

Palmer Center for Natural Healing

8600 E. Shea Blvd. #110, Scottsdale AZ 85260 480-443-2584 www.wellnessdoc.com

Date _____ Home Phone _____ Work Phone _____ Cell # _____
 Patient _____ e-mail: _____

Street Address _____ Last Name _____ First Name _____ City _____ State _____ Zip _____

Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced

Social Security # _____ - _____ - _____ Insured's Name _____ D.O.B. ____/____/____
 Last Name First Name Initial

Relationship to Insured Self Spouse Child Other How many dependent children do you have? _____

Is insurance thru your / you spouse's / or parents' employer? Yes No

Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time City _____ State _____ Zip _____
SPOUSE (PARENT)	Name _____ Last Name First Name Initial Birth date _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
PATIENT INSURANCE INFORMATION	Insurance Company or Health Plan _____ ID #: _____ Policy/Group #: _____ Name of Insured: _____ Effective Date _____ Ins. Address _____ Ins. Phone# _____
SPOUSE /2ndary INSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ ID#: _____ Name of Insured: _____ Effective Date: _____ Ins. Address: _____ Ins. Phone# _____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No Your Initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address _____
PATIENT AGREEMENT	<i>Legal Assignment of Benefits, Release of Medical/Plan Documents & Appointment of ERISA Representation</i> <p>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Palmer Center for Natural Healing all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer or my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.</p> <p>I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor/clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. I appoint this office to act as my ERISA Authorized Representative to appeal on my behalf. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy / plan, please advise & disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment shall be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.</p> <p>_____ Signature of Insured / Guardian</p> <p>_____ Date</p>

PALMER CENTER FOR NATURAL HEALING (480) 443-2584
PATIENT HISTORY

NAME _____ DATE _____

OFFICE USE ONLY

Consultant's Initials _____

YOUR HEALTH HISTORY

The general state of your health is:

(Excellent ____) (Good ____) (Average ____) (Fair ____) (Poor ____)

Describe your energy level on average from 1 –10 (10 being highest): _____

When during the day is your energy the best? _____ Worst? _____

What is your current approximate weight? _____ Height? _____ Weight 1 yr ago? _____

As an adult, what's been your maximum weight? _____ Minimum _____ Don't include pregnancy

What do you do for work? _____ Hours per day Sitting ____, Standing ____, Moving ____

How were you referred to us? _____

Any previous chiropractic care? Y / N If so, who and when? _____

What is your PRIMARY COMPLAINT? (Give as much detail as possible)

How Long Ago Was The Onset?: _____

Have You Ever Had Similar Symptoms Before? Y / N When: _____

Do You Know What Caused This? (TRAUMA / ACCIDENT / GRADUAL ONSET / DON'T KNOW)

Is The Pain; (CONSTANT / FREQUENT / OCCASIONAL)

Is The Condition; (GETTING BETTER / WORSE / STAYING THE SAME)

Does The Pain Radiate Or Refer Anywhere? _____

Does Coughing / Sneezing Increase The Pain? _____

What Have You Done For Treatment? (ICE / HEAT / NSAIDS / MEDICATIONS) Has That Helped? Y / N

What makes it worse? _____

Have You Seen Any Other Health Care Providers For This Condition? Y / N (Including naturopathic physician, acupuncturist, or other alternative health practitioner for your current problem)

If Yes; WHO _____ WHEN _____ TYPE OF PHYSICIAN _____

What was the treatment and the results? _____

Any Surgery Or Previous trauma To The Area? _____

VISUAL ANALOGUE SCALE for your Primary Complaint:
INDICATE THE INTENSITY OF YOUR PAIN
WITH AN X

NO PAIN WORST
0 _____ 10

What is your SECONDARY COMPLAINT? Please describe in detail. Note when you first noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and continuation?

VISUAL ANALOGUE SCALE for your Secondary Complaint:
INDICATE THE INTENSITY OF YOUR PAIN
WITH AN X

NO PAIN WORST
0 _____ 10

Patient Name _____ Date _____

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If there is a **THIRD OR MORE ISSUES**, please list them below in order of severity or importance to you. If you have a specific health condition please describe in detail as in your secondary complaint. Please include the types of practitioners you have seen for this issue, and the results

DO YOU:	<u>YES</u>	<u>NO</u>	<u>HOW MUCH / HOW OFTEN?</u>	PRODUCTS / DOSAGE
SMOKE	_____	_____	_____	
CAFFEINE	_____	_____	_____	
ALCOHOL	_____	_____	_____	TYPE: _____
EXERCISE	_____	_____	_____	
TAKE VITAMINS	_____	_____	PRODUCTS/DOSAGE	_____

