Registration Form

Date_____

Patient's Name: _____

Mailing Address:_____
(Street) (City) (State) (Zip)

Age:_____Birthday:_____ Phone: (___) _____

E-Mail_____

Social Security # _____ Driver's License #_____
(if you plan on using insurance) (if you plan on using insurance)

Referred By: _____

Occupation:_____Employer :_____

Work Phone:(___) _____

Married:_____ Single:_____ Divorced:_____ Widowed: _____ No. children:_____

Contact in case of emergency:_____Relationship_____Phone: (___)_____

If under 18 who is responsible for payment?_____

Method of payment: Cash/Check_____Personal Injury_____Insurance_____

Worker's Comp_____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for account: _____

HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE CARRIER AND THE PATIENT. THESE POLICIES ARE USUALLY DESIGNED TO OFFSET A LARGE PORTION OF THE TOTAL COST. OF TREATMENT. THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY TO THE PATIENT. IF SPECIAL CIRCUMSTANCES EXIST PLEASE NOTIFY US IN ADVANCE. IT SHOULD BE UNDERSTOOD THAT ALL SERVICES FURNISHED ARE CHARGED DIRECTLY TO THE PATIENT WHO IS PERSONALLY RESPONSIBLE FOR PAYMENT.

A FINANCE CHARGE OF 15 % WILL BE ADDED TO ANY UNPAID BALANCE AFTER 30 DAYS. IF AN APPOINTMENT IS MISSED WITHOUT A 24 HOUR NOTICE THERE WILL BE A $25 MISSED APPOINTMENT FEE

Patient Signature:_____

CONFIDENTIAL CASE HISTORY

Chief complaints due to: ___Physical illness ___Emotional illness ___Injury ___Auto accident

___Lifestyle ___Chemical exposure ___Work related injury ___Pregnancy or childbirth

Other _____

List symptoms briefly in order of importance:

1. _____Since _____
2. _____Since _____
3. _____Since _____
4. _____Since _____
5. _____ Since _____
6. _____ Since _____

What makes your symptoms better/worse:

What makes it better? _____

What makes it worse? _____

What time of day are the symptoms worse?

___ Morning ___Afternoon ___Evening ___During the night ___Symptom(s) is/are constant

Are you currently being treated for your condition(s) by another doctor or doctor(s) ___ Yes ___ No

	Doctor's name	Type of doctor	Approx. date started care
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please check health care providers you have had in the past:

___Chiropractor ____ Homeopath ___Acupuncturist ___Dentist ___Nutritionist

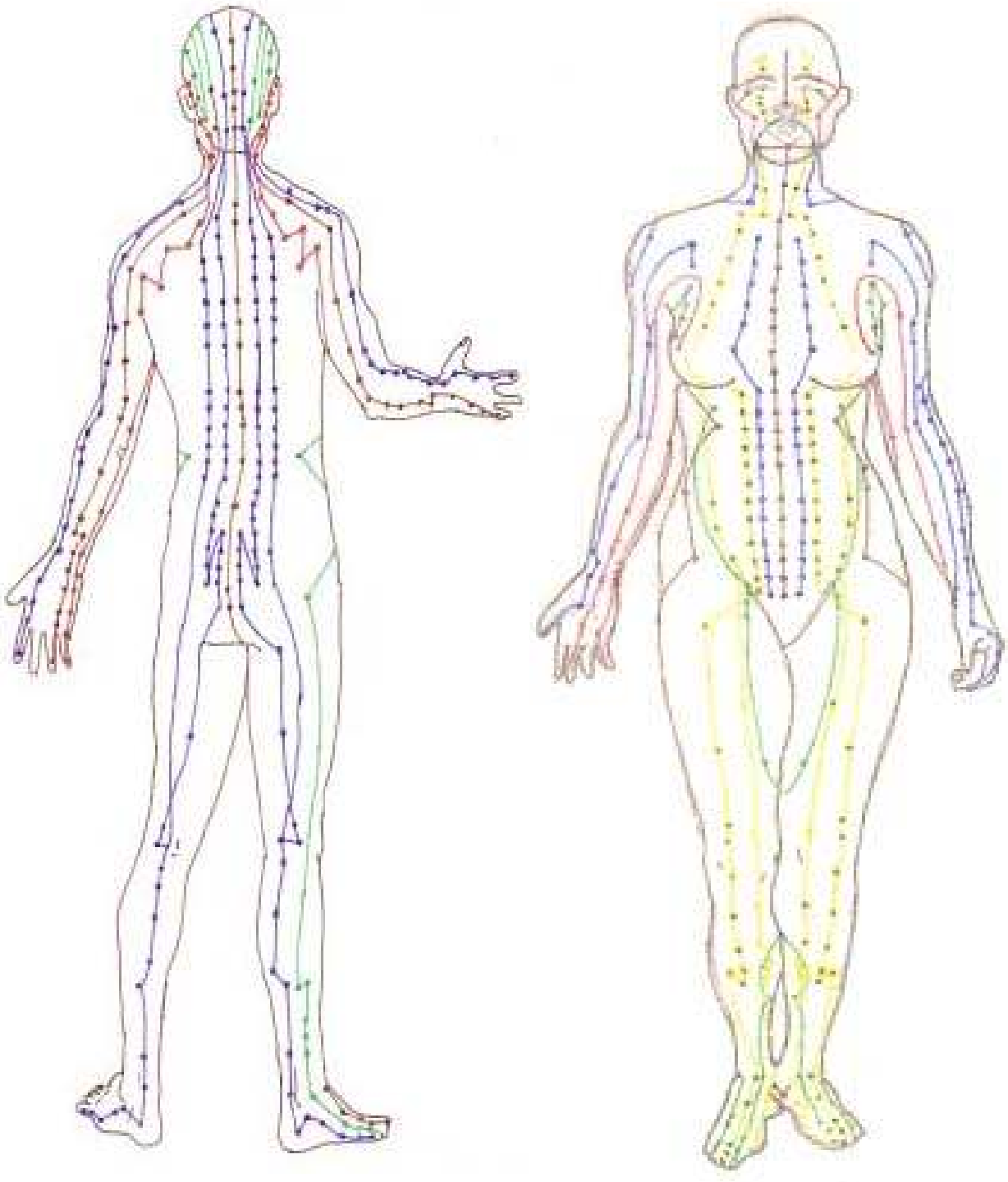
___Physical therapist ___Osteopath ___Medical doctor

- You may print the form in black and white or color

Using the symbols given below, circle or mark the areas of your body where you feel the described **pain or sensations of any kind**. Included all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
? ? ?	= = =	? ? ?	X X X	/ / /	? ? ?

For the purposes of this form we know that the front is a picture of a woman and the back is a picture of a man.. Think of this as gender neutral. If you are a man and the pain is in the chest, mark the chest area. Don't be concerned with the lines. They show energy flows in the body, this will help during the consultation.



Holistic Health Solutions ***HEALTH ASSESSMENT***

Circle any of the following medications are you taking:

Antacids	Chemotherapy	Hormones	Relaxants/Sleeping Pills
Antibiotic/Antifungal	Cortisone Anti-Inflammatories	Laxatives	Recreational Drugs
Antidepressants	Diuretics	Lithium	Specify _____
Antidiabetic/Insulin	Heart Medications	Oral Contraceptive	Thyroid
Aspirin/Tylenol	High Blood Pressure	Radiation	Ulcer Medications

Other _____

These questions help to evaluate energetic stress so that supportive therapy or nutrition can be given, they do not show the presence nor absence of disease.

List Vitamins and non-drug supplements you are taking:
List vitamins, minerals, herbs, homeopathics, etc. currently taken, including ascorbic acid, garlic, herbal laxatives, etc._____

_____

Circle if you eat, drink, or use:

Alcohol	Distilled Water	Luncheon Meats	Non-Herbal Teas
Candy	Fluoridated/Chlorinated Water	Margarine	Chew Tobacco
Carbonated Beverage	Eat at fast food restaurants regularly	Refined Sugars	Vitamins & Minerals
Cigarettes	Fried Foods	Milk Products	Specify _____
Coffee	Refined (White) Flour Products		Artificial Sweetner

Approximately how much water do you drink a day? _____

Circle if you:

Diet often	Exercise Less than 3 times weekly	Are exposed to chemicals at work

What is your blood type? ____Type A ____Type B ____Type AB ____Type 0 ____Not Sure

