CLIENT REGISTRATION FORM

Date_____

Name_____ Birth Date_____ Age_____

Address_____ City_____ State_____

Mailing Address if different_____Zip_____

Home Phone_____ Work Phone _____Cell_____

E-mail_____ Female_____ Male_____

Your Occupation_____ Employer_____

Employment Address_____

Living Situation: Alone ____ Partner ____ Spouse ____ Other _____

Number of children _____ ages _____

In case of emergency contact_____Tel.#_____

Nearest relative not living with you_____ Tel.#_____

Health Care Plan_____ ID#_____ Customer Service #_____

Relationship to subscriber_____ Referred by_____

Briefly outline why you are coming to see us_____

_____

Current and or past healthcare providers: medical, psychological, others (use back of sheet if needed)

Name	Practice	When
_____	_____	_____
_____	_____	_____

Medical history including surgeries: _____

_____ _____ _____

_____

For Office Use Only:

MRN#_____ DIAGNOSIS CODE:_____

ADDITIONAL HEALTH INFORMATION

Name: _____

Date: _____

Please check any of these items you use regularly and specify amounts used per day:

_____ Cigarettes _____ _____ Tea _____

_____ Coffee _____ _____ Soda _____

_____ Sugar/sweets _____

_____ Salt/salty foods (potato chips, etc.) _____

_____ Alcohol _____

SYMPTOMS REVIEW

Please check if you have recently experienced any symptoms listed below. Comment or answer as needed.

General

_____ General fatigue or weariness

_____ Dizziness

_____ Loss of balance

_____ Loss or gain of weight

_____ Motion Sickness

_____ Lack of endurance

_____ Loss of memory

_____ Fainting

Do you feel refreshed when you awaken in the morning? _____ Yes _____ No

Do you get fatigued or sleepy during the day? _____ Yes _____ No _____ When _____

Usual number of hours of sleep per night? _____

Quality of sleep: _____ Good _____ Fair _____ Poor _____

SKIN

_____ Rashes, itching, burning, flaking

_____ Lesions, cysts, callouses, lumps

_____ Hot or cold spots anywhere

_____ Changes in skin tone/texture

_____ Changes in finger/toenails

_____ Changes in hair texture

_____ Loss of hair; when did it start?

_____

_____ Acne, pimples; where _____

_____ Dry or oily skin

_____ Dry lips/mouth

_____ Hot hands or feet

_____ Scalp problems/dandruff

_____ Excessive perspiration

_____ Lack of perspiration

_____ Bruise easily

_____ Bleed easily

_____ Breast lumps

SENSES

_____ Wear glasses/contacts

_____ Eyesight worsening

_____ See halos or lights

_____ Night blindness

_____ Watering eyes

_____ Red or itchy eyes

_____ Spots in eyes

_____ Sensitive to light

_____ Seeing double

_____ Color blindness

_____ Eye pain/strain

_____ Dry eyes

_____ Eye swelling

_____ Cataracts/glaucoma

_____ Hearing difficulties

_____ Hearing aide

_____ Earaches

_____ Ear drainage

_____ Excessive ear wax

_____ Noises in ears

_____ Other eye/ear problems

GLANDULAR SYSTEM

_____ Frequently swollen glands

_____ Slow or fast metabolism

_____ Night sweats

_____ Swelling in armpit or groin

_____ Excessive thirst/hunger/perspiration

_____ Hot flashes _____ Other

NEUROMUSCULOSKELETAL (Nerves/Muscles/Bones)

_____ Trembling or numbness in extremities
_____ Poor balance or coordination
_____ Cold or heat in muscles or bones
_____ Weakness in arms or legs
_____ Bone pain/heat/discomfort
_____ Joint stiffness/swelling
_____ Hernia
_____ Discomfort with weather changes (describe) _____

_____ Back or hip pain
_____ Neck or shoulder pain
_____ Insomnia
_____ Muscle cramping
_____ Arm or hand pain
_____ Headaches Frequency _____

RESPIRATORY SYSTEM

_____ Sinus problems
_____ Nosebleeds
_____ Difficulty breathing
_____ Frequent coughing
_____ Sore throat
_____ Asthma/bronchitis/emphysema (circle)
_____ Other nose/throat/lung problems _____

_____ Dry throat/mouth
_____ Difficulty swallowing
_____ Hoarse voice
_____ Wheezing
_____ Excessive phlegm/mucus—color/thickness _____

_____ Frequent chest colds
_____ Sneezing spells
_____ Frequent head colds
_____ Coughing blood

CARDIOVASCULAR SYSTEM

_____ Heart or chest pain/discomfort
_____ Rapid or slow heart rate
_____ Skipped heartbeats
_____ High blood pressure
_____ Low blood pressure
_____ Frequently dizzy or faint

