

# WHAT TO EXPECT

## **VICTORY CHIROPRACTIC**

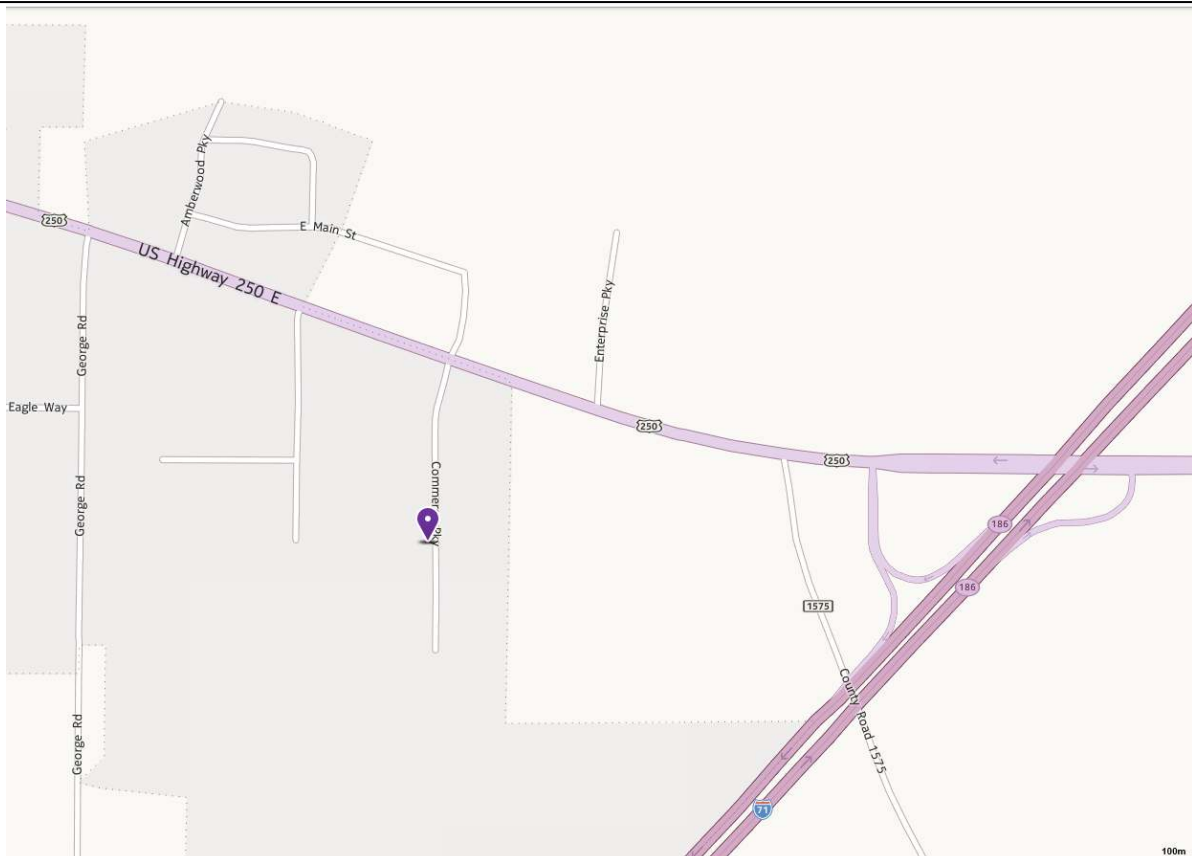
1062 Commerce Pkwy. Ashland, OH 44805  
419-281-1000

On the first office visit we will be searching for the cause of your malfunction or disease. Dr. Pamer will conduct an examination, posture analysis, and digital spine imaging, which will allow her to see any subluxations and get a better view of your health.

We will schedule you for a report of findings where Dr. Pamer will meet with you to discuss her findings from your initial examination.

We are located at 1062 Commerce Parkway in Ashland. We are across the street from Aldi in the same building as the AAA and the BMV. For more detailed directions call our office at (419) 281-1000

APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_





**VICTORY CHIROPRACTIC**

JENNY N. PAMER, D.C. DAVID C. PAMER, D.C. MATHIAS G. PAMER, D.C.

