Cedar Avenue
INTEGRATIVE MEDICINE

PATIENT REGISTRATION FORM

Today's Date

PATIENT INFORMATION

Name: | Date of Birth: | Age:

Gender: ☐ M ☐ F | Marital Status:

Address: | Phone (hm):

City/State/Zip: | Phone (cell):

Email: | May we leave messages at these numbers? ☐ H ☐ C

Preferred method of communication: ☐ Email ☐ Home phone ☐ Cell phone

Emergency Contact: Phone:

Their relationship to you:

For Minors Only: Name of Mother: Name of Father:

HOW DID YOU HEAR ABOUT US?

☐ Family/Friend ☐ Insurance ☐ Physician Referral

☐ Internet: Specify ☐ Other:

BILLING FORMATION

Is patient covered by insurance? ☐ Yes ☐ No | If No, Name of Person Responsible for Bill:

Primary Insurance: | *Address and Phone Number of Responsible Party (if different from above)

(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Subscriber's Name Employer: Occupation: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

Secondary Insurance: Subscriber's Name Employer: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

☐ By checking this box, I am verifying that the above is true to the best of my knowledge.

Date: _____

110 Cedar Avenue, Suite 101 | Snohomish, WA 98290
P: (360) 282-4014 | F: (360) 282-4017 | www.cedaravenuemedicine.com

HEALTH HISTORY QUESTIONNAIRE *For Women*

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	**Date**	**DOB**
PRIMARY CARE PHYSICIAN:	**Physician Phone #**:	
OTHER HEALTHCARE PRACTITIONERS: Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.:		
Name:	**Type of practice:**	**Phone number:**

Date of last physical exam:	**Date of last pap exam:**	**Date of last fasting blood labs:**

Please list your current health concerns in order of their importance to you

Concern:	Date of onset:
1.	
2.	
3.	
4.	
5.	

Previous medical diagnoses

Diagnosis:	Diagnosed by:	Date of diagnosis:
1.		
2.		
3.		
4.		
5.		

Traumas, Car Accidents, Injuries:

Surgeries and Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion?..... ☐ Yes ☐ No

MEDICATIONS

PRESCRIPTION & OTC MEDICATIONS	SUPPLEMENTS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

ALLERGIES

Drug Allergies	Reaction
1.	
2.	
3.	
Food Allergies	**Reaction**
1.	
2.	
3.	
Environmental Allergies	**Reaction**
1.	
2.	
3.	

CHILDHOOD MEDICAL HISTORY

Prenatal history: Any complications during your mother's pregnancy with you? ☐Yes ☐No
If so, describe:

Birth History: ☐Vaginal ☐Cesarean Section ☐Forceps/Vacuum ☐Other, describe:
Newborn problems: ☐Jaundice ☐Hospitalization ☐Other, describe:

Nourishment: As a baby, were you fed ☐Breast milk ☐Formula ☐Mixed
What age you first were given solid foods?
How would you describe your diet as a child?

Childhood Illnesses: How often did you get sick as a child? ☐Often ☐Not often
What kind of illnesses did you usually experience? (i.e. ear infections, sore throat, cough, allergies, asthma…)
How often did you take antibiotics? ☐Often ☐Not often
Other medications taken regularly as a child?
Did you ever have: ☐Measles ☐Mumps ☐Chicken Pox ☐Rubella ☐Polio ☐Pertussis
☐None of these ☐Other infectious diseases:

List Any Other Medical Problems You Had As A Child:

Vaccinations: ☐I am fully vaccinated ☐I am selectively vaccinated ☐I am not vaccinated
Check those vaccinations you've had:
☐Chicken Pox ☐MMR ☐DTaP ☐Pneumonia ☐Hep B ☐Polio ☐Hib ☐Hep A
Last tetanus booster: Do you get the flu vaccine? ☐Yes ☐No
Ever had an adverse reaction to vaccine? ☐Yes ☐No

Home Environment:

# of Siblings: Birth order: What adults lived with you?

Was your home safe? Did you have any traumas or losses as a child?

