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New Patient Registration

Name _____ Date of Birth _____

Female ◯ Male ◯ NB ◯

Street Address _____

PO Box _____ City _____ Zip Code _____

Phone: _____ Email _____

Referred by _____

Emergency Contact _____ Phone _____

Relationship _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Carrie Miller, ND or insurance company to release any information required to process my claims.

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature.

Signature _____ Date _____

Patient Name **Date of Birth**

What are your most important health concerns?

1. **2.**

3. **4.**

Current Medications and Doses

Current Supplements and Doses

List all knowns allergies (Drugs, foods, environmental)

Name and Fax Number of Primary Care Physician
I don't have one currently
I would like you to be my PCP

Last Full Physical Exam
Last Pap Smear **N/A**
Last Mammogram **N/A**
Last Colon Cancer Screeing **N/A**

Patient Name _____ Date of Birth _____

Health History (please check if you've experience this in your lifetime)

- [ ] Alcoholism
- [ ] Autoimmune Disease
- [ ] Cancer
- [ ] Cervical Dysplasia
- [ ] Depression
- [ ] Endometriosis
- [ ] Gall Stones
- [ ] Gout
- [ ] Hypertension
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental/Emotional Trauma
- [ ] Pancreatitis
- [ ] Seizures
- [ ] Severe Physical Injury
- [ ] STIs
- [ ] Traumatic Brain Injury

Family Health History

Hospitalization/Surgeries in the past 5 years, year and type of surgery

Chronic Stress in the past 5 years

Patient Name _____ **Date of Birth** _____

Current Symptoms (experienced in the past 3 months)

Breasts: ☐ Lumps ☐ Pain/tenderness ☐ Nipple discharge

Cardiovascular: ☐ Chest pain on exertion ☐ Heart palpitations

☐ Irregular heartbeat ☐ Tachycardia (racing heart)

Dermatology: ☐ Acne ☐ Boils ☐ Bruising ☐ Color Changes

☐ Eczema ☐ Hives ☐ Lumps ☐ Psoriasis ☐ Rashes

Ears: ☐ Discharge from ears ☐ Hearing changes ☐ Tinnitus

Endocrine: ☐ Heat/cold intolerance ☐ Fatigue

☐ Difficulty losing weight ☐ Hair loss ☐ Swelling around ankles

☐ Poor concentration

Gastrointestinal: ☐ Abdominal cramps/pain ☐ Burping

☐ Blood in stool ☐ Constipation ☐ Diarrhea

☐ Heartburn ☐ Indigestion ☐ Stomach bloating ☐ Nausea

☐ Vomiting ☐ Suspected Food Sensitivities

How many bowel movements do you have daily? _____

Gynecological: ☐ Bleeding between periods ☐ Difficulty conceiving

☐ Heavy menstrual bleeding ☐ Hot flashes/night sweats ☐ PMS

☐ Painful periods ☐ Pain with intercourse ☐ Recurrent UTIs

☐ Vaginal symptoms

Type of birth control: _____

Patient Name _____ Date of Birth _____

Lungs: ☐ Chronic cough ☐ Difficulty breathing deeply

☐ Pain with breathing ☐ Shortness of breath ☐ Wheezing

Men's Health: ☐ Enlarged Prostate ☐ Erectile Dysfunction

☐ Penile sores/discharge ☐ Testicular lumps ☐ Testicular pain

Mouth/Throat: ☐ Chronic Sore Throat ☐ Gingivitis

☐ Goiter ☐ Hoarseness ☐ Swollen Glands ☐ Thrush

Musculoskeletal: ☐ Joint pain/stiffness ☐ Chronic Low Back Pain

☐ Muscle aches/cramps

Neurological: ☐ Dizziness ☐ Fainting ☐ Memory Loss

☐ Migraines ☐ Muscle weakness ☐ Numbness ☐ Paralysis

☐ Seizures ☐ Tension Headaches

Nose/Sinuses: ☐ Chronic nasal congestion ☐ Loss of smell/taste

☐ Nosebleeds ☐ Recurrent sinus infections

Psychological: ☐ Anxiety ☐ Depression ☐ Irritability

☐ Mood Swings ☐ OCD ☐ Suicidal Thoughts

Sleep: ☐ Sleep Apnea ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep

☐ Wake feeling unrested Average Hours/night _____

Urinary: ☐ Blood in urine ☐ Incontinence

☐ Increased frequence ☐ Painful urination

Patient Name _____ **Date of Birth** _____

Women Only:

Do you have a regular menstrual cycle? _____

How many times have you been pregnant? _____

How many time have you given birth? _____

Diet/Lifestyle:

Energy: On a scale from 1-10, how would you rate your energy on most days? _____

Have you used tobacco? ☐ **In the past** ☐ **Currently** **What form** _____

Dietary Restrictions: _____

Water _____ **oz/day** **Coffee** _____ **cups/day** **Alcohol** _____ **drinks/week**

Any bad experiences with previous practitioners that you want me to know about? Any fears about seeing doctors?

Anything else you want me to know?