

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 _____

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:	YES	NO	HOW MUCH / HOW OFTEN?	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)

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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 >>>>
>>>>

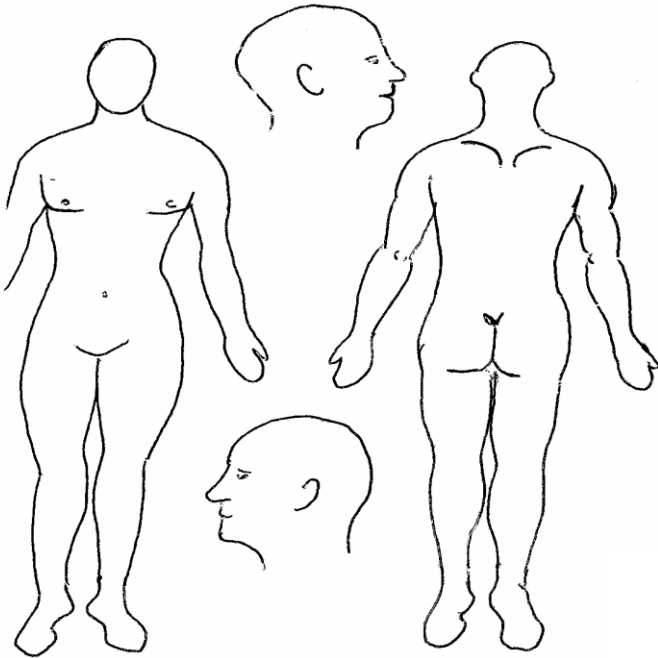
NUMBNESS =====
=====

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)