Thank you so much for taking the time to fill out this paperwork. We understand it is lengthy but it is our mission to understand your individual history, needs and goals in order to get you feeling your best!

PATIENT REGISTRATION

Today's Date ________________ First Name ________________________ Last Name __________________________

Date of Birth ____________________ Marital Status ______________ Age _______ SS# _____________________

Street Address ____

City_______________________________________ State_________________________ Zip_____________________

Phone (Home) __________________________________ Work ____________________________________

Mobile _____________________________ Email ____

Occupation ____________________________________ Employer ____

Spouse First Name ______________ Spouse Last Name _________________________ Date of Birth ______________

Employer ____ SS# _______________________________________

Legal Guardian Name (if applicable) ____

Relationship to Patient ____________________________________ Phone _________________________________

PERSONAL HEALTH HISTORY AND SELF REFLECTION INVENTORY

Primary Care Provider ____ Phone __________________________

Please list all physicians that you see. (Please include mental health professionals)

Name	Specialty, or condition that is being treated

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).

Approximate Date(s) of Treatment	Name of Therapist or Treatment Facility	Type of Treatment (e.g. Reiki, Qi Gong, Sand Tray)	Reason for Treatment	Beneficial Experience?

WHAT HEALTH ISSUES DO YOU WANT TO FOCUS ON DURING THIS VISIT?

PAST MEDICAL HISTORY

List any major past illnesses, hospitalizations (include year or date if known).

	Date		Date

PAST SURGICAL HISTORY

List any past surgeries (and what year/date).

	Date		Date

FAMILY HISTORY

Have your close relatives had any of the following? Write the relative (parent, brother or sister, child, grandparent, uncle, and/or aunt) and age of diagnosis (if known).

Heart attack, angina ________________________________

High blood pressure ________________________________

Diabetes ____

Cancer (list type) __________________________________

Rheumatoid Arthritis _______________________________

Mental health disorder _____________________________

Stroke ____

High cholesterol ________________________________

Thyroid disease __________________________________

Crohn's or Ulcerative Colitis ______________________

Asthma ____

Other Autoimmune Disease ______________________

PHARMACEUTICALS AND SUPPLEMENTS

Do you have Medication allergies? ❑ Yes ❑ No If yes, please list:

Medication	Reaction	Medication	Reaction

PLEASE LIST ALL PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS YOU TAKE REGULARLY

Please include all supplements, vitamins or herbal products.

Medicine/ Supplement	Frequency	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PLEASE OUTLINE YOUR USE OF THE FOLLOWING, PAST OR PRESENT

Product:	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Do others have concern about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine					

REVIEW OF SYMPTOMS

Please check no or yes for the following **current** symptoms (**within past 3 months**)

GENERAL	**YES**	**NO**	**GASTROINTESTINAL**	**YES**	**NO**
Fever			Diarrhea		
Sweats at night			Constipation		
Hot flashes			Indigestion/heartburn		
Temperature intolerance			Nausea/Vomiting		
Fatigue			Blood in stool		
Sleep difficulties			Bloating		
Daytime sleepiness			Pain		
Unplanned weight change			**GENITOURINARY**	**YES**	**NO**
SKIN	**YES**	**NO**	Pain or burning on urination		
Rash			Frequent urination		
EYES	**YES**	**NO**	Waking to urinate more than once at night		
Pain			Urinary incontinence		
Redness			Decreased sexual desire		
Vision Changes			Pain with intercourse		
Dryness			Sexually Transmitted Diseases		
Dark circles under eyes			Fertility Issues		
EAR, NOSE, THROAT	**YES**	**NO**	**MEN:**	**YES**	**NO**
Hearing loss			Erectile dysfunction		
Ringing in ears			**WOMEN:**	**YES**	**NO**

Dizziness or vertigo			Heavy menstrual bleeding		
Bleeding gums			Painful menstrual periods		
Nosebleeds			Irregular menstrual bleeding		
BREAST	**YES**	**NO**	**MUSCULOSKELETAL**	**YES**	**NO**
Breast Pain			Generalized or all-over pain		
Masses and or Lumps			Joint pain		
Nipple discharge			Stiffness		
Skin changes			Joint swelling		
CARDIOVASCULAR	**YES**	**NO**	Joint redness		
Chest pain			Back or neck pain		
Heart murmur			**NEUROLOGICAL**	**YES**	**NO**
Irregular heartbeat (palpitations)			Abnormal gait (Trouble Walking) or falls		
Leg swelling or edema			Headache severe and/or frequent		
PULMONARY	**YES**	**NO**	Seizures		
Wheezing or shortness of breath			Muscle weakness, TIA or stroke		
Chronic cough			Fainting or loss of consciousness		
HEMATOPOIETIC	**YES**	**NO**	Localized numbness, tingling, neuropathy		
Swollen lymph glands			**PSYCHOLOGICAL**	**YES**	**NO**
Blood clots			Anxiety		
Excessive bleeding			Depression		
Anemia			Memory loss		
			Mood swings		