Directions: **Please read each description and click on the number, which best describes the frequency of your symptoms within the past year.**

Key: **0 = Never** **1 = Mild** (Occurs once a month or less) **2 = Moderate** (Occurs several times monthly) **3 = Severe** (Aware of it almost constantly)

Category 1
Section A: Stomach Digestion Stress

1. Bad Breath, halitosis..... 0 1 2 3
2. Loss of taste for high protein foods (meat, etc.) 0 1 2 3
3. Burning (acid) or nervous stomach, eating relieves 0 1 2 3
4. Gas shortly after eating 0 1 2 3
5. Indigestion 1/2 to 1 hour after eating, may last 3-4 hours..... 0 1 2 3
6. Difficulty digesting fruits or vegetables; undigested foods found in stools 0 1 2 3
7. Acid or spicy foods upset stomach..... 0 1 2 3

Section B: Liver, Gallbladder Stress

8. Lower bowel gas and or bloating several hours after eating..... 0 1 2 3
9. Feet burn 0 1 2 3
10. "Whites" of eyes (sclera) yellow 0 1 2 3
11. Dry skin, itchy feet and /or skin peels on feet..... 0 1 2 3
12. Brown spots or bronzing of skin..... 0 1 2 3
13. Bitter metallic taste in mouth..... 0 1 2 3
14. Blurred vision 0 1 2 3
15. Headache over eyes 0 1 2 3
16. Feel nauseous, queasy or gag easily 0 1 2 3
17. Color of stools light brown or yellow..... 0 1 2 3
18. Greasy or high fat foods cause distress..... 0 1 2 3
19. Pain between shoulder blades..... 0 1 2 3
20. Dark circles under eyes..... 0 1 2 3
21. "Acid"breath..... 0 1 2 3
22. History of gallbladder attacks or gallstones..... 0 1 2 3
    OR gallbladder removed..... YES NO
23. Appetite reduced..... 0 1 2 3

Section C: Intestinal Stress

24. Coated tongue or "fuzzy" debris on tongue..... 0 1 2 3
25. Pass large amounts of foul smelling gas..... 0 1 2 3
26. Irritable bowel or mucous colitis..... 0 1 2 3
27. Constipation, diarrhea alternating or stools alternate from soft to watery 0 1 2 3

Section C: Intestinal Stress (Continued)

28. Bowel movements painful or difficult, constipation, and/or laxatives used 0 1 2 3
29. Burning or itching anus 0 1 2 3

Category 2: Allergic Stress

30. Head congestion/sinus fullness 0 1 2 3
31. Sneezing attacks 0 1 2 3
32. Dreaming, nightmare-like bad dreams..... 0 1 2 3
33. Milk products and/or wheat products cause distress 0 1 2 3
34. Eyes and nose watery 0 1 2 3
35. Eyes swollen and puffy..... 0 1 2 3
36. Pulse speeds after meals and/or heart pounds after retiring..... 0 1 2 3

Category 3:
Section: A Blood Sugar Stress

37. Crave sweets or coffee in afternoon or mid-morning..... 0 1 2 3
38. Hungry between meals or excessive appetite..... 0 1 2 3
39. Overeating sweets upsets 0 1 2 3
40. Eat when nervous 0 1 2 3
41. Irritable before meals 0 1 2 3
42. Get "shaky" or light-headed if meals delays 0 1 2 3
43. Fatigue, eating relieves 0 1 2 3
44. Heart palpitates if meals missed or delayed..... 0 1 2 3
45. Awaken a few hours after sleep, hard to get back to sleep..... 0 1 2 3

Section: B Vitamin Deficiency

46. Muscle soreness after moderate exercise..... 0 1 2 3
47. Vulnerability to insect bites (especially fleas and mosquitoes..... 0 1 2 3
48. Loss of muscle tone or "heaviness" in arms or legs..... 0 1 2 3
49. Enlarged heart and/or heart failure 0 1 2 3
50. Worried, feel insecure and/or highly emotional..... 0 1 2 3
51. Pulse slow/below 65 or irregular pulse ..... YES NO