Did you grow up in the: ☐City ☐Suburbs ☐Rural area Exposure to smoke or use drugs regularly? ☐Yes ☐No

SOCIAL AND LIFESTYLE FACTORS

HABITS	**Yes**	**No**	**Details**
Current tobacco use	☐	☐	Packs per day:
Past tobacco use	☐	☐	Packs per day: When did you quit?
Alcohol consumption	☐	☐	Per day? Per week? Types:

Are you concerned about the amount you drink? ☐ No ☐ Yes
Have you ever had a problem with drinking in the past? ☐ No ☐ Yes

Recreational drug use	☐	☐	Types:
Ever been treated for drug/alcohol abuse?	☐	☐	When?
Seat belt use	☐	☐	
Caffeine use	☐	☐	Cups per day? Types:
Regular exercise?	☐	☐	How much? What type?

SOCIAL	**Yes**	**No**	
Happy with your relationship?	☐	☐	Length?

What is your predominant emotion?

Do you feel well-supported socially?

Are you religious or spiritual? Explain:

Have you ever been emotionally or physically abused? ☐ Yes ☐ No
Do you have concerns about abuse/violence in your life right now? ☐ Yes ☐ No

HOME	**Yes**	**No**	
Is your home a sanctuary?	☐	☐	

Who lives with you?

Do you have any pets?	☐	☐	What type and how many?
Does your home have lead paint?	☐	☐	
Is your home moldy/damp?	☐	☐	
Is your home safe?	☐	☐	
Is their a gun in your home?	☐	☐	

OCCUPATION	**Yes**	**No**	

Type of work?

How many hours per week? How many days per week?

Do you take vacations?	☐	☐	
Do you enjoy your work?	☐	☐	

STRESS

Stress level: ☐ Low ☐ Medium ☐ High
Stress source: ☐ Money ☐ Job ☐ Family/Relationship ☐ Other:
What do you do to relieve stress?

SLEEP	**Yes**	**No**	
Problems falling asleep?	☐	☐	
Problems staying asleep?	☐	☐	
Do you wake up refreshed?	☐	☐	

How many hours of sleep do you normally get per night?

SEXUAL AND REPRODUCTIVE HEALTH

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Menstrual History

Age of first period? _____

First day of your most recent period? _____

How long is your cycle, month to month? _____

Is your cycle length regular?..... ☐Yes ☐No

How many days do you bleed? _____

Is your flow … ☐Light ☐Moderate ☐Heavy

PMS? …… ☐Yes ☐No

Describe:

Do you skip periods? …… ☐Yes ☐No

Any mid cycle spotting? …… ☐Yes ☐No

Cramps with menses? …… ☐Yes ☐No

Menopause? …… ☐Yes ☐No

Gynecologic Conditions

check if you have had any of the following

- ☐Yeast Infection
- ☐Bacterial vaginosis
- ☐Trichimonas
- ☐Itching, odor, discharge
- ☐PCOS
- ☐Endometriosis
- ☐None of these
- ☐Uterine fibroid
- ☐Ovarian Cyst
- ☐Breast lump
- ☐Fibrocystic breasts
- ☐Nipple discharge
- ☐Pain with intercourse

Sexual History

Are you currently sexually active? ☐Yes ☐No With: ☐Men ☐Women ☐Both

Have you been sexually active with: ☐Men ☐Women ☐Both ☐Neither ☐Bisexual Men ☐Bisexual women ☐Prostitutes ☐IV drug users

Are you satisfied with your sex life? ☐Yes ☐No | Do you practice safer sex? ☐Yes ☐No

Do you have need for birth control? ☐Yes ☐No | Number of sexual partners this year:

STDs: ☐HIV ☐Herpes ☐HPV/Warts ☐Gonorrhea ☐Chlamydia ☐Syphilis ☐Hepatitis

Contraceptive/Safe-sex practice History: *What birth control methods/safe-sex practices have you used? (Fertility awareness, condoms, sponge, cap, diaphragm, IUD, oral contraceptives, norplant, Depo-provera…)*

Type:	How long?	Any problems?	Current use?