REVIEW OF SYSTEMS

Were you born vaginally or via C-section? ❑ Vaginally ❑ C-section

Were you breastfed? ❑ Yes ❑ No If yes, for how long? ____

Frequent use of antibiotics as a child? ❑ Yes ❑ No

If yes, how frequently and for how long? ____

CHILDHOOD HISTORY

Did you have frequent ear/nose/throat infections as a child? ❑ Yes ❑ No

History of Tonsillectomy? ❑ Yes ❑ No

History of Ear Tubes? ❑ Yes ❑ No

TRAUMA HISTORY

Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ❑ Yes ❑ No

If yes, is this an active issue in your life that you would like to address while you are here? ❑ Yes ❑ No

EXERCISE

What forms of exercise and movement do you enjoy? ____

On a scale of 1-10 (10 being high), how satisfied are you in the area of exercise? ____________________________

Please describe your usual physical activity:

Activity	How often	How long each time

SLEEP

How many hours of sleep do you usually get each night? ____

Describe any issues you have with sleep. ____

FOOD

Please list any food allergies or sensitivities:

Foods	Reaction	Foods	Reaction

Please list everything you ate in the last 24 hours.

Morning:
Afternoon:
Evening:
Snacks:

Do you currently or have you ever had a problem with weight or eating? ❑ Yes ❑ No

If yes, please describe:____

Are you comfortable with your relationship with food? ❑ Yes ❑ No

Do you feel knowledgeable about your nutritional needs? ❑ Yes ❑ No

What percentage of your food is home-cooked?____

Do you crave sugar, coffee, cigarettes or have any other addictions? ❑ Yes ❑ No

If yes, which do you crave and how often? ____

EMPLOYMENT

Are you currently ❑ employed? ❑ retired? ❑ working at home? ❑ care-taking? ❑ disabled?

❑ unemployed?

Indicate your past occupation if applicable: ____

On a scale of 1-10 (10 being high), how satisfied are you in the area of employment? _________________________

Why? ____

Do you anticipate any work changes in the near future (Retirement, etc.)? _________________________________

____

EDUCATION

How many years of education do you have?

❑ No high school diploma

❑ High School or equivalent diploma

❑ Education beyond high school, but have not completed college bachelor's degree

❑ College degree

❑ Graduate or professional degree

RELATIONSHIPS

Relationship status: ____

If married or partnered, what is your relationship length? ____

What are your living arrangements? ____________ Number of children and ages: ____________________________

Are you sexually active? ❑ Yes ❑ No Are you happy with your sexual life? ❑ Yes ❑ No

Which relationship(s) fulfill and/or empower you? ____

Who or what drains your energy? ____

On a scale of 1-10 (10 being high), how satisfied are you in the area of relationships? __________________________

On a scale of 1-10 (10 being high), how hard do you feel it is to express your emotions? ________________________

SPIRITUALITY

What things or activities bring you your greatest joy and meaning? What inspires you?

____

____

What things create the greatest challenges for you?

____

____

What makes you feel connected to the larger world? Describe your spiritual or religious practices if any (i.e., meditation, prayer, time in nature, worship attendance, etc.). ____

____

On a scale of 1-10 (10 being high), how satisfied are you in the area of spirituality? ____________________________

RELAXATION

Rate the amount of stress in your life: ❑ None ❑ A Little Bit ❑ Moderate ❑ Quite a Lot ❑ Extreme

How well do you manage stress? ❑ Not at All ❑ A Little Bit ❑ Moderate ❑ Quite well ❑ Excellent

What are the main sources of stress in life? (Personal, professional, financial etc.) ________________________________

____

What are your methods of coping with the stress in your life? ____

____

On a scale of 1-10 (10 being high), how satisfied are you in the area of relaxation? ________________________________

WHAT ARE YOUR HEALTH GOALS?

What are your overall goals for improving your health and your life? ____

____

____

PHYSICAL ENVIRONMENT

Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)?

____

Have you had hazardous environmental or occupational exposures? If yes, please describe.

____

HOW DID YOU LEARN ABOUT US?

- ❑ Website/Internet search
- ❑ Print/Media
- ❑ Direct mail
- ❑ Health care provider (non-MD)
- ❑ another patient
- ❑ an individual (non-patient)
- ❑ Physician (please specify): ____
- ❑ At an event (please specify): ____
- ❑ Other (please specify): ____

Patient signature ____ Date _______________________________