

PATIENT REGISTRATION – Print Clearly

LAST NAME	FIRST	MIDDLE	GENDER	DATE of BIRTH
ADDRESS	CITY	STATE	ZIP	PHONE #
OCCUPATION (IF CHILD, PARENT) <input type="checkbox"/> STUDENT <input type="checkbox"/> RETIRED		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		WORK #
BUSINESS NAME	BUSINESS ADDRESS			EMAIL:
IF CHILD, PARENT NAME	PARENT ADDRESS if different			PARENT #
SPOUSE NAME	SPOUSE EMPLOYER			SPOUSE WORK #
NEARBY FRIEND OR RELATIVE	ADDRESS			FRIEND #
WHO REFERRED YOU	PHARMACY			EMAIL #

INSURANCE INFORMATION

Insurance Name _____
PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> Y <input type="checkbox"/> N
INSURED'S ID NUMBER _____ POLICY GROUP OR FECA _____
IF DIFFERENT FROM PATIENT REGISTRATION
INSURED NAME: FIRST _____ M.I. _____ LAST _____ INSURED'S DOB: _____
PHONE OF INSURED: _____ EMPLOYER'S NAME OR SCHOOL NAME _____

CURRENT / RECENT HEALTH CARE PROVIDERS • List Primary Care Physician First

HEALTH CARE SPECIALTY	NAME OF PROVIDER	ADDRESS	PHONE NUMBER

PAYMENT POLICY

<p>Payment is to be made of the time services are rendered. The law of insurance payment or reimbursement is between you and you insurance carrier. Any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, credit card (through internet processing), or money order. I agree to promptly pay all charges for services tendered and accept legal responsibility for any and all charges for the patient named above Date _____ Signature of Patient / Responsible Party _____</p>
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Date: _____

Medical History Questionnaire

Name: _____ Birth: _____ Age: _____ Gender: _____ Blood type: _____
 Height: _____ / Weight: _____ Blood Pressure: _____ Cholesterol: _____
 LDL – HDL: _____

PRESENTING HEALTH PROBLEM(S) & DESCRIPTION

TREATMENTS & RESULTS

HISTORY OF PRESENT ILLNESS: *Describe how and when the problems began and progressed*

CURRENT MEDICATIONS DOSE & FREQUENCY

RESPONSE TO MEDICATIONS

CURRENT SUPPLEMENTS DOSE & FREQUENCY

RESPONSE TO MEDICATIONS

DRUG ALLERGIES: *List and describe reactions to drugs, medications, or anesthetics.*

Allergies to Foods?

- Milk products
- Wheat or other grains
- Food dyes, additive
- Others

Allergies to Inhalants?

- Dust
- Grass. trees. pollen
- Animal dander
- Mold

Reactions to Chemicals?

- Chlorine, formaldehyde
- Cosmetics, detergents, perfumes
- Gas, glues, newsprint. paint, dye
- Smoke

INJURIES (SPRAINS, FRACTURES, SURGERIES DISLOCATIONS & SCARS)

DATE

HOSPITALIZATIONS

DATE

Please fill this portion out completely

TESTS	DATE RESULTS	TESTS	DATE RESULTS
<input type="checkbox"/> EEG	_____	<input type="checkbox"/> CT Scan	_____
<input type="checkbox"/> EKG	_____	<input type="checkbox"/> MRI	_____
<input type="checkbox"/> EMG	_____	<input type="checkbox"/> Stress Test	_____
<input type="checkbox"/> SCAN	_____	<input type="checkbox"/> X-rays	_____

FAMILY HISTORY: check any which has effected your parents, grandparents, siblings, children.

Condition	Relative/s Affected	Condition	Relatives Affected	Condition	Relatives Affected
<input type="checkbox"/> Addiction(s)	_____	<input type="checkbox"/> Depression	_____	<input type="checkbox"/> High Blood P.	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Lung Problem	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Digestive/Intest	_____	<input type="checkbox"/> Overweight	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Genetic Disease	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Bladder	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> Kidney	_____	<input type="checkbox"/> Headache	_____	<input type="checkbox"/> Suicide	_____
<input type="checkbox"/> Bleeding	_____	<input type="checkbox"/> Migraine	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Other	_____

YOUR HISTORY: Check any of the following that you have now or ever have had.

