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
- ❑ Bloated 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
- ❑ Motions sickiness
- ❑ 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 _____