Allison Linley Howard, DOM Date: _____

Confidential Patient Registration Form

(Please Print)

Name: _____ Date of Birth: _____

Address: _____

City, State & Zip: _____

Home Phone: _____ Business Phone: _____

E-mail address: _____

Place of Birth: _____ Marital Status: _____

Occupation: _____ Employer: _____

In case of emergency, call: Name _____Phone# _____

Relationship: _____

Who referred you to this office? _____ May we contact this person to say thank you? _____

Please describe the health problems for which you came to this office: _____

_____

_____

_____

_____

Duration of this condition: _____

What makes it better? _____

What makes it worse? _____

What surgeries have you had? When? _____

_____

What other serious injuries or illnesses have you had? _____

_____

_____

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Are you exposed to any chemicals or occupational hazards as part of your day or work?

_____

Do you have any allergies that you know of? _____

What medications are you taking? _____

_____

What herbs/supplements/vitamins are you taking? _____

_____

Please indicate for each of the questions below your experience by use of one of the following codes: 1 for presently have; 2 for previously had.

___ Thyroid disorder	___ Bleeding disorder	___ Anemia
___ Hemorrhoids	___ Hernia	___ Hepatitis
___ Diabetes	___ Surgical implants	___ HIV/AIDS
___ Cardiac pacemaker	___ History of smoking	___ Hypertension
___ Epilepsy or convulsions	___ Urinary bladder problems/infections	

Menstrual History:

Age of first period: _____ Length of cycle, day 1 to day 1: _____

Length of flow (days): _____ Date of last period: _____ Do you believe you are pregnant? _____ Method of Birth Control: _____

Do you have any of the following?:

___ Menstrual cramps ___ Menstrual blood clots ___ Excessive bleeding

___ PMS ___ Breast swelling/pain ___ Breast cysts ___ Hot flashes

___ Emotional changes with period ___ Vaginal Yeast (*Candida*) infections

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Diet:

Please grade according to the following scale:

O- Do not consume this

M- Consume this monthly

FM- Consume a few times per month

W- Consume this weekly

FW- Consume this a few times per week

D- Consume this daily

FD- Consume this a few times per day

Alcohol _____ Coffee _____ Tobacco _____ Artificial Sweeteners _____

Soda _____ Sugar _____ Eggs _____ Cooked vegetables _____

Raw vegetables _____ Fruit _____ Dairy (milk products) _____ Fried foods ____

Organic Foods _____ Poultry _____ Fish _____ Beef _____ Wheat _____

Bread _____ Pasta _____ Iced drinks _____

Typical Daily Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Your referrals are most welcomed.

0-5 Severity Scale- Circle your level (0 = not present 5 = most severe)

Insomnia- 0 1 2 3 4 5
Poor quality of sleep- 0 1 2 3 4 5
Anxiety- 0 1 2 3 4 5
Palpitations- 0 1 2 3 4 5
Frequent UTI- 0 1 2 3 4 5
Nightmares- 0 1 2 3 4 5

Constipation- 0 1 2 3 4 5
Diarrhea- 0 1 2 3 4 5
Nausea/vomiting- 0 1 2 3 4 5
Bloating/gas- 0 1 2 3 4 5
Heartburn/acid reflux- 0 1 2 3 4 5
Abdominal pain- 0 1 2 3 4 5
Poor appetite- 0 1 2 3 4 5
Poor energy level- 0 1 2 3 4 5

Chronic cough- 0 1 2 3 4 5
Airborne allergies (pollen/ dust etc.) 0 1 2 3 4 5
Sinus problems- 0 1 2 3 4 5
Tendency to catch colds/sick easily-0 1 2 3 4 5
Shortness of breath- 0 1 2 3 4 5
History of lung issues- 0 1 2 3 4 5
Bronchitis- 0 1 2 3 4 5
Pneumonia- 0 1 2 3 4 5

Stress level- 0 1 2 3 4 5
Depression- 0 1 2 3 4 5
Mood swings- 0 1 2 3 4 5
Irritability- 0 1 2 3 4 5
Dizzyness/vertigo- 0 1 2 3 4 5
Headaches/migraines- 0 1 2 3 4 5
Tight muscles- 0 1 2 3 4 5
Teeth grinding/TMJ- 0 12 3 4 5
Eye dryness- 0 1 2 3 4 5
Floaters- 0 1 2 3 4 5
Red, irritated eyes- 0 1 2 3 4 5

Night sweats- 0 1 2 3 4 5
Low back pain/weakness- 0 1 2 3 4 5
Decreased libido- 0 1 2 3 4 5
Knee pain/weakness- 0 1 2 3 4 5
Up at night to urinate- 0 1 2 3 4 5
Heat/cold intolerance- 0 1 2 3 4 5
Cold hands/feet- 0 1 2 3 4 5
Edema/swelling- 0 1 2 3 4 5
Prostate problems- 0 1 2 3 4 5
Difficult urination- 0 1 2 3 4 5
Poor memory- 0 1 2 3 4 5