

ADULT REGISTRATION FORM
(AGES 16-100+)

Name _____ Birthdate _____

Home Address _____ Phone _____

City, State, Zip _____ Phone(cell) _____

E-mail _____ Phone(work) _____

Usual occupation _____ Company _____

Referred by _____ Medical insurance _____

Person to contact in case of emergency _____ Phone _____

MEMBERS OF HOUSEHOLD

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

What would you like help with?

If you have recently been bothered with any of the following problems please indicate.

- Frequent or severe headaches
- Neck pains
- Neck lumps or swelling
- Loss of balance
- Dizzy spells
- Blackouts/fainting
- Blurry vision
- See halos or lights
- Eye pains or itching
- Watering eyes

- Hearing difficulties
- Earaches
- Running ears
- Noises in ears

- Dental problems
- Sore or bleeding gums

- Congested nose
- Running nose
- Sneezing spells
- Head colds
- Nosebleeds
- Sore throat
- Difficulty swallowing
- Hoarse voice

- Wheezing or gasping
- Frequent coughing
- Cough up phlegm
- Cough up blood
- Chest colds

- Rapid or skipped heartbeats
- Chest pains
- Shortness of breath
- Swollen feet or ankles

- Recurring indigestion
- Frequent belching
- Nausea
- Vomiting
- Pain in Abdomen
- Bloating Abdomen
- Constipation
- Loose bowels
- Black stools
- Pain in rectum
- Itching rectum
- Blood with stools

- Frequent urination
- Involuntary escape of urine
- Burning on urination
- Bloody urine
- Weak urine stream
- Difficulty starting
- Constant urge

MEN ONLY

- Burning / discharge
- Lumps/swelling testicles
- Painful testicles

WOMEN ONLY

- A missed period
- Menstrual problems
- Bleeding between periods
- Menstrual cramps
- Heavy bleeding
- Bearing down feeling
- Vaginal discharge
- Genital irritation
- Pain on intercourse
- Lumps in breasts
- Painful breasts
- ___ Number of pregnancies
- ___ Number of births
- ___ Cesareans
- ___ Abortions

- Aching muscles or joints
- Swollen joints
- Back or shoulder pains
- Weakness in arms or legs
- Painful feet
- Trembling
- Numbness
- Leg cramps

- Skin problems
- Scalp problems
- Itching or burning skin
- Bruises easily

- Nervousness or anxiety
- Nervous with strangers
- Nail biting
- Difficulty making decisions
- Lack of concentration
- Loss of memory
- Lonely or depressed
- Frequent crying
- Hopeless outlook
- Difficulty relaxing
- Worry a lot
- Frightening dreams
- Pessimistic
- Overly sensitive
- Irritable
- Rage
- Family problems
- Sexual difficulties
- Change of sexual energy
- Sought psychiatric help

- Loss or gain in weight
- Feel warmer or colder than others
- Loss of appetite
- Always hungry
- Unusual fatigue
- Difficulty sleeping
- Fever or chills
- Motion sickness
- Excessive sweating
- Night sweats
- Hot flashes

Hospitalization (1) Hospitalization(2) Hospitalization(3)

Type of operation or illness _____

Year of hospitalization _____

Allergies to medications ? _____

DO YOU USE:

Amount

- Coffee _____
- Cigarettes _____
- Alcohol _____
- Birth Control Pills _____
- Sedatives _____
- Herbs/vitamins _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- Medications _____
- _____
- _____

INDICATE WHICH TESTS YOU HAVE HAD
AND WHEN:

- Chest x-ray _____
- Kidney x-ray _____
- G.I. series _____
- Colonoscopy _____
- EKG _____
- MRI/CAT Scan _____