Do you have any allergies to any drugs, herbs, foods, animals or other? Y / N What? _____

PLEASE LIST ANY MEDICATIONS OR OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING, FOR WHAT REASON, AND DOSAGE:

Any Surgery Anywhere In The Body? (Provide dates) _____

Are You Taking Immune Strengthening Supplements? _____

Are You Being Treated For Any Other Conditions? _____

Have You Ever Been Involved In An Auto Accident? Y / N If yes, when? _____

Have You Ever Had Chiropractic Care? Y / N How long ago? _____

Name of Doctor _____

FEMALE: Are You Pregnant? Y / N PLEASE INITIAL _____

Date Last Menstrual Cycle began? _____

PERSONAL HABITS:

What do you enjoy most in your life? _____

What are your interests and hobbies? _____

What do you worry about most in your life? _____

On a scale of 1-10, how would you rate your quality of sleep? _____

Do you awaken at night? _____ What time do you usually awaken? _____

Do you sweat while sleeping? Y / N Do you wake up feeling refreshed? _____

Do you nap often? Y / N For how long? _____

Do you feel warm / cool or average when you wake up? _____

Do you feel that your hands or feet are warm or cool or average temp when you wake up? _____

Do you enjoy your work? Y / N Do you take vacations? Y / N How often? _____

Are you in a happy, satisfying relationship with someone? (Very, mostly, somewhat, not)

How often do you get colds or flu, sore throat or yeast infections/year? _____

When you rise quickly from a sitting or lying down position, do you get dizzy? Y / N

If yes, how often? (daily, few times/week, 1xweek, 2xmonth, 1xmonth, rarely)

OFFICE USE ONLY

Consultant's Initials _____

Patient Name _____ Date _____

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What is your current level of education? _____ Are you satisfied with this? Y / N
What do you use for drinking water? (*bottled, filtered or tap water*) Ounces of water per day _____

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OCCUPATIONAL/HOUSEHOLD

How long have you lived at present address? _____ (*Please describe location. I.e.: old / new, construction, damp, moldy*) _____

Where have you lived previously? _____ (*Please describe location. I.e.: old / new, construction, damp, moldy*) _____

Do you have specialized air filtration at home? Y / N Do you live in the city? Y / N

Do you work in an office building? Y / N Is there any specialized air filtration at work? Y / N

Do you work in the presence of toxic fumes of chemicals? Y / N

Do any of your hobbies involve toxic materials? Y / N

Are you exposed to second hand smoke currently? Y / N

Organ Systems Health Issues- If you would like us to evaluate you for organ / gland systems issues to determine if we can help you or, who we may suggest that you be referred to, please ask for the Supplemental **Systems Review Intake Form**.

FAMILY HEALTH HISTORY:

- | | | | |
|-----------------|------------------------|---------------------|---------------------|
| _____ ALLERGIES | _____ DEPRESSION | _____ HEART DISEASE | _____ SICKLE CELL |
| _____ ANEMIA | _____ DIABETES | _____ SKIN DISEASE | _____ CATARACTS |
| _____ ARTHRITIS | _____ GENETIC PROB. | _____ SEIZURES | _____ VENEREAL DIS. |
| _____ ASTHMA | _____ HYPOGLYCEMIA | _____ STROKE | |
| _____ CANCER | _____ HIGH BLOOD PRES. | _____ THYROID PROB. | |

What is your weakest organ system and why? _____

PERSONAL HEALTH HISTORY: List all current © or past (P) conditions

_____ (C or P)	_____ (C or P)	_____ (C or P)
_____ (C or P)	_____ (C or P)	_____ (C or P)
_____ (C or P)	_____ (C or P)	_____ (C or P)
_____ (C or P)	_____ (C or P)	_____ (C or P)

Please list anything else that you wish us to know about

Patient Name: _____

Signature _____ Date: _____

PAIN DRAWING

Tell Us Where You Hurt

Mark the areas on your body where you feel discomfort. Mark areas of radiating pain from origin to end point. Use the appropriate symbols below to describe the character of the pain.

