PATIENT REGISTRATION

(Please print)

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1 PATIENT INFORMATION

Date _____

Name _____

Address _____

_____

Age _____ Date of Birth _____

Occupation _____

Primary Physician _____

Physician Phone _____

Who may I thank for referring you? _____

_____

Primary reason for treatment? _____

_____

2 CONTACT INFORMATION

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Best time/method to reach you _____

_____

Another person we may contact if necessary:

Name _____

Relationship _____

Home Phone _____

Work Phone_____

3 MEDICATIONS/HISTORY

Medications/food supplements you are taking

_____

_____

_____

_____

_____

Serious illnesses, accidents, or surgeries

_____

_____

_____

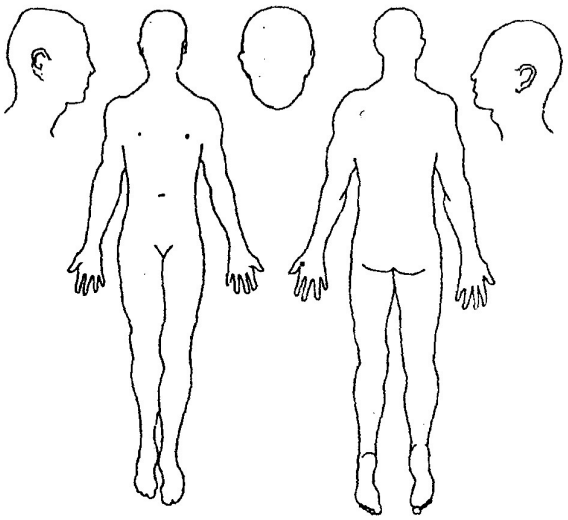
_____

Illnesses that have occurred in blood relatives:

❑Cancer ❑Hypertension
❑Diabetes ❑Kidney disease
❑Heart disease ❑Stroke

4 AREAS OF CONCERN

Please indicate painful or distressed areas.



Comments:

5 HEALTH HISTORY

Check symptoms you currently have or have had in the past year.

- ❑ Depression
- ❑ Difficulty in focusing
- ❑ Dizziness
- ❑ Easily startled
- ❑ Excessive worry
- ❑ Excessive anger
- ❑ Excessive fear
- ❑ Fatigue/tiredness
- ❑ Headaches
- ❑ Loss of sleep/poor sleep
- ❑ Loss or gain of weight
- ❑ Nervousness/irritability
- ❑ Overwhelmed by life

MUSCLE/JOINT/BONES
- ❑ Muscle tremors
- ❑ Joint pain
- ❑ Swelling in joints

Pain, weakness, numbness in
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

❑ Other pain

_____

GASTROINTESTINAL
- ❑ Belching, gas, or bloating
- ❑ Colon trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty swallowing
- ❑ Distention of abdomen
- ❑ Excessive hunger
- ❑ Gall bladder trouble
- ❑ Hemorrhoids (piles)
- ❑ Indigestion
- ❑ Nausea
- ❑ Pain in stomach
- ❑ Poor appetite
- ❑ Vomiting

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Hardening of arteries
- ❑ High or low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Previous heart attack
- ❑ Rapid/irregular heartbeat
- ❑ Swelling of ankles

EENT/RESPIRATORY
- ❑ Asthma/wheezing
- ❑ Blurred/failing vision
- ❑ Difficulty breathing
- ❑ Earache
- ❑ Enlarged glands
- ❑ Eye pain
- ❑ Frequent colds
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Gum trouble
- ❑ Nose bleeds
- ❑ Loss of hearing
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems

SKIN
- ❑ Boils
- ❑ Bruise easily
- ❑ Dry skin
- ❑ Itching/rash
- ❑ Sensitive skin
- ❑ Sore won't heal
- ❑ Sweats

GENITO/URINARY
- ❑ Blood/pus in urine
- ❑ Frequent urination
- ❑ Inability to control urine
- ❑ Kidney infection/stones
- ❑ Lowered libido

FOR MEN ONLY
- ❑ Erection difficulties
- ❑ Infertility
- ❑ Discharge from penis
- ❑ Prostrate trouble

FOR WOMEN ONLY
- ❑ Bleeding between periods
- ❑ Clots in menses
- ❑ Excessive menstrual flow
- ❑ Infertility
- ❑ Irregular cycle
- ❑ Menopausal symptoms
- ❑ Menstrual pain
- ❑ PMS
- ❑ Previous miscarriage
- ❑ Scanty menstrual flow

❑ Last period _____

Check conditions you currently have or have had in the past.

- ❑ AIDS
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Cancer
- ❑ Diabetes
- ❑ Eczema
- ❑ Emphysema
- ❑ Heart Disease
- ❑ Hepatitis Type ___
- ❑ Herpes
- ❑ HIV positive
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Ulcers

How long has it been since you had a complete medical exam?

_____

6 LIFESTYLE

Check substances you use and describe amount used.

- ❑ Alcohol _____
- ❑ Caffeine _____
- ❑ Drugs _____
- ❑ Sugar _____
- ❑ Tobacco _____

Check if your work or lifestyle exposes you to these:
- ❑ Insufficient sleep
- ❑ Hazardous substances or heavy lifting
- ❑ Long commuting times/traffic
- ❑ Stress
- ❑ Very long working hours
- ❑ Other _____

7 SIGNATURE

The information on this form is correct to the best of my knowledge. I understand that my protected health information will be used and disclosed consistent with the policies in the office's Notice of Privacy Practices, a copy of which I have received.

Signature _____ Date _____