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema Asthma	<input type="checkbox"/> Muscle Problems	<input type="checkbox"/> Thyroid: Hypo: <input type="checkbox"/> Hyper <input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Neurological Prob	<input type="checkbox"/> TMJ / Jaw Dysfunction
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Eye Problem	<input type="checkbox"/> Psychological Prob	<input type="checkbox"/> Viral: Herpes: <input type="checkbox"/> CMV: <input type="checkbox"/>
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Genetic Condition	<input type="checkbox"/> Respiratory Problems	Polio: <input type="checkbox"/> Mono: <input type="checkbox"/>
<input type="checkbox"/> Bladder/Kidney	<input type="checkbox"/> Headaches	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Scarlet Fever	How much? ___ Time? ___
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sexually Trans Dis	<input type="checkbox"/> Weight Gain:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Sinus / Upper Respir	How much? ___ Time? ___
<input type="checkbox"/> Ear Infections/Prob	<input type="checkbox"/> Hormonal	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other _____
<input type="checkbox"/> Eczema/Skin Prob	<input type="checkbox"/> Intestinal Problems	<input type="checkbox"/> Swallowing Problem	_____

Exams	Last Complete Physical ?	Results:	By whom?
	_____	_____	_____
	Hemocult (blood in stool)?	Results:	By whom?
	_____	_____	_____
	Last Sigmoidoscopy of colon?	Results:	By whom?
	_____	_____	_____

Females Last menses? _____ Menopause? Yes No # of pregnancies ___ # of children ___

Pregnant? Yes No

Last Mammogram? _____ Results? _____ Last Pap Smear: _____ Results? _____

Last Breast Exam? _____ Results? _____ Breast Self Examination?

Frequent urination: Yes No Incontinence: Yes No

Libido: normal decreased increased Additional: _____

Males Prostatitis: Yes No Last Prostate Exam: _____ Result: _____

Frequent urination: Yes No Incontinence: Yes No

Libido: normal decreased increased Additional: _____

Children Learning problems: Yes No Poor attention span: Yes No

 Hyperactivity: Yes No Behavior problems: Yes No

ACTIVITY LEVEL:

- Sedentary (inactive) by choice
- Sedentary (inactive) due to inability or restriction
- light: light daily work and no regular exercise
- Moderate: light daily work and exercise 3 X week
- Sustained: moderate daily work and exercise 5 X week
- Heavy: heavy work and heavy exercise 5 X week

STRESSORS AFFECTING YOUR LIFE:

- Difficulties with work or lifestyle
- Recent change in marital status
- Death or serious illness family or friend
- Dysfunctional family Past Present
- Lack of love or fulfilling relationships
- Illness - self!

DIETARY HISTORY: How many servings and how often do you eat the following foods?

- | | | | |
|----------|--|---|--|
| Dairy: | Milk, Cheese, Cottage Cheese, Yogurt | <input type="checkbox"/> Cow <input type="checkbox"/> Goat | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Protein: | Chicken, Turkey | <input type="checkbox"/> Fried | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Beef, Lamb, Pork, Veal, Liver | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Bacon, Bologna, Ham, Hot Dogs, Deli Meats | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Scale fish, Shell Fish, Mollusks | <input type="checkbox"/> Fried | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Bean, Peas, Lentils, Soy, Tofu, Nuts Seeds | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Grains: | Bread, Pasta, Crackers, Rice, Cereals | <input type="checkbox"/> White <input type="checkbox"/> Whole Grain | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Vegies: | Greens: Broccoli, Spinach, Kale, Lettuces | <input type="checkbox"/> Raw <input type="checkbox"/> Cooked | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Yellow: Carrots, Squash, Yams, Tomato | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Other: Potato, Beet, Celery, Artichoke, etc | <input type="checkbox"/> Raw <input type="checkbox"/> Cooked | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Fruits: | All varieties | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Sweets: | Cookies, Candy, Pastry, Jam, Syrup | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Oils: | Mayonnaise, Dressing, Oils | <input type="checkbox"/> Natural <input type="checkbox"/> Processed | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Fats: | Fats: Hydrogenated (margarine, Crisco), Butter | <input type="checkbox"/> Hydrog <input type="checkbox"/> Butter | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Other: | Ketchup, Steak Sauce, Soy Sauce | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| Drink: | Water | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Natural Vegetable, Fruit Juices | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Soft Drinks | <input type="checkbox"/> Caffeine <input type="checkbox"/> Decaf | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Coffee, Teas | <input type="checkbox"/> Caffeine <input type="checkbox"/> Decaf | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |
| | Alcohol: Beer, Wine, Coolers, Hard Liquor | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rare/Never |

Is your diet primarily Natural Organic Prepared at Home Commercially Prepared Fast Food

What diet is best for you? _____

ADDITIONAL INFORMATION: Please attach any information you feel would be helpful.