ACHE >>>>
>>>>

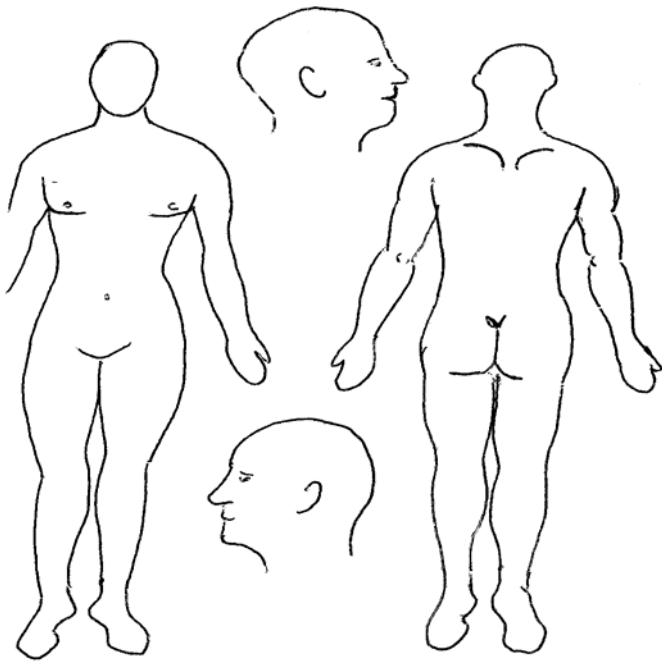
NUMBNESS =====
=====

PINS & NEEDLES *****

BURNING+++++
+++++

STABBING //////////////
////////////////

THROBBING ~~~~~
~~~~~



Different people understand information via different means. Some are more visual, some by listening to audio or verbal, and some by feelings (kinesthetic). So that we may be most effective in communicating information to you in your preferred style, please place a number 1 to 3 next to the appropriate style you learn and understand (1 best - 3 least):

\_\_\_\_\_ Visual (by seeing)

\_\_\_\_\_ Auditory (by hearing)

\_\_\_\_\_ Feelings (Kinesthetic)

Patient Name \_\_\_\_\_

PALMER CENTER FOR NATURAL HEALING (480) 443-2584

Date \_\_\_\_\_

## Conditions Checklist

### Acne

Alcoholism  
Allergic Rhinitis  
Alopecia  
Alzheimers Disease  
Amenorrhea  
Amyloidosis  
Anemia  
Angina  
Angiodema  
Anorexia Nervosa  
Anxiety  
Appendicitis  
Arthritis  
Asthma  
Atherosclerosis  
Attention Deficit Hyperactivity Disorder  
Benign Prostatic Hyperplasia  
Bile Insufficiency  
Bronchitis  
Bulimia Nervosa  
Burns  
Cancer Bone  
Cancer Brain  
Cancer Breast  
Cancer Colorectal  
Cancer Lung  
Cancer Prostate  
Cancer, Skin  
Candidiasis  
Carpal Tunnel Syndrome  
Cataracts  
Chronic Fatigue Syndrome  
Chronic Obstructive Pulmonary Disease  
Cirrhosis of the Liver  
Common Cold  
Congestive Heart Failure  
Conjunctivitis  
Constipation  
Cough  
Crohns Disease  
Cutaneous Drug Reactions  
Cystic Fibrosis  
Degenerative Disk Disease  
Dementia  
Depression  
Dermatitis  
Diabetes Mellitus  
Diarrhea  
Diverticular Disease  
Dysbiosis  
Dysmenorrhea  
Dysphagia  
Eczema  
Edema  
Encephalitis, Viral  
Endocarditis  
Endometriosis  
Erythema  
Fainting  
Fever of Unknown Origin  
Fibromyalgia  
Flu  
Food Allergy  
Food Poisoning  
Frequent Cold and Flu  
Frostbite  
Gallbladder Disease  
Gastritis  
Gastroesophageal Reflux Disease

### TO THE LEFT OF THE CONDITION

Please mark **(H)** if you currently have,  
Mark **(P)** if you have had in the past, or  
Mark **(I)** if you would like more  
information.

Glaucoma  
Gout  
Hair Disorders  
Headache, Migraine  
Headache, Sinus  
Headache, Tension  
Heat Exhaustion  
Hemophilia  
Hemorrhoids  
Hepatitis Viral  
Herpes Simplex Virus  
Herpes Zoster Varicella Zoster Virus  
Hirsutism  
Histoplasmosis  
HIV and AIDS  
Hyperchlorhydria  
Hypercholesterolemia  
Hyperkalemia  
Hyperparathyroidism  
Hypertension  
Hypert thyroidism  
Hypochlorhydria  
Hypochondriasis  
Hypoglycemia  
Hypoparathyroidism  
Hypothermia  
Hypothyroidism  
Infantile Colic  
Influenza  
Insect Bites and Stings  
Insomnia  
Intestinal Parasites  
Irritable Bowel Syndrome  
Laryngitis  
Leaky Gut Syndrome  
Leukemia  
Low Back Pain  
Lyme Disease  
Lymphoma  
Macular Degeneration  
Measles  
Meningitis  
Menopause  
Metabolic Syndrome  
Miscarriage  
Mononucleosis  
Motion Sickness  
Multiple Sclerosis  
Mumps  
Muscular Dystrophy  
Myeloproliferative Disorders  
Myocardial Infarction  
Nail Disorders  
Neuralgias  
Neuritis  
Obesity  
Osteoarthritis  
Osteomyelitis  
Osteopenia  
Osteoporosis

Otitis Media  
Pancreatic Insufficiency  
Pancreatitis  
Parkinsons Disease  
Pelvic Inflammatory Disease  
Peptic Ulcer  
Pericarditis  
Perimenopause  
Peritonitis  
Pertussis  
Pharyngitis  
Photodermatitis  
Post Traumatic Stress Disorder  
Preeclampsia  
Premenstrual Syndrome PMS  
Primary Pulmonary Hypertension  
Proctitis  
Prostatitis  
Psoriasis  
Pulmonary Edema  
Pyloric Stenosis  
Radiation Damage  
Raynauds Phenomenon  
Reiters Syndrome  
Rheumatoid Arthritis  
Roseola  
Roundworms  
Rubella  
Sarcoidosis  
Scleroderma  
Scoliosis  
Seizure Disorders  
Serum Sickness  
Sexual Dysfunction  
Sexually Transmitted Diseases  
Shock  
Sinusitis  
Sleep Apnea  
Sprains and Strains  
Stress  
Stroke  
Systemic Lupus Erythematosus  
Tempomandibular Joint Dysfunction  
Tendinitis  
Thyroiditis  
Transient Ischemic Attacks  
Tuberculosis  
Ulcerative Colitis  
Urethritis  
Urinary Incontinence  
Urinary Tract Infection in Women  
Urolithiasis  
Uveitis  
Vaginitis  
Varicose Veins  
Warts  
Wounds

**Stress can be an important factor in any and all health conditions. The following Survey will help us to determine the Stress “Load” that you have experienced in the last 2 years.**

(Your Name)

(Date)

## The Holmes-Rahe Stress Scale for \_\_\_\_\_

Read each of the events listed below, and check the box next to any event which has occurred in your life **in the last two years**. There are no right or wrong answers. The aim is just to identify which of these events you have experienced lately.