Category 4:
Section: A Pituitary Hormone Stress

52. Sex drive increased 0 1 2 3
53. "Splitting" type headaches 0 1 2 3
54. Memory failing 0 1 2 3
55. Tolerance for sugar reduced 0 1 2 3

Section: B Pituitary Hormone Fatigue Stress

56. Sex drive reduced or absent 0 1 2 3
57. Abnormal thirst 0 1 2 3
58. Weight gain around hips or waist 0 1 2 3
59. Tendency to ulcers or colitis 0 1 2 3
60. Increased ability to eat sugar without symptoms 0 1 2 3
61. Menstrual disorders (women) 0 1 2 3
62. Lack of menstruation (young girls) 0 1 2 3

Section: C Thyroid Stress1

63. Difficulty gaining weight, even if large appetite 0 1 2 3
64. Heart palpitations 0 1 2 3
65. Nervous, emotional, and/or can't work under pressure 0 1 2 3
66. Insomnia 0 1 2 3
67. Inward trembling 0 1 2 3
68. Night sweats 0 1 2 3
69. Fast pulse at rest 0 1 2 3
70. Intolerant to high temperatures 0 1 2 3
71. Easily flushed 0 1 2 3

Section: D Thyroid Fatigue Stress

72. Difficulty losing weight 0 1 2 3
73. Reduced initiative and/or mental sluggishness 0 1 2 3
74. Easily fatigued, sleepy during the day 0 1 2 3
75. Sensitive to cold, poor circulation (cold hands and feet) 0 1 2 3
76. Dry or scaly skin 0 1 2 3
77. "Ringing" in ears/noises in head 0 1 2 3
78. Hearing impaired 0 1 2 3
79. Constipation 0 1 2 3
80. Excessive falling hair and/or course hair 0 1 2 3
81. Headaches when awaken/wear off during day 0 1 2 3

Section: E Adrenal Stress

82. Blood pressure increased 0 1 2 3
83. Headaches 0 1 2 3
84. Hot flashes 0 1 2 3
85. Hair growth on face or body (women) 0 1 2 3
86. Masculine tendencies (women) 0 1 2 3

Section: F Adrenal Fatigue Stress

87. Blood pressure low 0 1 2 3
88. Crave salt 0 1 2 3
89. Chronic fatigue/get drowsy 0 1 2 3
90. Afternoon yawning 0 1 2 3
91. Weakness/dizziness 0 1 2 3
92. Weakness after colds/slow recovery 0 1 2 3
93. Circulation poor 0 1 2 3
94. Muscular and nervous exhaustion 0 1 2 3
95. Subject to colds, asthma, bronchitis (respiratory disorders) 0 1 2 3
96. Allergies and/or hives 0 1 2 3
97. Difficulty maintaining manipulative correction 0 1 2 3
98. Arthritic tendencies 0 1 2 3
99. Nails weak, ridged 0 1 2 3
100. Perspire easily 0 1 2 3
101. Slow starter in morning 0 1 2 3
102. Afternoon headaches 0 1 2 3

Category 5
Section A: Mineral depletion

103. Frequent skin rashes and/or hives 0 1 2 3
104. Muscle-leg-toe cramping at rest and/or while sleeping 0 1 2 3
105. Fever easily raised/fevers common 0 1 2 3
106. Crave chocolate 0 1 2 3
107. Feet have bad odor 0 1 2 3
108. Hoarseness frequent 0 1 2 3
109. Difficulty swallowing 0 1 2 3
110. Joint stiffness after rising 0 1 2 3
111. Vomiting frequent 0 1 2 3
112. Tendency to anemia 0 1 2 3
113. "Whites" of eyes (sclera) blue 0 1 2 3
114. "Lump" in throat 0 1 2 3
115. Dry mouth-eyes-nose 0 1 2 3
116. White spots on finger nails 0 1 2 3
117. Cuts heal slowly and/or scar easily 0 1 2 3
118. Reduced or "lost" sense of taste and/or smell 0 1 2 3
119. Susceptible to colds, fevers, and/or infections 0 1 2 3
120. Strong light irritates eyes 0 1 2 3
121. Noises in head or ringing in ears 0 1 2 3
122. Burning sensations in mouth 0 1 2 3
123. Numbness in hands and feet (extremities " go to sleep") 0 1 2 3
124. Intolerant to monosodium glutamate (MSG ..... YES NO
125. Cannot recall dreams 0 1 2 3
126. Nose bleeds frequent 0 1 2 3
127. Bruise easily, "black and blue" spots 0 1 2 3
128. Muscle cramps, worse with exercise ("charley horses") ... 0 1 2 3

