NEW PATIENT REGISTRATION FORM

Please print

PERSONAL INFORMATION

Name_____Birth Date_____Age_____
Address (include city, zip)_____
Email_____ Referred by_____
Phone(home)_____(work)_____(cell)_____
Closest relative (include address)_____
_____
Relative phone_____ Spouse/significant other_____
Who lives at home?_____
Employer_____ Occupation_____
Any possible occupational exposure?_____
Medications/supplements/herbs/home remedies(include dose) _____
_____
_____
_____
Allergies(including medications)_____
Diet (please describe)
Breakfast_____
Lunch_____
Dinner_____
Coffee/black tea _____cups/day Sugar use_____ Chocolate _____
Alcohol use _____/week Tobacco use _____/day _____ years Street drug use_____
Exercise (please describe)_____
_____
Education_____

INSURANCE INFORMATION: Please bring your insurance card.

Please list surgeries, serious injuries, fractures, illnesses, hospitalizations or car accidents:

Event	Date	Outcome

REASON FOR VISIT

_____
_____
Was there an initiating event? _____
What was different within 6 months before the onset of the problem? _____
_____
_____

MEDICAL HISTORY

✔ Check every condition you have *ever* had. ◯ Circle conditions currently present. Write age of onset.

STRESS
Check any of the following that occurred in your family the past year:
☐ Married ☐ Births ☐ Illness
☐ Divorced ☐ Deaths ☐ Separation
☐ Job loss ☐ Move ☐ Other_____

DENTAL
☐ Orthodontic treatment: age_____
☐ Dental extractions
☐ Crowns
☐ Root canal work
☐ Fillings
☐ Bridgework
☐ Retainer/nightguard
☐ Gum problems
☐ TMJ

EYES
☐ Failing vision
☐ Double or blurred vision
☐ Squinting/"crossed" eyes
☐ Asymmetric gaze
☐ Eye pain
☐ Eye infections
☐ Lose placement reading
☐ Poor reading comprehension
☐ Eyestrain or fatigue from reading
☐ Headache from reading
☐ Glasses or contacts
☐ Monovision/progressive lens

ENT
☐ Decreased hearing
☐ Loud voice
☐ Snoring/mouth breathing
☐ Ringing/buzzing in the ears
☐ Ear infections
☐ Allergies/hay fever/runny nose
☐ Sinus problems,
☐ Nosebleeds
☐ Frequent sore throats
☐ Prolonged hoarseness
☐ Speech problems

CARDIOPULMONARY
☐ Asthma
☐ Emphysema
☐ Chronic cough
☐ Bronchitis
☐ Pneumonia
☐ Tuberculosis
☐ Shortness of breath on exertion
☐ Shortness of breath on lying flat
☐ Chest pains
☐ Heart murmurs
☐ Palpitations
☐ Swollen ankles
☐ Fainting spells
☐ Leg pain when walking
☐ Varicose veins/phlebitis
☐ High blood pressure
☐ High cholesterol

GI
☐ Eating disorder
☐ Recent loss of appetite
☐ Difficulty swallowing
☐ Heartburn
☐ Persistent nausea/vomiting
☐ Ulcers
☐ Chronic abdominal pain
☐ Recent change in bowel habits
☐ Diarrhea
☐ Constipation
☐ Black or tarry stools
☐ Red blood in stools
☐ Hemorrhoids
☐ Diverticulosis
☐ Gallbladder trouble
☐ Jaundice/hepatitis
☐ Hernia

ENDO
☐ Chronic fatigue
☐ Recent weight loss
☐ Excessive weight gain
☐ Thyroid disease
☐ Cancer
☐ Diabetes

NEURO
☐ Right or ☐ Left handed
☐ Convulsions/seizures
☐ Stroke
☐ Tremors
☐ Muscle weakness
☐ Numbness/tingling sensation
☐ Frequent headaches
☐ Clumsiness

MS
☐ Joint pain
☐ Neck pain
☐ Back pain
☐ Scoliosis/kyphosis
☐ Arthritis
☐ Gout
☐ Cold or numb feet
☐ Involved in contact sports

DERM
☐ Rashes
☐ Psoriasis
☐ Eczema
☐ Hives
☐ Unusual moles

PSYCH/EMOTIONAL
☐ Difficulty sleeping
☐ Nightmares
☐ Nervousness/anxiety
☐ Stress
☐ Depression
☐ Memory loss
☐ Moodiness
☐ Phobias
☐ Nail biting/thumb sucking
☐ Bad temper/breath-holding
☐ Jealously

ILLNESSES
☐ Mumps
☐ Measles
☐ German measles
☐ Chicken pox
☐ Polio
☐ Scarlet fever
☐ Rheumatic fever
☐ Meningitis
☐ Other infections

HEME
☐ Anemia
☐ Malaria
☐ Bruise or bleed easily
☐ Mononucleosis
☐ Unexplained lumps
☐ Fever/chills/excessive sweating

GU
☐ Bedwetting
☐ Bladder infections
☐ Kidney infection
☐ Pain on urination
☐ Poor control of urination
☐ Decreased force of urination
☐ Blood in urine
☐ Kidney stones
☐ Discharge from penis or vagina
☐ Sexually transmitted disease
☐ Vaginal or anal itching

FEMALE ONLY:
First day of last menstrual period_____
Number of pregnancies_____
Number of live births_____
Number of miscarriages_____
Method of birth control_____
Age of onset of menses _____
Flow: ☐ Light ☐ Moderate ☐ Heavy
Length of flow_____
Length of cycle _____
☐ Period not regular
☐ Pain/bleeding with intercourse
☐ PMS (medium to severe)

FAMILY HISTORY:

Mother: age_____ Medical problems:_____
Father: age_____ Medical problems:_____
Sibling: age_____ Medical problems:_____
Sibling: age_____ Medical problems:_____
Sibling: age_____ Medical problems:_____
Maternal Grandmother: age_____ Medical problems:_____
Maternal Grandfather: age_____ Medical problems:_____
Paternal Grandmother: age_____ Medical problems:_____
Paternal Grandfather: age_____ Medical problems:_____
Other:_____

OTHER MEDICAL TREATMENT: List all physicians from whom you are currently receiving treatment along with the condition(s).

Physician Name Illness(es) Treatment program

_____
_____
_____
_____
_____
_____

DRAWING: Please bring a drawing of yourself to your first visit. Stick figures are okay!