1062 Commerce Pkwy.  
Ashland, OH 44805  
(419) 281-1000

**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 (Cell) \_\_\_\_\_  
Email Address \_\_\_\_\_ Cell Phone Provider \_\_\_\_\_ Receive Text Messages Y / N

Sex M F	Married Single Widowed Divorced	Age	Date of Birth / /	Social Security Number -- --
Employer's Name _____ Address _____ City _____ State _____ Zip Code _____ Phone _____ Occupation _____				EMPLOYED Full Time Part Time Retired Not Employed
Spouse's Name _____ Spouse's Employer _____ Spouse's Date of Birth _____				STUDENT Full Time Part Time Non-Student

**REFERRED BY:** \_\_\_\_\_

**INSURANCE INFORMATION**

**\*\* Please give the front desk your insurance card and driver's license so they can make a copy for your records. \*\***

<b>Primary Insurance Company Name</b> _____ Insured's Name _____ ID/Membership # _____ Policy/Group # _____ Provider Customer Service Phone _____	<b>PLEASE BRING IN A COPY OF YOUR INSURANCE CARD AND YOUR I.D. SO WE CAN MAKE A COPY FOR YOUR RECORDS.</b>	<b>Complete only if patient is not the insured</b> Patient's Relationship to Insured _____ Insured's Date of Birth ____/____/____ Insured's Employer _____
<b>Secondary Insurance Company Name</b> _____ Insured's Name _____ ID/Membership # _____ Policy/Group # _____ Provider Customer Service Phone _____		<b>Complete only if patient is not the insured</b> 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**

Victory Chiropractic 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 Victory 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 Victory Chiropractic 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 Victory Chiropractic 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 Victory Chiropractic 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**

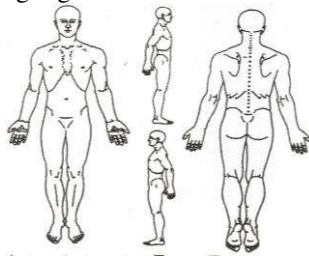
4. What was the **cause** of your major complaint that brought you into the office today (how did it happen)?  
\_\_\_\_\_  
\_\_\_\_\_

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.