_____ Varicose veins/blood clots
_____ Changes in color of limbs
_____ Heart murmur

Are you frequently warmer or colder than others? Yes _____ No _____
Do you experience swelling of hands/feet or other areas? Yes _____ No _____

DIGESTIVE SYSTEM

_____ Recurring heartburn or indigestion
_____ Excessive or poor appetite
_____ Food feels stuck in stomach
_____ Changes in appetite/eating habits
_____ Frequent belching
_____ Nausea or vomiting
_____ Vomit blood
_____ Grey or whitish stool
_____ Black or tarry stool
_____ Anal burning/itching

_____ Peculiar tastes/smells
_____ Strong thirst/no thirst
_____ Food cravings
_____ Abdominal cramping
_____ Abdominal pain
_____ Abdominal swelling
_____ Constipation
_____ Diarrhea
_____ Rectal pain
_____ Hemorrhoids

Bowel movements per 24 hours, frequency _____
Color _____ Odor (strong, etc.) _____ Laxatives _____
Form (loose, etc.) _____

URINARY SYSTEM

_____ Burning/discharge in urination
_____ History kidney/bladder problem
_____ Involuntary escape of urine
_____ Waking to urinate at night

_____ Frequent urination
_____ Weak urine stream
_____ Urgency to urinate
_____ Frequent infection

_____ Unable to hold
_____ Blood in urine
_____ Difficulty starting
_____ Bedwetting

Urination frequency per 24 hours _____ Color _____
Odor _____ Other _____

DENTAL

_____ Dental problems _____ Sore/bleeding gums

_____ Sore tongue/sores on tongue _____ Canker/cold sores; where? _____

_____ Jaw pain/tension _____ Jaw clicks _____ Facial pain _____ Dentures

_____ Grinding teeth _____ Other _____

MEN ONLY

_____ Sores on penis/scrotum _____ Lumps/swelling on or in testicles

_____ Burning discharge from penis _____ Pain in prostate or testicles

_____ Changes in sexual energy

_____ Other _____

WOMEN ONLY

Age you started menstruating_____ Frequency of periods _____

Duration of flow _____ _____ Light _____ Moderate _____ Heavy _____ Clots

Circle color: pale/bright red/dark/other

Any bleeding between periods? _____

Discomfort with period:

_____ Abdominal cramping _____ Abdominal heaviness/bloating

_____ Low back discomfort _____ Leg cramping/heaviness/discomfort

_____ Breast tenderness _____ Breast swelling/fullness/lumps

Do you experience mood changes before or after your period? _____

Do you experience any vaginal discharge that is either bothersome or worrisome? _____

Describe _____

Age at menopause _____

Check any complications of menopause:

_____ Headaches _____ Discomfort

_____ Irritable/easily angered _____ Hot flashes

_____ Unusual bleeding _____ Insomnia

_____ Changes in breasts—lumps/cysts/nipple discharge

_____ Other _____

PREGNANCY HISTORY

_____ Number of births _____ Number of pregnancies

_____ Miscarriages _____ Cesareans

_____ Still births _____ Abortions

Describe any special difficulties you had with pregnancy, labor and delivery, or post partum: _____

_____

GENERAL

_____ Genital itching/swelling

_____ Sores around vaginal or rectal area

_____ Discomfort with intercourse (during or after)

_____ Changes in sexual energy

_____ Do you use vaginal douches, sprays, scented tampons/pads?

_____ Have you had any complications with birth control?

_____ Are you currently using birth control pills?

Date of your last Pap test. _____

Name: _____

Date: _____

Medication, Vitamin and Food Supplement History

Please list below all medication, vitamin, mineral and food supplements prescribed by a practitioner, or self chosen, that you are currently taking or have taken within the past year. Please include brand name and/or generic name and current doses. (Use an additional page if necessary.)

A. Prescription Medication

Brand Name/Generic Name	Dosage	Times/day	Presently (yes or no)	Past (time period of use)	Prescribed by

B. Over-the-counter medications or preparations used (drugs, creams, ointments, etc.)

_____

_____

C. Vitamins, minerals, and other accessory food factors and food supplements you are or were taking:

Brand Name/Generic Name	Dosage	Times/day	Presently (yes or no)	Past (time period of use)	Prescribed by

D. Please list any known allergies and/or sensitivities to drugs, medication, food, or any other preparations or supplements you have taken, and describe the reaction(s):

Allergies	Sensitivities