Palms Medical Group
Your home for health, wellness, life

WELCOME

PATIENT INFORMATION

Date: _____ E-mail: _____

Patient Name: _____

Address: _____

_____

City State Zip

Sex: M F Age: ____ Birthdate: _____
O Single O Married O Widowed O Divorced
Patient SS# : _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____ SS# _____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

_____

Relationship to you?_____
Primary Care Doctor? _____
Address?_____

Phone #_____

PHONE NUMBERS

Home: _____ Cell: _____

Best time/place to reach you? _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____Ext.___

ACCIDENT INFORMATION

Is condition due to an accident? O Yes O No Date: _____
Type of accident? O Auto O Work O Home O Other

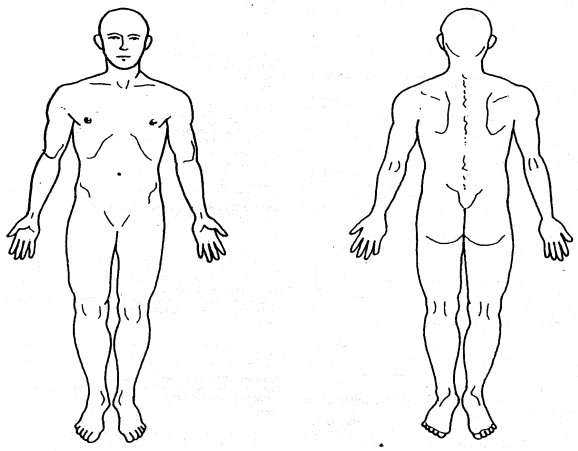
To whom have you made a report of your accident?

O Auto Insurance O Employer O Worker Comp. O Other

Attorney name (if Applicable): _____

_____

Mark an X on the picture where you have symptoms:



PATIENT CONDITION

Reason for this visit: _____

When did your symptoms first appear? _____Why?_____

_____

Is this condition getting progressively worse? O Yes O No O Unknown _____
Rate the severity of your pain on a scale from 1 (least pain) to 100 (severe pain) _____
Type of pain: O Sharp O Dull O Throbbing O Numbness O Aching O Shooting O Burning O Tingling
O Cramps O Stiffness O Swelling O Other
How often do you have this pain? _____ of times per (Daily / Weekly / Monthly) (Constant or Off/On)
Does it interfere with your: O Work O Sleep O Recreation O Daily Routine (specifically _____)
Activities or movements that are painful to perform: O Sitting O Standing O Walking O Bending O Lying Down

O Other: _____

EXERCISE

O None

WORK ACTIVITY

O Sitting

HABITS

O Smoking

Packs/Day _____

O Moderate O Standing O Alcohol Drinks/Week _____
O Daily O Light Labor O Coffee/Caffeine Drinks Cups/Day _____
O Heavy O Heavy Labor O High Stress Level Reason _____
Are you pregnant? O Yes O No Due Date: _____ Date of last Menses: _____

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

HEALTH HISTORY

What treatment have you received for this condition? O Medications O Surgery O Physical Therapy
O Chiropractic Services O None O Other _____
Name and address of other doctor(s) who have treated this condition: _____
_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	O Yes O No	Emphysema	O Yes O No	Miscarriage	O Yes O No	Scarlet Fever	O Yes O No
Alcoholism	O Yes O No	Epilepsy	O Yes O No	Mononucleosis	O Yes O No	Stroke	O Yes O No
Allergy Shots	O Yes O No	Fractures	O Yes O No	Multiple Sclerosis	O Yes O No	Suicide Attempt	OYes O No
Anemia	O Yes O No	Glaucoma	O Yes O No	Mumps	O Yes O No	Thyroid Problems	O Yes O No
Anorexia	O Yes O No	Goiter	O Yes O No	Osteoporosis	O Yes O No	Tonsillitis	O Yes O No
Appendicitis	O Yes O No	Gonorrhea	O Yes O No	Pacemaker	O Yes O No	Tuberculosis	O Yes O No
Arthritis	O Yes O No	Gout	O Yes O No	Parkinson's Disease	O Yes O No	Tumors or Growths	O Yes O No
Asthma	O Yes O No	Heart Disease	O Yes O No	Pinched Nerve	O Yes O No	Typhoid Fever	O Yes O No
Bleeding Disorders	O Yes O No	Hepatitis	O Yes O No	Pneumonia	O Yes O No	Ulcers	O Yes O No
Breast Lump	O Yes O No	Hernia	O Yes O No	Polio	O Yes O No	Vaginal Infections	O Yes O No
Bronchitis	O Yes O No	Herniated Disk	O Yes O No	Prostate Problem	O Yes O No	Venereal Disease	O Yes O No
Bulimia	O Yes O No	Herpes	O Yes O No	Prosthesis	O Yes O No	Whooping Cough	O Yes O No
Cancer	O Yes O No	High Cholesterol	O Yes O No	Psychiatric Care	O Yes O No	Other _____	
Cataracts	O Yes O No	Kidney Disease	O Yes O No	Rheumatoid Arthritis	O Yes O No		
Chemical Dependency	O Yes O No	Liver Disease	O Yes O No	Rheumatic Fever	O Yes O No		
Chicken Pox	O Yes O No	Measles	O Yes O No				
Diabetes	O Yes O No	Migraine Headaches	O Yes O No				

ASSIGMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Trenton Medical Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____Relationship: _____Date: _____