| Life Events                               | Life Crisis Units |                          | Life Events                                                                                                                                                  | Life Crisis Units |                          |
|-------------------------------------------|-------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------|
| Death of spouse                           | 100               | <input type="checkbox"/> | Son or daughter leaving home                                                                                                                                 | 29                | <input type="checkbox"/> |
| Divorce                                   | 73                | <input type="checkbox"/> | Trouble with in-laws                                                                                                                                         | 29                | <input type="checkbox"/> |
| Marital separation                        | 65                | <input type="checkbox"/> | Outstanding personal achievement                                                                                                                             | 28                | <input type="checkbox"/> |
| Jail term                                 | 63                | <input type="checkbox"/> | Wife begins or stops work                                                                                                                                    | 26                | <input type="checkbox"/> |
| Death of close family member              | 63                | <input type="checkbox"/> | Begin or end school                                                                                                                                          | 26                | <input type="checkbox"/> |
| Personal injury or illness                | 53                | <input type="checkbox"/> | Change in living conditions                                                                                                                                  | 25                | <input type="checkbox"/> |
| Marriage                                  | 50                | <input type="checkbox"/> | Revision in personal habits                                                                                                                                  | 24                | <input type="checkbox"/> |
| Fired at work                             | 47                | <input type="checkbox"/> | Trouble with boss                                                                                                                                            | 23                | <input type="checkbox"/> |
| Marital reconciliation                    | 45                | <input type="checkbox"/> | Change in work hours or conditions                                                                                                                           | 20                | <input type="checkbox"/> |
| Retirement                                | 45                | <input type="checkbox"/> | Change in residence                                                                                                                                          | 20                | <input type="checkbox"/> |
| Change in health of a family member       | 44                | <input type="checkbox"/> | Change in schools                                                                                                                                            | 20                | <input type="checkbox"/> |
| Pregnancy                                 | 40                | <input type="checkbox"/> | Change in recreation                                                                                                                                         | 19                | <input type="checkbox"/> |
| Sex Difficulties                          | 39                | <input type="checkbox"/> | Change in church activities                                                                                                                                  | 19                | <input type="checkbox"/> |
| Gain of new family member                 | 39                | <input type="checkbox"/> | Change in social activities                                                                                                                                  | 18                | <input type="checkbox"/> |
| Business readjustment                     | 39                | <input type="checkbox"/> | Mortgage or loan less than \$30,000                                                                                                                          | 17                | <input type="checkbox"/> |