Category 6
Cardio Vascular Stress

129. Aware of heavy and/or irregular breathing 0 1 2 3
130. Discomfort in high altitudes 0 1 2 3
131. "Air hunger"/ sigh frequently 0 1 2 3
132. Swollen ankles/worse at night 0 1 2 3
133. Shortness of breath with exertion 0 1 2 3
134. Dull pain in chest and/or pain radiating into left arm, worse on exertion 0 1 2 3

Category 7 Female Only
Female Hormone Stress

135. Premenstrual tension 0 1 2 3
136. Painful menses (cramping, etc.) 0 1 2 3
137. Menstruation excessive or prolonged 0 1 2 3
138. Painful/tender breasts 0 1 2 3
139. Menstruate too frequently 0 1 2 3
140. Acne, worse at menses 0 1 2 3
141. Depressed feelings before menstruation 0 1 2 3
142. Vaginal discharge 0 1 2 3
143. Menses scanty or missed 0 1 2 3
144. Hysterectomy/ovaries removed ..... YES NO
145. Menopausal hot flashes 0 1 2 3
146. Depression

Category 8 Men Only
Male Hormone Stress

147. Prostate trouble 0 1 2 3
148. Urination difficult or dribbling 0 1 2 3
149. Night urination frequent 0 1 2 3
150. Pain on inside of legs or heels 0 1 2 3
151. Feeling of incomplete bowel evacuation 0 1 2 3
152. Leg nervousness at night 0 1 2 3
153. Tire easily/avoid activity 0 1 2 3
154. Reduced sex drive 0 1 2 3
155. Depression 0 1 2 3
156. Migrating aches and pains 0 1 2 3

MENTAL STRESS

Have you ever been to a psychologist? _____ Yes _____ No

For what purpose?

1. _____Date_____

2. _____Date_____

Have you ever been to a psychiatrist? Yes No

_____ In the past _____ Currently

Type of treatment rendered:
_____Talking only _____ Drugs prescribed _____ Hypnosis _____ Electric shock
_____ Brain surgery

DENTAL SURVEY

Tooth decay: _____ Mild _____ Moderate _____ Severe _____ None

Gum disease: _____ Mild _____ Moderate _____ Severe _____ None

Do you have silver/mercury fillings? _____ Yes _____ No _____ Uncertain

How many root canals have you had? _____

Last dental visit _____ What was done? _____

Ever had braces or other dental appliance? If yes, please describe: _____

_____

Drugs

_____ I have used recreational drugs in the past: _____ Rarely _____ Occasionally ___ Frequently
_____ Heavily

Recreational drugs used in the past: _____ Marijuana/Hashish _____ Barbiturates (downers)

_____ Sleeping pills _____ Speed _____ Cocaine _____ LSD

Other: _____

CHEMICAL EXPOSURE

What is your current occupation? _____

List all chemicals you currently come in contact with: _____

_____

How often are you required to work with the above mentioned substances?
_____ Rarely_____ Occasionally _____ Frequently _____ Daily

Chemical exposure in the past:
_____ Pesticides _____ Automotive _____ Solvents _____ Poisons _____ Accidental

Other _____

Briefly describe, include length of exposure:
_____

_____

ALLERGIES

_____ Food allergies. Describe: _____

_____ Drug allergies. Describe: _____

_____Pollens _____ Dust _____ Cat hair _____ Dog hair _____ Grasses

Other: _____

SURGERIES

Check any surgeries/operations you have had and the approximate date:

_____ Tonsillectomy _____ Appendectomy _____ Gall bladder removed

_____ Heart surgery

_____ Orthopedic surgery _____ Metal implants. Describe: _____

_____ Cosmetic surgery Describe:_____

_____ Complete hysterectomy (Uterus/Both ovaries) _____ Uterus only _____ Uterus and one ovary

_____ Spinal surgeries

1. _____Date_____
2. _____Date_____
3. _____Date_____

HOSPITALIZATIONS

List all hospitalizations and approximate dates (no need to include surgeries listed above):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

PAST MEDICAL HISTORY

Please list all health problems you have had in the past. That includes birth defects, all childhood illnesses, any diagnosed diseases, high fevers or recurring infections and the approximate dates. If the name of the disease is not known, briefly describe the symptoms. Include severity, medicine taken or any other important details. Use back of page if needed.

