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: _____

☐ Single ☐ Married ☐ Widowed ☐ 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? ☐ Yes ☐ No Date: _____

Type of accident? ☐ Auto ☐ Work ☐ Home ☐ Other

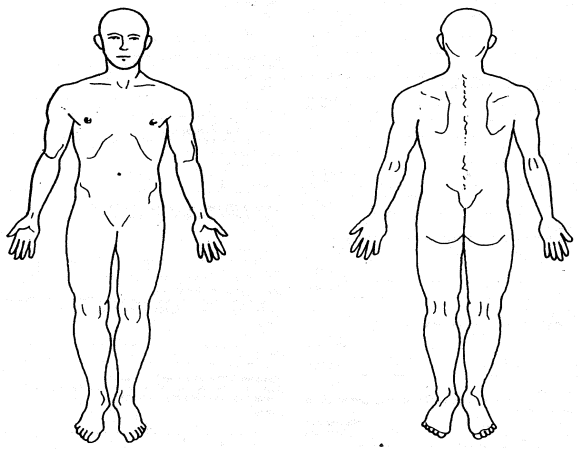
To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney name (if Applicable): _____

_____

Mark on the picture where you have symptoms / use your marker/pen tool:



PATIENT CONDITION

Reason for this visit: _____

When did your symptoms first appear? _____Why?_____

_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown _____

Rate the severity of your pain on a scale from 1 (least pain) to 100 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other ☐ ☐ ☐ ☐ ☐

How often do you have this pain? _____ of times per (Daily / Weekly / Monthly) (Constant or Off/On)

Does it interfere with your: ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Routine (specifically _____)

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

☐ Other: _____

EXERCISE

☐ None

WORK ACTIVITY

☐ Sitting

HABITS

☐ Smoking

Packs/Day _____

☐ Moderate ☐ Standing ☐ Alcohol Drinks/Week _____
☐ Daily ☐ Light Labor ☐ Coffee/Caffeine Drinks Cups/Day _____
☐ Heavy ☐ Heavy Labor ☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ 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? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ 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	○ Yes ○ No	Emphysema	○ Yes ○ No	Miscarriage	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Alcoholism	○ Yes ○ No	Epilepsy	○ Yes ○ No	Mononucleosis	○ Yes ○ No	Stroke	○ Yes ○ No
Allergy Shots	○ Yes ○ No	Fractures	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No	Suicide Attempt	○ Yes ○ No
Anemia	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mumps	○ Yes ○ No	Thyroid Problems	○ Yes ○ No
Anorexia	○ Yes ○ No	Goiter	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Appendicitis	○ Yes ○ No	Gonorrhea	○ Yes ○ No	Pacemaker	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Arthritis	○ Yes ○ No	Gout	○ Yes ○ No	Parkinson's Disease	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Asthma	○ Yes ○ No	Heart Disease	○ Yes ○ No	Pinched Nerve	○ Yes ○ No	Typhoid Fever	○ Yes ○ No
Bleeding Disorders	○ Yes ○ No	Hepatitis	○ Yes ○ No	Pneumonia	○ Yes ○ No	Ulcers	○ Yes ○ No
Breast Lump	○ Yes ○ No	Hernia	○ Yes ○ No	Polio	○ Yes ○ No	Vaginal Infections	○ Yes ○ No
Bronchitis	○ Yes ○ No	Herniated Disk	○ Yes ○ No	Prostate Problem	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Bulimia	○ Yes ○ No	Herpes	○ Yes ○ No	Prosthesis	○ Yes ○ No	Whooping Cough	○ Yes ○ No
Cancer	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Other _____	
Cataracts	○ Yes ○ No	Kidney Disease	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No		
Chemical Dependency	○ Yes ○ No	Liver Disease	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No		
Chicken Pox	○ Yes ○ No	Measles	○ Yes ○ No				
Diabetes	○ Yes ○ No	Migraine Headaches	○ Yes ○ 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: _____