Orange County Migraine & Wellness Center

NEW PATIENT REGISTRATION

Patient

First Name ____________ Middle Name ____________ Last Name ____________

Date of Birth ____________ Gender ____________

Name of Parent/Guardian/Legal Representative ____________

Contact Information

Cell Phone ____________

Home Phone ____________

Email ____________

Emergency Contact

Name ____________

Phone Number ____________

Relationship ____________

Address

Street ____________

City ____________ State ____________ Zip Code ____________

Primary Care Physician

Name ____________ Phone Number ____________

Street ____________

City ____________ State ____________ Zip Code ____________

Preferred Pharmacy

Name ____________ Phone Number ____________

Street ____________

City ____________ State ____________ Zip Code ____________

Primary Insurance

Insurance Co. ____________

ID # ____________

Group # ____________

Primary Policy Holder ____________

Relationship ____________ Date of Birth ____________

Secondary Insurance

Insurance Co. ____________

ID # ____________

Group # ____________

Primary Policy Holder ____________

Relationship ____________ Date of Birth ____________

Current Medications

List all medications that you are currently taking, including hormones, sleeping pills, aspirin, vitamins, etc.

Medication	Dosage	Frequency	How long have you taken it?

Allergies

Are you allergic or sensitive to any medications or any chemical/substances?
Please explain in the space provided below.

(Please include allergy to Iodine, Shellfish, Latex, etc.)

Name of Medication or Substance	Type of Reaction

Substance Use Assessment Form

For each category check the circle that most accurately reflects your history and current usage patterns. Answer honestly to ensure the best care and support.

Tobacco use :

- ○ Never Used
- ○ Former User
- ○ Current Occasional User
- ○ Current Regular User

Marijuana use :

- ○ Never Used
- ○ Former User
- ○ Current Occasional User
- ○ Current Regular User

Alcohol Consumption :

- ○ None
- ○ Social Drinker (e.g., 1 – 2 drinks on occasion)
- ○ Moderate Drinker (e.g., 1 – 2 drinks per day)
- ○ Heavy Drinker (e.g., 3 or more drinks per day)

Illicit Drug Use :

- ○ Never Used
- ○ Former User
- ○ Current User

Prescription Medication Misuse :

- ○ None
- ○ Past Misuse
- ○ Current Misuse

Lifestyle and Wellness Assessment Form

Select the option that best describes your typical behavior for each category to help us understand your daily habits and lifestyle choices. If you have any additional comments, please write them in the notes line.

Diet :

- ○ Balanced
- ○ Gluten – Free
- ○ Vegetarian
- ○ High – Protein
- ○ Vegan
- ○ Low – Carb

Other ____________________________

Hydration :

- ○ Less than 4 glasses/day
- ○ 4 – 8 glasses/day
- ○ More than 8 glasses/day

Note: ______________________________

Caffeine Intake :

- ○ None
- ○ Less than 1 serving/day
- ○ 1 – 3 servings/day
- ○ More than 3 servings/day

Note: ______________________________

Exercise :

- ○ Sedentary (little to no exercise)
- ○ Light Exercise (1 – 3 days/week)
- ○ Moderate Exercise (2 – 5 days/week)
- ○ Vigorous Exercise (6+ days/week)

Note: ______________________________

Sleep Patterns :

- ○ Less than 6 hours/night
- ○ 6 – 8 hours/night
- ○ More than 8 hours/night
- ○ Irregular Sleep Pattern

Note: ______________________________

Past Medical History

(Please check any medical problems that you have had in the past)

- ○ Abnormal pap smear
- ○ Alcoholism
- ○ Allergies
- ○ Anemia
- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Blood transfusion
- ○ Cancer
- ○ Cataracts
- ○ Clotting disorder
- ○ Colonic adenoma
- ○ Concussion
- ○ Congestive heart failure
- ○ COPD (lung disease)
- ○ Coronary artery disease
- ○ Depression
- ○ Diabetes mellitus
- ○ Diverticulitis
- ○ GERD (heartburn)
- ○ Glaucoma
- ○ Headaches
- ○ Heart murmur
- ○ HIV/AIDS
- ○ Hyperlipidemia (high cholesterol)
- ○ Hypertension (high blood pressure)
- ○ Hypothyroidism
- ○ Irregular menses
- ○ Kidney disease
- ○ Liver disease
- ○ Menorrhagia
- ○ Myocardial infarction (heart attack)
- ○ Nerve/muscle disease
- ○ Osteoporosis
- ○ Seizures
- ○ Sickle cell anemia
- ○ Sleep apnea
- ○ Stroke
- ○ Substance abuse
- ○ Tuberculosis
- ○ Ulcers

○ Other ______________________________________

Past Surgical History

(Check any surgeries you have had and the date of surgery if you know it)

- ○ Appendectomy
- ○ Bariatric surgery
- ○ Brain surgery
- ○ Breast surgery
- ○ CABG (bypass)
- ○ Cesarean section
- ○ Cholecystectomy (gall bladder removal)
- ○ Colon surgery
- ○ Cosmetic surgery
- ○ Eye surgery
- ○ Fracture surgery
- ○ Hernia repair
- ○ Hysterectomy (ovaries removed)
- ○ Hysterectomy (ovaries remain)
- ○ Joint replacement
- ○ Prostate surgery
- ○ Small intestine surgery
- ○ Spine surgery
- ○ Tonsillectomy and Adenoidectomy
- ○ Tubal ligation (tubes tied)
- ○ Valve replacement
- ○ Vasectomy

○ Other ______________________________________

Additional Information :

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I verify that the above information is true and accurate to the best of my knowledge.

_________________________________ _________________________________

Signature of Patient or Guardian DATE