Review of Systems

For "Past": V if it applies nor "Now" - Rate 0 - 3: 0 = Not present 1 = Mild 2 = Moderate 3 = Severe

Symptoms	Past	Now	Comments
General / Immune			
Frequent Fatigue			
Hot / Heat Intolerant			
Cold/ Cold Intolerant			
Perspire Easily			
Lack of Perspiration			
Frequent Infections			
Immune / Auto-immunity			
History of "Mono"			
Swollen Glands			
Endocrine			
Low body temperatures			
Cold Extremities			
Thyroid Disorder			
Dizzy Upon Standing			
Low Blood Pressure			
Skin/ Nails			
Acne, Eczema, Dermatitis			
Brown Spots			
Gooseflesh / Folliculitis			
Hives / Rashes			
Itch Burning, Dry			
Oily			
Pale			
White Spots: Loss of Pigment			
Yellow Tone			
Nails: Brittle, Peeling			
Ridges			
White Lines			
Head and Neck			
Headaches			
Migraines			
Head injury			
Face / Jaw Pain			
Neck Pain, Stiff Neck			
Hair. Brittle Dry			
Hair Loss of Color			
Hair Loss			
Eyes			
Wear Glasses			
Blurred Vision			
Blood Shot			
Burning / Dry / Itching			
Cataracts			
Floater (see Spots)			
Glaucoma / Retina Problems			
Light Sensitive			
Night Blind			

Symptoms	Past	Now	Comments
Ears			
Ear Infections			
Itching			
Hard Ear Wax			
ringing /Tinnitus			
Nasal			
Bleeds			
Burning / Dryness / Crusts			
PND/ Rhinitis			
Sinusitis			
Sense of Smell Loss			
Mouth/Throat			
Bleeding Gums			
Bone Loss (Periodontitis)			
Bruxism (Grinding)			
Face / Jaw Pain / TMJ			
Fillings: Silver / Mercury			
Lip Cracks			
Mouth Ulcers			
Swallowing Problem			
Taste Loss			
Tongue coated			
Tongue Fissured			
Voice Hoarse			
Digestive			
Belching, Bloating, Gas			
Colitis / Irritable Bowel			
Constipation			
Diarrhea			
Gastritis, Pain, Ulcer			
Heartburn, Reflex			
Hemorrhoids/Rectal Bleed			
Liver/Gall Bladder			
Nausea / Vomiting			
Stool: Dark green / black			
Blood			
Mucous			
Yellow			
Respiratory			
Asthma			
Bronchitis			
Cancer - Lung			
Chemically Induced Prob			
Chest pain			
Colds + Flu (frequency)			
Cough - chronic			
Exercise Induce Problems			
Shortness of Breath			

Symptoms	Past	Now	Comments
Cardiovascular			
High Blood Pressure			
Chest Pain			
Dizzy Spells			
Leg Pain With Walking			
Numb Extremities			
Palpitations / Tachycardia			
Stroke			
Varicosities			
Muscles & Joints			
Arthritis/Joint Pain			
Back Pain / Disc Problems			
Bursitis/Tendonitis			
Muscle Aches / Pains			
Muscle Cramps / Spasms			
Muscle Weakness			
Neurological			
Clumsy			
Convulsions / Seizures			
Fainting Spells			
Neuralgia Tingling			
Numbness			
Raynaud's			
Spastic Motion / Tremors			
Urinary			
Bladder Infectious - frequent			
Blood in Urine			
Frequent Urination			
Incontinence			
Kidney Stones			
Pain, Burning			
Behavioral & Psychological			
Addictions (list)			
Anxiety			
Attention Deficit (ADD)			
Bizarre Behavior			
Depression			
Developmental Delays			
Eating Disorder (list)			
Fearful / Worrier			
Hyperactive / Manic			
Insomnia			
Lack of Dream Recall			
Learning Problems			
Memory Problems			
Mood Swing			
Narcolepsy - Oversleeping			
Obsessive / Compulsive			
Phobias			
Schizophrenia			
Suicidal			

Symptoms	Past	Now	Comments
Male			
Discharge			
Impotence			
Lumps			
Pain- Testicular			
Prostate Problems			
Weak Urine Stream			
STD's			
Female			
Breasts: Cancer			
Fibrocystic			
Sore			
Endometriosis			
Fibroids / Cysts			
Hormone Replacement			
Hot Flashes			
Periods: Cramps			
Heavy Flow			
Irregular			
Infertility			
Peri-menopausal			
Menopausal: Natural			
Surgical			
Night Sweats			
Osteoporosis			
Ovarian/Uterine Cancer			
Painful Intercourse			
Pap Smears - abnormal			
Pre-Menstrual Tension			
Pregnancies: Incomplete			
Full Term			
Sexually Transmitted Dis.			
Vaginal: Dryness			
Infection			
Inflammation			
Yeast			
Discharge			
Spotting			
Foods / Glucose Tolerance			
Afternoon Drowsiness			
Cravings : Butter/Fats			
Foods (list)			
Ice			
Fatigue After Eating			
Hunger Headaches			
Hunger Irritability			
Skin Crawling Sensations			
Symptoms from Foods			
Other			
Best time of the day			
Worst time of the day			
Best season for you			
Worst season for you			