

NEW CLIENT REGISTRATION

(Please print)

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CLIENT INFORMATION

Date _____

Name _____

Address _____

Age _____ Date of Birth _____

Occupation _____

Primary Physician _____

Physician Phone _____

Who may I thank for referring you? _____

Primary reason for treatment? _____

2

CONTACT INFORMATION

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Best time/method to reach you _____

Another person we may contact if necessary:

Name _____

Relationship _____

Home Phone _____

Work Phone _____

3

MEDICATIONS/HISTORY

Medications/food supplements you are taking

Serious illnesses, accidents, or surgeries

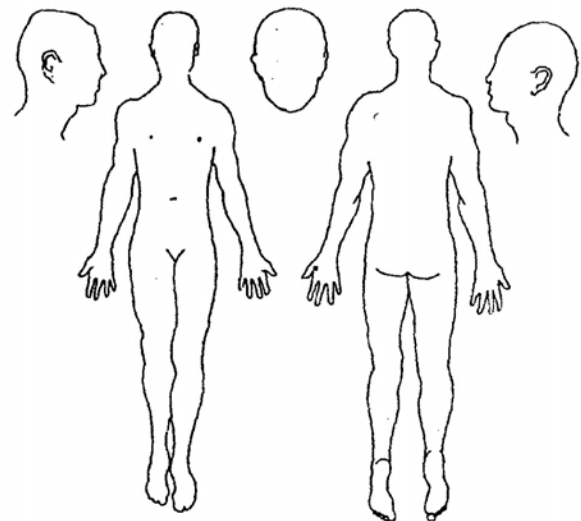
Illnesses that have occurred in blood relatives:

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |

4

AREAS OF CONCERN

Please indicate painful or distressed areas.



Comments:

HEALTH HISTORY

Check symptoms you currently have or have had in the past year.

- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches
- Loss of sleep/poor sleep
- Loss or gain of weight
- Nervousness/irritability
- Overwhelmed by life

MUSCLE/JOINT/BONES

- Muscle tremors
- Joint pain
- Swelling in joints

Pain, weakness, numbness in

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

- Other pain

GASTROINTESTINAL

- Belching, gas, or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain in stomach
- Poor appetite
- Vomiting

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heartbeat
- Swelling of ankles

EENT/RESPIRATORY

- Asthma/wheezing
- Blurred/failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

FOR MEN ONLY

- Erection difficulties
- Infertility
- Discharge from penis
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Infertility
- Irregular cycle
- Menopausal symptoms
- Menstrual pain
- PMS
- Previous miscarriage
- Scanty menstrual flow

- Last period _____

Check conditions you currently have or have had in the past.

- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes

- Eczema
- Emphysema
- Heart Disease
- Hepatitis Type ____
- Herpes
- HIV positive
- Kidney disease
- Liver disease

- Pneumonia
- Rheumatic fever
- Scarlet fever
- Seizures
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

How long has it been since you had a complete medical exam?

LIFESTYLE

Check substances you use and describe amount used.

- Alcohol _____
- Caffeine _____
- Drugs _____
- Sugar _____
- Tobacco _____

Check if your work or lifestyle exposes you to these:

- Insufficient sleep
- Hazardous substances or heavy lifting
- Long commuting times/traffic
- Stress
- Very long working hours
- Other _____

SIGNATURE

The information on this form is correct to the best of my knowledge. I understand that my protected health information will be used and disclosed consistent with the policies in the office's Notice of Privacy Practices, a copy of which I have received.

Signature _____

Date _____