<p><b>HEAD:</b>  <input type="checkbox"/> Headache  <input type="checkbox"/> Sinus  <input type="checkbox"/> Entire head  <input type="checkbox"/> Back of head  <input type="checkbox"/> Forehead  <input type="checkbox"/> Temples  <input type="checkbox"/> Migraine  <input type="checkbox"/> Loss of memory  <input type="checkbox"/> Light-headed  <input type="checkbox"/> Fainting  <input type="checkbox"/> Light bothers eyes  <input type="checkbox"/> Blurred vision  <input type="checkbox"/> Double vision  <input type="checkbox"/> Loss of vision  <input type="checkbox"/> Loss of balance  <input type="checkbox"/> Loss of taste  <input type="checkbox"/> Loss of hearing  <input type="checkbox"/> Dizziness  <input type="checkbox"/> Pain in ears  <input type="checkbox"/> Ringing or noises in ears</p> <p><b>NECK:</b>  <input type="checkbox"/> Pain in neck              <input type="checkbox"/> Sharp              <input type="checkbox"/> Dull              <input type="checkbox"/> Ache  <input type="checkbox"/> Neck pain with movement              <input type="checkbox"/> Forward              <input type="checkbox"/> Backward              <input type="checkbox"/> Turning (L) (R)              <input type="checkbox"/> Bending (L) (R)  <input type="checkbox"/> Pinched nerve in neck  <input type="checkbox"/> Neck feels out of place  <input type="checkbox"/> Muscle spasms in neck  <input type="checkbox"/> Grinding sounds in neck  <input type="checkbox"/> Popping sounds in neck</p> <p><b>SHOULDERS:</b>  <input type="checkbox"/> Pain in joint (L) (R)  <input type="checkbox"/> Pain across shoulders  <input type="checkbox"/> Arthritis (L) (R)  <input type="checkbox"/> Can't raise arm              <input type="checkbox"/> Above shoulder level              <input type="checkbox"/> Over head  <input type="checkbox"/> Tension in shoulders  <input type="checkbox"/> Pinched nerve in shoulder (L) (R)  <input type="checkbox"/> Muscle spasms in shoulder</p> <p><b>ARMS AND HANDS:</b>  <input type="checkbox"/> Pain in arm  <input type="checkbox"/> Tennis elbow</p>	<p><input type="checkbox"/> Pain in hands/fingers (L) (R)  <input type="checkbox"/> Pins and needles sensation (L)(R)  <input type="checkbox"/> Numbness (L) (R)  <input type="checkbox"/> Hands cold  <input type="checkbox"/> Loss of grip strength  <input type="checkbox"/> Sore/swollen joints in fingers</p> <p><b>MIDBACK:</b>  <input type="checkbox"/> Mid-back pain  <input type="checkbox"/> Pain between shoulder blades  <input type="checkbox"/> Sharp stabbing  <input type="checkbox"/> Dull ache  <input type="checkbox"/> Muscle spasms</p> <p><b>CHEST:</b>  <input type="checkbox"/> Chest pain  <input type="checkbox"/> Shortness of breath  <input type="checkbox"/> Rib pain  <input type="checkbox"/> Breast pain  <input type="checkbox"/> Irregular heartbeat</p> <p><b>ABDOMEN:</b>  <input type="checkbox"/> Nervous stomach  <input type="checkbox"/> Foods can't eat _____  <input type="checkbox"/> Nausea  <input type="checkbox"/> Gas  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Hemorrhoids</p> <p><b>LOW BACK:</b>  <input type="checkbox"/> Lower back pain              <input type="checkbox"/> Sharp              <input type="checkbox"/> Dull              <input type="checkbox"/> Ache</p> <p>Location:              <input type="checkbox"/> Upper lumbar              <input type="checkbox"/> Lower lumbar              <input type="checkbox"/> Hip  <input type="checkbox"/> Low back pain is worse when              <input type="checkbox"/> Working              <input type="checkbox"/> Lifting              <input type="checkbox"/> Stooping              <input type="checkbox"/> Standing              <input type="checkbox"/> Sitting              <input type="checkbox"/> Bending              <input type="checkbox"/> Coughing              <input type="checkbox"/> Lying down              <input type="checkbox"/> Walking  <input type="checkbox"/> Pain relieved when _____  <input type="checkbox"/> Slipped disc  <input type="checkbox"/> Low back feels out of place  <input type="checkbox"/> Muscle spasms</p>	<p><b>HIPS, LEGS &amp; FEET:</b>  <input type="checkbox"/> Pain in buttocks (L) (R)  <input type="checkbox"/> Pain in hip joint (L) (R)  <input type="checkbox"/> Pain down leg (L) (R)  <input type="checkbox"/> Knee pain (L) (R)              <input type="checkbox"/> Outside              <input type="checkbox"/> Inside  <input type="checkbox"/> Leg cramps  <input type="checkbox"/> Feet cramps  <input type="checkbox"/> Pins and needles in legs  <input type="checkbox"/> Numbness in legs/feet  <input type="checkbox"/> Swelling in legs/feet</p> <p><b>WOMEN ONLY:</b>  <input type="checkbox"/> Menstrual pain  <input type="checkbox"/> Cramping  <input type="checkbox"/> Irregularity  <input type="checkbox"/> Cycle _____ Days  <input type="checkbox"/> Birth control _____ type  <input type="checkbox"/> Hysterectomy  <input type="checkbox"/> Tumors/Cancer _____  <input type="checkbox"/> Discharge  <input type="checkbox"/> Menopause  <input type="checkbox"/> Abortions  <input type="checkbox"/> Are you pregnant</p> <p><b>MEN ONLY:</b>  <input type="checkbox"/> Urinary frequency  <input type="checkbox"/> Difficulty urination  <input type="checkbox"/> Night urination  <input type="checkbox"/> Prostate swelling</p> <p><b>GENERAL:</b>  <input type="checkbox"/> Nervousness  <input type="checkbox"/> Irritable  <input type="checkbox"/> Depressed  <input type="checkbox"/> Fatigue  <input type="checkbox"/> Run-down feeling  <input type="checkbox"/> Normal sleep _____ hrs  <input type="checkbox"/> Loss of sleep  <input type="checkbox"/> Loss of weight _____ lbs  <input type="checkbox"/> Weight gain _____ lbs  <input type="checkbox"/> Coffee _____ cups/day  <input type="checkbox"/> Tea _____ cups/day  <input type="checkbox"/> Cigarettes _____ pack/day  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Hypoglycemia</p> <p><b>OTHER</b> _____          _____          _____</p> <p><b>Medications:</b> _____          _____          _____          _____</p>
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**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:

- |  |  |
|--|--|
| <input type="checkbox"/> Of Legal Age            | <input type="checkbox"/> Medicated, but Unimpaired                   |
| <input type="checkbox"/> Oriented x3             | <input type="checkbox"/> Denies Use of Alcohol or Recreational Drugs |
| <input type="checkbox"/> Coherent/Lucid          | Prior to Consent   |
| <input type="checkbox"/> Proficient English      | <input type="checkbox"/> Unable to Give Legal Consent                |
| <input type="checkbox"/> Assisted by Interpreter | <input type="checkbox"/> 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