| Change in financial state                 | 38                | <input type="checkbox"/> | Change in sleeping habits                                                                                                                                    | 16                | <input type="checkbox"/> |
| Death of close friend                     | 37                | <input type="checkbox"/> | Change in number of family get-togethers                                                                                                                     | 15                | <input type="checkbox"/> |
| Change to different line of work          | 36                | <input type="checkbox"/> | Change in eating habits                                                                                                                                      | 15                | <input type="checkbox"/> |
| Change in number of arguments with spouse | 35                | <input type="checkbox"/> | Vacation                                                                                                                                                     | 13                | <input type="checkbox"/> |
| Mortgage over \$100,000                   | 31                | <input type="checkbox"/> | Christmas alone                                                                                                                                              | 12                | <input type="checkbox"/> |
| Foreclosure of mortgage or loan           | 30                | <input type="checkbox"/> | Minor violations of the law                                                                                                                                  | 11                | <input type="checkbox"/> |
| Change in responsibilities at work        | 29                | <input type="checkbox"/> | <p><b>Your score is: (we will score for you) _____</b></p> <p><b>On a scale of 1-10 (1 is poorly, 10 is great), how well do you handle stress? _____</b></p> |                   |                          |

**Wellness Information You'd Like to Receive:**

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**Children's and Teens' Health**

- Babies and Toddlers
- Children and Chiropractic
- Illness and Prevention
- Mental Health
- School-Age Children
- Teen Health

**Fitness**

- Exercise Reference
- Fit Life
- Fitness and Chiropractic
- Sports and Activities
- Sports Injuries
- Sports Nutrition

**Health at Work**

- Stress Management
- Travel and Commuting
- Work and Chiropractic
- Work Environment

**Men's Health**

- Fitness and Nutrition
- Illness and Prevention
- Men's Health and Chiropractic
- Mental Health
- Sexual Health

**Mental Health**

- Brain and Memory
- Conditions and Disorders
- Psychology and Behavior
- Therapies

**Nutrition**

- Healthy Kitchen
- Herb Reference
- Illness and Prevention
- Nutrition and Chiropractic
- Nutritional Health Encyclopedia
- Supplement Reference
- Drug Reference

**Seniors' Health**

- Fitness and Nutrition
- Illness and Prevention
- Mental Health
- Seniors and Chiropractic
- Sexual Health

**Women's Health**

- Fertility and Pregnancy
- Fitness and Nutrition
- Illness and Prevention
- Menopause
- Mental Health
- Sexual Health
- Women's Health and Chiropractic

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**Allied Therapies That Interest You:**

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- Chiropractic
- Acupuncture
- Aromatherapy
- Ayurveda
- Biofeedback
- Clinical Nutrition
- Herbal Medicine
- Homeopathy
- Hypnotherapy
- Massage Therapy
- Mind/Body Medicine
- Naturopathy
- Relaxation Techniques
- Reflexology
- Spirituality
- Tai Chi
- Therapeutic Touch
- Traditional Chinese Medicine
- Yoga

## OCCUPATIONAL/HOUSEHOLD

How long have you lived at present address? \_\_\_\_\_ (Please describe location. I.e.: old/new, construction, damp, moldy)

Where have you lived previously? \_\_\_\_\_ (Please describe location. I.e.: old/new, construction, damp, moldy)

Do you have specialized air filtration at home? (Y or N) Do you live in the city? (Y or N)

Do you work in an office building? (Y or N) Is there any specialized air filtration at work? (Y or N)

Do you work in the presence of toxic fumes of chemicals? (Y or N)

Do any of your hobbies involve toxic materials? (Y or N) Are you exposed to second hand smoke currently? (Y or N)

Do you have anything else you would like to comment on? \_\_\_\_\_

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## SEASONAL ADDRESS & PHONE INFORMATION

**Address (Street)** \_\_\_\_\_

**City** \_\_\_\_\_, **State** \_\_\_\_\_, **Postal** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Months living there** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_