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:_____
Last Name First Name
Street Address_____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_____☐ Full-time ☐ 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 someone else might be legally liable for? ☐ **Yes** ☐ **No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT	*Legal Assignment of Benefits, Release of Medical/Plan Documents & Appointment of ERISA Representation* 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. 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. _____ _____ Signature of Insured / Guardian Date

PALMER CENTER FOR NATURAL HEALING (480) 443-2584
YOUR CHILD'S HEALTH HISTORY

YOUR NAME_____DATE_____

YOUR CHILD"S NAME_____ MALE_____ FEMALE_____ AGE_____

OFFICE USE ONLY

Consultant's Initials ____

HEALTH HISTORY

The general state of their health is:

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

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

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

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

What's been their maximum weight? _____ Minimum_____

How were you referred to us? _____

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

_____

Rate your pregnancy on a scale of 1-10 (1 being a breeze and 10 being horrendously difficult) _____and why_____

_____

Were you ill during your pregnancy? _____ If so, what?_____

_____

Did you take antibiotics during pregnancy? _____ If so, how many courses? _____ For what? _____

Was the delivery vaginal_____ C-Section _____ How many hours did the birth take_____

Rate the birth process using the same scale ____ and why

_____

_____

Did your child ever fall off of the bed or changing table as an infant? _____ Describe_____

_____

Do you notice that they have their head turned one way more that the other while sleeping on their back or in their car seat? If so, which way? Right____ Left ____ Did you breastfeed? _____ If so, for how long? _____

At what age did they begin to walk? _____

Were they vaccinated? ____ If so, how many times ____ and against how many different diseases? ____

Give us a history of illnesses that they have has starting with their most common or severe to the least common or severe (i.e. skin, eye-ear-nose-throat, digestion or bowels, lungs, etc.):

1) _____
2) _____
3) _____
4) _____
5) _____

Have they ever taken antibiotics? ____ If so, how many courses and at what ages? _____

List any behavioral issues they have had:

1) _____
2) _____
3) _____

Have they had any learning challenges? _____ If so, what? _____

_____

List the falls or injuries that they have had:

1) _____ Age____
2) _____ Age____
3) _____ Age____
4) _____ Age____
5) _____ Age____

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

_____

_____

_____

_____

Patient Name _____

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Date _____

How Long Ago Was The Onset?:_____
Have they 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 their 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 their Primary Complaint:
INDICATE THE INTENSITY OF THEIR PAIN
WITH AN X

NO PAIN WORST

0 _____ 10

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

_____

_____

VISUAL ANALOGUE SCALE for their Secondary Complaint:
INDICATE THE INTENSITY OF THEIR PAIN WITH AN X

NO PAIN WORST

0 _____ 10

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

_____

_____

_____

DO THEY:	YES	NO	HOW MUCH / HOW OFTEN?	PRODUCTS / DOSAGE
SMOKE	_____	_____	_____	
CAFFEINE	_____	_____	_____	
ALCOHOL	_____	_____	_____	TYPE: _____
EXERCISE	_____	_____	_____	
TAKE VITAMINS	_____	_____	PRODUCTS/DOSAGE_____	

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

_____

_____

OFFICE USE ONLY

Consultant's Initials ____

Patient Name _____

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Date _____

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

_____
_____
_____

OFFICE USE ONLY

Any Surgery Anywhere In The Body? (Provide dates)_____
Are They Taking Immune Strengthening Supplements? _____
Are They Being Treated For Any Other Conditions?_____
Have They Ever Been Involved In An Auto Accident? Y / N If yes, when?_____
FEMALE: Are They Pregnant? Y / N *PLEASE INITIAL*_____
Date Last Menstrual Cycle began?_____

PERSONAL HABITS:

What do they enjoy most in their life? _____
What are their interests and hobbies? _____
What do they worry about most in their life? _____
On a scale of 1-10, how would you rate their quality of sleep? _____
What do you use for drinking water? *(bottled, filtered or tap water)* Ounces of water per day _____

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 any of their hobbies involve toxic materials? Y / N Are they exposed to second hand smoke currently? Y / N

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 their 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)
_____	_____	_____	_____	_____	_____

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

_____

_____

_____

_____

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

Parent's Signature _____ Date: _____

Patient Name _____
Date _____

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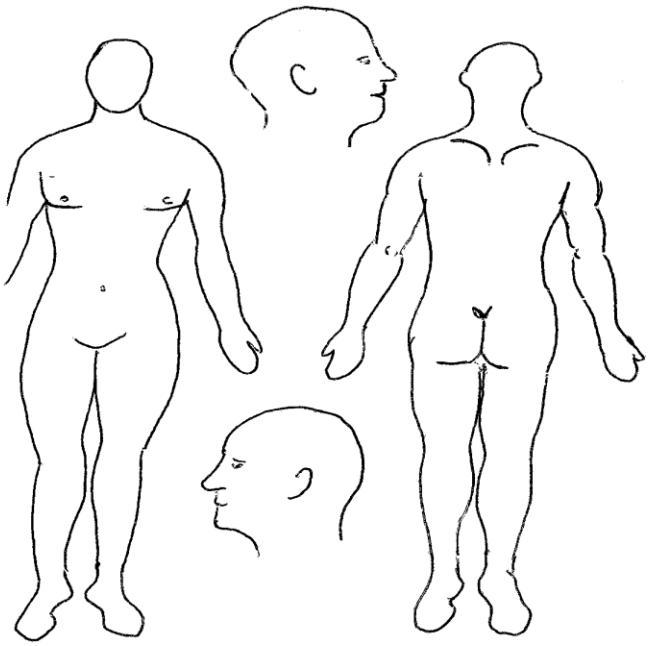
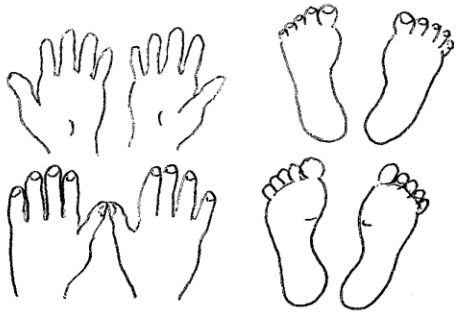
PAIN DRAWING

Tell Us Where They 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 their 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)