

## Patient Registration Form

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender (sex): \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work or cell phone: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_  
Are you: \_\_\_ Single \_\_\_ Married \_\_\_ Partnered \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed  
Do you have children? Y / N (names and ages): \_\_\_\_\_  
Your occupation: \_\_\_\_\_ Your education: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

\*Email will only be used to contact you or to send you newsletters. It will not be shared with anyone.

Present Health Concerns (in order of importance): \_\_\_\_\_ Duration: \_\_\_\_\_

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_

Please describe what you think is the cause of your health conditions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any vitamins/herbs/supplements that you are taking:

Name	Reason for taking	Dose/day	For how long	Who prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any prescription drugs or over-the-counter medicines that you are taking:

Name	Reason for taking	Dose/day	For how long	Who prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Allergies:** (Please circle any which are life-threatening)

Are you sensitive to chemical smells? \_\_\_\_\_ Have you had repeated exposure to any chemicals, fumes, dust? (if so, please specify) \_\_\_\_\_

**Medical History:**

Primary Care Doctor/Provider: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Reason for seeing: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other Health Care Providers:

1 \_\_\_\_\_ Phone: \_\_\_\_\_

2 \_\_\_\_\_ Phone: \_\_\_\_\_

3 \_\_\_\_\_ Phone: \_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_ Results: \_\_\_\_\_

Date of last blood work: \_\_\_\_\_ Results: \_\_\_\_\_

Date of last PAP/pelvic exam: \_\_\_\_\_ Results: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

Date of last prostate exam: \_\_\_\_\_ Results: \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ How far along? \_\_\_\_\_

Are you sexually active? (circle one) Yes / No If yes, is it with (circle one): male female both

Do you or your partner(s) use any form of contraception? Yes / No If so, what type(s)? \_\_\_\_\_

**Family History:** Please designate which family members have had the following health conditions. M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

Allergies	Diabetes	Mood/Mental disorder
Alcoholism	Cancer	Neurological disease
Anemia	Endometriosis	Obesity
Arthritis-Rheumatoid	Heart Disease	Skin problems
Arthritis-Osteo	High Blood Pressure	Stroke
Autoimmune disease	High Cholesterol	Thyroid disease
Depression	Kidney disease	Tuberculosis

**Exercise:** (Please specify what type of exercise, duration, and frequency per week)

\_\_\_\_\_  
\_\_\_\_\_

**Sleep Habits:**

How many hours do you sleep per night? \_\_\_\_\_ Do you wake refreshed? \_\_\_\_\_

Do you have problems: falling asleep staying asleep waking up in the morning

**Energy Level:** (Please circle your average daily energy level)

(lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

**Stress Level:** (Please circle your average daily stress level)

(lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)

How do you cope with stress? \_\_\_\_\_

**Review of Systems** (please circle any symptoms you have experience in the last 6 months)

<b>General</b>	<b>Skin/EENT</b>	<b>Heart/Lung</b>	<b>Gastrointestinal</b>	<b>Endocrine</b>
Weight change	Itching	High blood pressure	Poor appetite	Diabetes
Fever/chills	Rashes	Low blood pressure	Heartburn/GERD	Hypothyroid
Weakness	Hives	Heart palpitations	Constipation	Hyperthyroid
Fatigue	Eczema	Heart attack	Diarrhea	Goiter
Night sweats	Vision changes	Heart disease	Gas/bloating	Hypoglycemia
Dizziness	Dental problems	Shortness of breath	Nausea/vomiting	Hot flashes
Memory loss	Ringing in ears	Wheezing	Hemorrhoids	Increase thirst
Mood changes	Earaches	Chronic coughing	Ulcers	High appetite
Sleep issues	Sinus infections	Stroke	Blood in stool	Hair loss
Anxiety/Depression	Sore throats	Swollen ankles	Anal discomfort	Weight gain
<b>Genitourinary</b>	<b>Musculoskeletal</b>	<b>Female Only</b>	<b>Male Only</b>	<b>Other</b>
Low back pain	Neck pain	PMS	Breast lumps	Anemia
Painful urination	Low back pain	Breast lumps	Erection difficulty	Osteoporosis
Blood in urine	Hip pain	Heavy menses	Pain in testicles	Cancer
Frequent urination	Foot pain	Hot flashes	Penis discharge	Fibromyalgia
No bladder control	Shoulder pain	Painful intercourse	Sores on penis	Crohn's dz
Nighttime urination	Arm pain	Hysterectomy	Infertility	Colitis
Bladder infections	Arthritis	Fibroids	Low libido	STDs
Kidney infections	Tendonitis	Abnormal pap	Swelling of testes	ADD/ADHD
Kidney stones	Strain/sprain	Low libido	Hernia	Mood disorder
Renal failure	Spasm/Swelling	Vaginal infections		Eating disorder

**Diet History:**

How many meals do you eat per day? (please circle) One Two Three Four or more  
 How much water do you drink per day? (please circle) None 8-24oz 24-64oz 64oz or more  
 Coffee: (Number of cups per day) \_\_\_\_\_ Soda (Number of cans per day) \_\_\_\_\_  
 Tea: (Specify type and number of cups per day) \_\_\_\_\_

Please specify a typical daily diet:

Meal	Time	Food and Amount	Beverages
Breakfast			
Snack			
Lunch			
Snack			
Dinner			

Please list any food allergies that you have and the type (anaphylactic or food intolerances)

**Personal Habits:** (Please specify current or past usage of these substances and how much)

Tobacco: \_\_\_\_\_  
 Alcohol: \_\_\_\_\_

Caffeine: \_\_\_\_\_  
Recreational drugs: \_\_\_\_\_

**Digestive Health:**

Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food?  
(please circle or specify): \_\_\_\_\_

Bowel movement frequency:(how often) \_\_\_\_\_ Consistency:(hard, soft, watery,  
normal) \_\_\_\_\_

Do you experience constipation or diarrhea? (please circle or specify) \_\_\_\_\_

Do you have blood or mucus in the stool? (please circle or specify) \_\_\_\_\_

**Eliminations:**

Do you experience pain with urination, incontinence, other urinary symptoms? (please circle or  
specify)? \_\_\_\_\_

Urination frequency: (how often per 24 hour period) \_\_\_\_\_

Color of urine: (dark yellow, light yellow, green, colorless) \_\_\_\_\_ Blood in urine? \_\_\_\_\_

**Menses:** (female)

Are your menses regular (average every 28 days)? \_\_\_\_\_

Do you experience cramps, excessive menstrual flow, hot flashes, fibrocystic breasts, mood  
issues, bloating and swelling, bleeding in between menstrual cycles, other PMS issues? (please  
circle or specify) \_\_\_\_\_

**Life Balance:** Wellness is a balance of many factors in life. Using the circle, please shade your  
level of satisfaction in each area. For example, if you are 60% satisfied with your career, shade  
the first 6 levels in the career slice. Do the same for each area starting from the center point  
radiating out.

