

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 _____

OFFICE USE ONLY

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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: _____

Patient Name _____

Date _____

PALMER CENTER FOR NATURAL HEALING (480) 443-2584

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

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 >>>>
>>>>

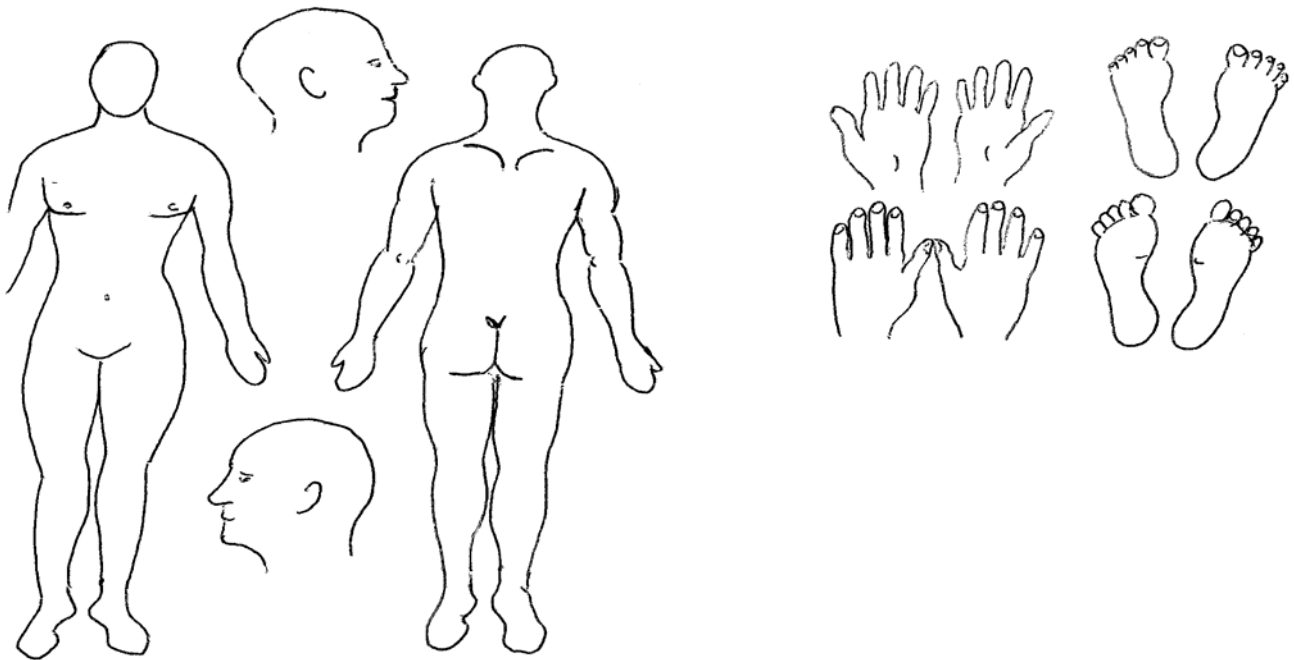
NUMBNESS =====
=====

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)

**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"/> <b>Your score is: (we will score for you) _____</b><br><b>On a scale of 1-10 (1 is poorly, 10 is great), how well do you handle stress? _____</b> |                             |

**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

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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: \_\_\_\_\_