Prenatal/Birth (if known): _____

Newborn: _____

_____

Childhood: _____

_____

_____

Adolescence: _____

_____

Adult: _____

_____

_____

Have you ever been diagnosed with any of the following? Include the approximate date of first occurrence.

_____ Mono/Epstein Barr virus Date:_____
_____ Herpes: oral genital Date:_____
_____ Canker sores Date:_____
_____ Scarlet fever Date:_____
_____ Rheumatic fever Date:_____
_____ Bladder infections Date:_____
_____ Kidney infections Date:_____
_____ Hepatitis (liver inflammation) _____
Which type? _____ Hepatitis A _____ Hepatitis B _____ Hepatitis C _____ Other _____ Not sure

ACCIDENT HISTORY

Include date and brief description.

_____ Broken bones:_____

_____ Motor vehicles: _____

_____ Head trauma: _____

_____ Other injuries: _____

_____

IMMUNIZATION RECORD

_____ Usual childhood immunizations _____ Partial immunization _____ Never been immunized

_____ Immunizations for overseas travel

List the type of vaccines and approximate number of times: _____

_____

_____

_____

FOR FEMALES ONLY

BIRTH CONTROL:
___ I.U. D. ___ Currently use ___ Used in the past from _____ to _____
___ Birth control pills ___ Currently use ___ Used in the past from _____ to _____
___ Barrier method Type: _____
___ Other: _____

MENSTRUAL CYCLE
___ Regular periods Last period _____
___ Irregular periods. Since: _____ Describe: _____
___ No periods. Since: _____ Describe: _____

MENSTRUAL SYMPTOMS: ___ Cramps ___ Back pain ___ Breast soreness
___ Normal flow ___ Light flow ___ Heavy flow ___ Sometimes hemorrhage

Are the symptoms: ___ Mild ___ Moderate ___ Severe
__ Other difficulties (mood swings, food cravings, etc.): _____

_____

CHILDBIRTH HISTORY
Number of pregnancies: _____Births: _____Miscarriages; _____Abortions: _____

Did you have any difficulties during pregnancy?
Please describe; _____

Did you have any difficulties during labor and delivery? Please describe: _____

_____

VAGINAL DISCHARGE
___ Chronic ___ Have had in the past(not currently a problem) ___ Yeast/Candida ___ Bacterial
___ Not sure

What treatment was given? _____ ____ Not sure

FIBROUS CYSTS:
___ Breasts ___ Uterus ___ Ovaries ___ Other _____

Please describe: _____

SEXUALLY TRANSMITTED DISEASES (Include date diagnosed)

___ Chlamydia Date:_____ ___Trichamonas Date:_____ ___ Gonorrhea Date: _____

___ Syphilis Date:_____ ___ Genital herpes Date: _____ ___ Oral herpes Date:_____

___ Genital warts Date: _____ ___ Other: _____

___ Not sure ___ Never had

MALE ONLY

URINARY TRACT:

_____ Urination slow to start _____ Stream too small _____ Dribbling

_____ Frequent night urination _____ Bladder pain after urination

_____ Pain or pressure after sexual relations _____ Burning _____ Discharge

SEX DRIVE:

_____ Excessive _____ Diminished _____ Absent _____ Normal

_____ Overly tired and exhausted _____ Impotency

DO YOU HAVE ANY OF THE FOLLOWING:

_____ Testicle pain _____ Hernia _____ No difficulties at all

Other: _____

SEXUALLY TRANSMITTED DISEASES: (Include approximate date diagnosed)

____Non-specific urethritis Date: _____ ____ Chlamydia Date _____

____ Trichamonas Date: _____ ____ Gonorrhea Date: _____

____ Syphilis Date: _____ ____ Genital warts Date: _____

____ Genital herpes Date: _____ ____ Oral herpes Date: _____

Other: _____

_____ Not sure _____ Never had