

HEALTH ASSESSMENT/REGISTRATION FORM



LEGAL NAME: _____

NICKNAME: _____

ADDRESS: _____

PHONE: home _____ cell _____

EMAIL: _____

EMERGENCY CONTACT: _____

DATE OF BIRTH: _____ AGE: _____

SOCIAL SECURITY #: _____

I have read the care agreement given to me with this packet and agree to the policies explained in that agreement. I request medical treatment and care from Family to Family. I agree to pay in full at the time of service. I understand that non-standard therapies may be offered or recommended.

_____ (signature) _____ (date)

MEDICAL HISTORY

Current Medical History

Describe your main health concern(s)/Reason for Visit

List any current illnesses (include age or date of onset)

List other Health Practitioners/Modalities you work with

Medication Allergies (include reaction)

Medications (list all and bring all on your first visits)

Supplements (list all and bring in bottles to your visit)

Past Medical History

Share any known history of your own birth

Childhood Illnesses (with approximate date/age)

Previous Illnesses (with approximate date/ age)

Hospitalizations (with approximate date/age)

Operations (with approximate date/ age)

Accidents (include approximate date or age)

Reproductive History

Onset of Menses (age) _____

Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Type of Previous Contraception _____
Onset of Menopause @ age _____

Preventive Medicine

Immunizations

Tetanus (Date) _____
Hepatitis B (Date) _____
Flu (Date) _____
Other _____

Tests

Cholesterol _____
Colonoscopy (Date) _____
PSA (Date) _____
Mammogram (Date) _____
Pap Smear (Date) _____
Bone Density (Date) _____

FAMILY & SOCIAL HISTORY

Current Relationship:
Single? _____ Married? _____ Divorced? Year _____
In Significant Relationship? _____
Name of Partner _____

List the people in your current household (name, relationship, current age, and health problems):

List the people who were in your house growing up (name, relationship, current age)

Family Health History

Please list health problems of the following people:

Mother _____
Father _____
Paternal GF _____
Paternal GM _____
Maternal GF _____
Maternal GM _____
Aunts/ Uncles _____
Siblings _____
Children _____
History of loss? _____
Where did you grow up? _____

Educational History

What is the highest grade in school completed? _____

Degree, Date, Place (if applicable)

Occupational History

Current Job _____
Significant past employment: _____

WELLNESS HISTORY

Diet (Typical day)

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____

Substances

How many drinks of alcohol do you drink in one week? ____
Caffeine/ Coffee (Drinks/ day) _____
Did you ever smoke? yes/no
of packs/day? _ # of years? _____
Do you currently smoke? yes/no
of packs/day? ____ # of years? _____
If you quit, when did you quit? _____
Have you ever used smokeless tobacco? yes/no

Exercise

Type _____
How often _____

Recreation/ Fun

What do you do for recreation?

Pets

Do you have any pets? List.

Safety

What % do you use your seatbelt? _____
Do you use the cell phone while driving? _____
What % do you wear a bike helmet? _____

Environmental Exposures

Time spent in front of a computer? _____
Time watching TV? _____
Time spent on a cell phone? _____
Other Exposures _____

Belief Systems

Please say something about your spiritual life

REVIEW OF SYSTEMS

(Circle all that currently apply)

General

Weight Loss or Weight Gain
Night Sweats
Chronic Fatigue
Intolerant of Heat/Cold
Excessive Thirst

Skin

Rashes/ Moles
Warts/ Lumps/bumps
Hives/ Itching/ Dry Skin
Fungal infection / Poison Ivy
Pimples/ Acne
Easy Bruising/ Skin Cancer

Hair

Dandruff
Unwanted hair/ Hair Loss
Hair coloring or permanent

Eyes

Glasses/Contacts
Eye Pain/ Blurriness
Watery, Itchy Eyes
Double Vision/ Loss of Vision
Glaucoma/ Cataracts

Ears

Ringing/ Hearing loss
Chronic Ear Infections
Swimmers Ear/ Ear Wax

Nose & Sinus

Frequent Colds/ Nose Bleeds
Hayfever /Sneezing
Congestion/Sinus Pressure/ Pain

Mouth & Throat

Cavities/Fillings/Dentures/Root Canals
Recent Extractions/ Gum problems
Bad breath
Tooth Pain/ Throat Pain
Jaw click/ Teeth clenching/ Facial Pain
Canker Sores
Hoarseness
Speech Problems

Neck

Pain/ Stiffness
Swollen lymph glands
Enlarged thyroid gland

Breast

Pain/ Lumps
Nipple Discharge
Cysts (Fibrocystic)

Respiratory

Cough (productive or dry)
Shortness of breath/ Wheezing
Recurrent Infections
Conscious of Breathing?

CardioVascular

Chest Pain/ Angina
Swelling of ankles or legs

Irregular Heart Beat
Fainting Spells
Sleep with extra pillows
Awaken with trouble breathing
Cold hands and feet
Varicose veins
Leg Cramps @ rest/ while walking

Digestion

Poor Appetite/ Excessive Hunger
Food Allergies or sensitivities
Difficulty swallowing
Nausea/ Vomiting
Belching/ Heartburn/ Regurgitation
Cramping/ Bloating
Flatus/gas
Upper/Lower Abdominal Pain
Jaundice
Diarrhea/ Constipation
Hemorrhoids/ Rectal Pain/Itching
Frequency of stools _____
Bloody/ Black Stools

Urinary

Frequency or pain
Difficulty starting/stopping stream
Leakage of urine/ incontinence
Wake up to urinate, # of times ____
Bed Wetting

Reproductive

Female

Last Menstrual Period _____
Current contraception _____
Days between cycles:
<21 / 22-25 / 26-30 / >31/ irregular
PMS symptoms
Constipation/ Swelling
Moodiness/ depression/ irritability
Sore breast/ sugar cravings
Symptoms with Period
Cramping/Clotting
Heavy or Minimal Flow
Days of flow ____
Hot flashes
Vaginal dryness/itching
Vaginal discharge/ irritation
Vaginal pain/Pelvic pain
Hot flashes

Men

Penile discharge
Scrotum pain/ lumps
Loss of erection

Sexual

Sexually active
Are you satisfied with your sexual life
Problems with sexual arousal
Loss of sexual interest
Excessive sexual interest

Pain with intercourse
History of sexual trauma
History of sexually transmitted infections
Other sexual concerns _____

Neurologic

Headaches/ Seizures
Loss of consciousness/ Fogginess
Poor memory/ Difficulty concentrating
Dizziness/ Vertigo
Trouble with balance
Tremors/ Shakiness
Loss of sensation/ numbness
Restless legs

MusculoSkeletal

Joint Pain/ Stiffness/ Swelling
Muscle weakness/pain
Back Trouble

Psychological

Nervousness/Anxious
Excess worry/Stress/Grief
Source _____
Depression
Irritability
Thoughts of Suicide
Marital problems

Sleep

When do you go to sleep?
When do you awaken?
Difficulty falling asleep/Staying asleep
Difficulty going back to sleep
Recurrent dreams or Nightmares
Daytime sleepiness/ Snoring
Do you take anything to help you sleep?

Allergies

Environmental _____
Chemical _____
Food _____
Other _____

OTHER

please list any additional symptoms below