O	Birth Control Pills	O	O	High blood pressure	O	O	Smoking/tobacco Use
O	O	Cancer	O	O	Hip/upper leg pain	O	O	Stroke
O	O	Chest Pains	O	O	HIV/AIDS	O	O	Systematic Lupus
O	O	Chronic Sinusitis	O	O	Hormone Therapy	O	O	Thoracic Outlet Syndrome
O	O	Depression	O	O	Jaw pain	O	O	Tumor
O	O	Dermatitis/Eczema	O	O	Joint swelling/stiffness	O	O	Ulcer
O	O	Dizziness	O	O	Kidney Stones	O	O	Upper back pain
O	O	Drug/Alcohol Use	O	O	Knee/lower leg pain	O	O	Wrist pain

Do you have a pacemaker?________________ Females, are you pregnant?_____________

Please list an medical conditions you have/had that may not be listed above____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_______________________________________Date__________

Palank Chiropractic
Dr. Brad A. Palank
1304 Main Street
Hellertown, PA 18055
Phone: (610) 838-6891
Fax: (610) 838-6754

Signature on File

I authorize use of this form on all my insurance submissions.

I authorize release of my information to all my insurance companies.

I understand I am fully responsible for all applicable deductibles, co-payments, and co-insurance amounts.

I permit a copy of this authorization to be used in place of the original.

I authorize and assign the health insurance benefits to which I am entitled (including any checks I may receive directly from my insurance) to Palank Chiropractic for their services

I authorize Palank Chiropractic to release all information when necessary to secure the payment of benefits

I understand I may be charged a $25.00 fee for a cancellation of an appointment with less than 24 hours notice or a missed appointment.

Name____

Signature__________________________________ Date_____________________

Palank Chiropractic
Dr. Brad A. Palank
1304 Main Street
Hellertown, PA 18055
Phone: (610) 838-6891
Fax: (610) 838-6754

INFORMED CONSENT TO CHIROPRACTIC CARE

Palank Chiropractic
Dr. Brad A. Palank
1304 Main Street
Hellertown, PA 18055
610-838-6891

I hereby request and consent to the performance of an examination and treatment consisting of any of the following: various modes of physical therapy (heat, ice, electric stimulation, and ultrasound) chiropractic manipulative therapy, therapeutic exercises, therapeutic stretches, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named in this document.

I have had the opportunity to discuss with the doctor and/or any other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments listed below. Any alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom any problem. I understand and am informed that there may be some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, strains, muscle and/or joint tenderness. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I understand that I may be receiving any of the following treatments:

- Examination
- Chiropractic Adjustments (hands-on and with low force instruments)
- Flexion and Distraction Tractioning of the Spine
- Ice, Heat, Ultrasound, Electric Stimulation
- Rehabilitation Strengthening and Stretching Exercises

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions, and that all of my questions have been answered to my satisfaction. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

Patient Name: ____ Date: __________

Patient Signature: ____ Date: __________