



Patient Registration and Health History

Please complete this form prior to your visit and bring it with you to your appointment.
All answers will be *absolutely confidential*. If you have any questions please feel free to ask.

Name _____ Age _____ Today's Date _____

Gender: M F MTF FTM Birthdate (M/D/Y) _____

Home Address _____

Occupation _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Email Address _____

Spouse/Partner's Name _____ Children (Name(s)/Age(s)) _____

Names Of Other Healthcare Providers:

Medical Doctors _____ Naturopathic Physician _____

Chiropractor _____ Others _____

Who may we thank for referring you to our clinic?



Your Main Health Concern

Why are you coming to the clinic today?

When did your problem(s) begin (be as specific as possible)?

Your Past Medical History

(Please check and date)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sexually Transmitted Infxns |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis/Kidney Disease | <input type="checkbox"/> Anemia (All types) |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other Major Illness |
| <input type="checkbox"/> Rheumatic Fever | | (Specify) _____ |
| <input type="checkbox"/> Significant Trauma (auto accidents, falls, other) | | _____ |
| <input type="checkbox"/> Allergies (drugs, chemicals, foods) | | |
| (Specify) _____ | | |

Occupational Stress (chemical, physical, psychological)

- How many packs of cigarettes do you smoke a day?
- How much coffee, tea, cola, or alcohol do you drink per week?

Describe Your Weekly Exercise

Current Medicines

List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.



Diet

Are you or have you ever been on a restricted diet? If so, what kind?

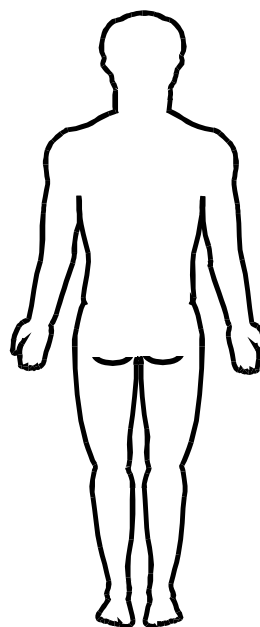
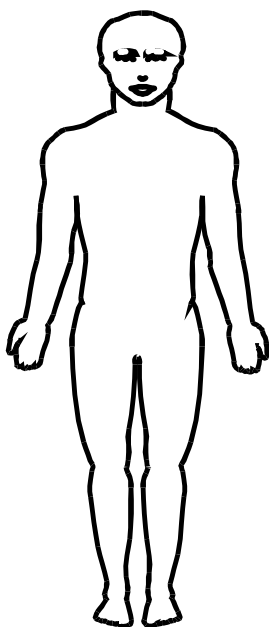
Please describe your average daily diet:

- Morning _____

- Afternoon _____

- Evening _____

Indicate Painful or Distressed Areas





Please check if the following symptoms are a current or recurring problem.

General

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Sudden energy drop (time?) |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Cravings | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Peculiar tastes or smells |

Skin and Hair

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Other hair or skin problems? |
| <input type="checkbox"/> Pimples | | |

Head, Eyes, Ears, Nose, And Throat

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Colour blindness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Jaw clicks or pain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Tooth pain |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Mercury tooth fillings |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Using glasses | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |

Heart and Circulation

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood clots | |

Lungs and Breathing

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of phlegm, (colour)? | <input type="checkbox"/> Other problems |



Digestion and Elimination

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bad Breath | | |

Genito-Urinary

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Distinctive or odd colour | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Do you wake to urinate? | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Other problems |

Women

- | | | |
|----------------------------------|---|--|
| ___ Age of first menses | <input type="checkbox"/> Unusual menses | <input type="checkbox"/> Irregular periods |
| ___ Duration of menses | <input type="checkbox"/> Heavy | <input type="checkbox"/> Painful periods |
| ___ Date of start of last menses | <input type="checkbox"/> Light | <input type="checkbox"/> Vaginal discharge |
| ___ Date of last PAP exam | <input type="checkbox"/> Clots | <input type="checkbox"/> Vaginal sores |
| ___ Date of last mammogram | | <input type="checkbox"/> Breast lumps |
- Do you perform a monthly self - breast exam? _____
- Changes in body or emotions prior to menstruation? _____
- Do you practice birth control? Y/N _____
- What type and for how long? _____
- Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions _____

Muscles, Joints, and Bones

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Foot / ankle pain | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Hand / wrist pain | <input type="checkbox"/> Hip pain | |
| <input type="checkbox"/> Shoulder pains | <input type="checkbox"/> Other joint or bone problems? | |

Brain, Nerves, and Emotions

- | | | |
|---|--|---|
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Lack of coordination |
| <input type="checkbox"/> Quick temper / irritable | <input type="checkbox"/> Depression | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Susceptible to stress | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Areas of numbness |
- Have you ever been treated for emotional problems? _____
- Have you ever considered or attempted suicide? _____
- Any other neurological or psychological problems? _____



Vaccination History

- TDaP (Tetanus, Diptheria, Pertussis) _____
- MMR (Measles, Mumps, Rubella) _____
- Hepatitis B _____
- Flu _____
- Tuberculosis _____
- Polio _____
- Pneumovax (Meningitis) _____
- Varivax (Chicken Pox) _____
- Did you have any ill effects from any of the above vaccines? _____

Family History

Place an X in the box that corresponds with the medical history of your family members. I use this information to determine your risk factors and identify areas for prevention strategies.

	Mom	Dad	Maternal Grandmother	Maternal Grandfather	Mat. Aunts Uncles	Paternal Grandmother	Paternal Grandfather	Pat. Aunts Uncles	Siblings	Kids
Allergies										
Asthma										
Cancer										
Diabetes										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Osteoporosis										
Seizure										
Stroke										
Thyroid Disorders										
Other:										