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Patient Registration Today's Date _________________
Name __________________________________ Age ________ Date of Birth _______________
Sex (circle one) M F
Address ____
Home Phone ________________________Cell_______________Email____________________
City ________________________________ State __________ Zip __________
Email ____
Employer ________________________________ Occupation__________________
Work Phone ________________________________
Marital Status _________________ Spouse's Name (if applicable) _________________________
Emergency Contact:
Name ____Relationship ______________________
Address____
Home Phone ___________________ Cell ____________________ Work Phone______________
Referred by (circle): Friend/Relative website Name: _____________________________________

Reason for visit: ___________________________________
What concern brought you here today?
____
____
Date of Onset ____________________
In your opinion, what are your most important health problems (physical and emotional)?
Please list in order of importance.
1) ______________________________ 5) _______________________________
2) ______________________________ 6) _______________________________
3) ______________________________ 7) _______________________________
4) ______________________________ 8) _______________________________

Personal Health History Please check applicable areas, and give details below.
__Autism
__ Alcoholism __ Colitis /Crohn"s __ Heart Disorder __ Sexually Transmitted Disease
__ Allergies __Dementia __ Herpes __ Skin Disorders
__ Depression __ High Blood Pressure
__ Anemia __ Diabetes __ Hypoglycemia __ Stress
__ Arthritis __ Fatigue __ Injury __ Stroke
__ Asthma __ Frequent Colds __ Liver Disorder __Thyroid Disorder
__ Cancer __ Gout __ Tuberculosis
Other:____

Hospitalizations (with dates and type of illness/operation):
____
____
____

Known Allergies (to medication, food, pollen, etc.):____
____
____

Medications and Supplements (include prescription and non-prescription items, herbs, vitamins, minerals, etc.):
____
____
____
____

Family History (write YES, NO, DK [don't know] for blood relatives.)
__ Alcoholism __ Diabetes __ Hemophilia __ Sickle Cell Anemia
__ Anemia __ Glaucoma __ High Blood Pressure __ Skin Disorders
__ Arthritis __ Gout __ Hypoglycemia __ Stroke
__ Asthma __ Hay Fever __ Mental Illness __Thyroid Disorder
__ Cancer __ Heart Disease __ Seizure or Epilepsy __ Tuberculosis
__ Sexually Transmitted Disease Other significant family health problems:
____
____

Health Habits
Do you get regular exercise? YES NO What form?____
____
Do you drink alcohol? If so, how much, how often, and what kind?
____
Past Usage: ____
Do you use drugs? If so, what kinds and how often?
____
___________________________Past Usage:
____
Do you use tobacco? If so, how much, and how long have you used it?
____
__________________________Past Usage:
____
Do you drink coffee? If so, how much?____
____
Past usage: ____
How many meals do you generally eat per day? _________________How many snacks?_______
Favorite Snacks____
____
What foods make up your primary diet?
____
____
Which foods do you generally exclude from your diet?
____
____
____

Menstrual History (for women)
Menstrual cycles regular? YES NO Length of cycle: ___________________________________
First day of last period _______________ Symptoms?__________________________________
Method of Birth Control, if used: ______________________________________
Number of: Pregnancies ____ Births ____ Miscarriages ____ Abortions ____
When was your last PAP Smear? ___________________________ Was it normal? YES NO
Have you ever had an abnormal PAP Smear? YES NO_________________________________
Menopausal? YES NO If yes, date of final menses __________ Hysterectomy? YES NO
History of breast lumps? YES NO Do you do regular self-breast exams? YES NO

Difficulties before, during or after pregnancy:______________________________________
____
____
Medications during pregnancy____
____
Interventions during pregnancy____
____
Vaccinations____