Pregnancy History:

Date	Outcome (vaginal delivery, caesarean, miscarriage, abortion, etc)	Did you breastfeed?	How long?
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	
		☐Yes ☐No	

Are you currently trying to get pregnant?..... ☐Yes ☐No

Have you made any changes in your diet/lifestyle while trying to get pregnant?..... ☐Yes ☐No

If so, what?

Do you plan to become pregnant in the future?..... ☐Yes ☐No

Have you ever had difficulty getting or staying pregnant?..... ☐Yes ☐No

FAMILY HEALTH HISTORY

Are you adopted? ..... ☐ Yes ☐ No

Mother:	☐ Living ☐ Deceased	Cause:	Age:
Father:	☐ Living ☐ Deceased	Cause:	Age:
Siblings:	Number living:	Number deceased:	Causes/Ages:
Children	Number living:	Number deceased:	Causes/Ages:

Has any family member (or you) been diagnosed with:	**YES**	**NO**	**Who? At what age?**	**Details**
Asthma	☐	☐		
Emphysema	☐	☐		
Severe allergies	☐	☐		
Thyroid problems	☐	☐		
Stroke	☐	☐		
Heart disease	☐	☐		
Heart attack	☐	☐		
Blood clots in lungs or legs	☐	☐		
High blood pressure	☐	☐		
High cholesterol	☐	☐		
Ulcers	☐	☐		
Kidney disease	☐	☐		
Gallbladder disease	☐	☐		
Osteoporosis	☐	☐		
Liver disease	☐	☐		
Colitis/Crohn's/Celiac	☐	☐		
HIV/AIDs	☐	☐		
Anemia	☐	☐		
Blood disorder	☐	☐		
Diabetes	☐	☐		
Alcohol or drug problems	☐	☐		
Eating disorders	☐	☐		
Cancer	☐	☐		
Mental illness/depression	☐	☐		
Alzheimer's disease	☐	☐		
Other:	☐	☐		

REVIEW OF SYSTEMS			
(Please check if you have had problems with the following)			
Now	**Past**	**Condition**	**Notes**
		1. General	
☐	☐	Weight loss/gain (circle)	
☐	☐	Poor memory/Brain fog	
☐	☐	Fatigue	Energy level (1 – 10)?
☐	☐	Decreased libido	
☐	☐	Too hot/cold (circle)	
☐	☐	Excessive sweating/Night sweats	
☐	☐	Frequent colds/flus	
		2. Skin	
☐	☐	Dryness	
☐	☐	Rashes/Itching/Eczema	
☐	☐	Hair or nail changes	
☐	☐	Easy bruising	
☐	☐	Acne	
		3. Head/Neck	
☐	☐	Headache/Migraines	
☐	☐	Ringing in ears	
☐	☐	Poor hearing	
☐	☐	Earaches	
☐	☐	Tooth/Gum problems	Number of mercury fillings?
☐	☐	Hoarseness	
☐	☐	Sore throat	
☐	☐	Poor vision	When was your last eye exam?
☐	☐	Light sensitivity	
☐	☐	Blurred/Double vision	
☐	☐	Dry eyes	
☐	☐	Poor night vision	
		4. Lungs	
☐	☐	Difficulty breathing	
☐	☐	Persistent cough	
☐	☐	Wheezing	
		5. Cardiovascular	
☐	☐	Heart palpitations	
☐	☐	Chest pain	
☐	☐	Irregular heartbeat	
☐	☐	Swelling in hands or feet	

Now	Past	Condition	Notes
		6. Gastrointestinal	
☐	☐	Change in appetite	
☐	☐	Nausea/Vomiting	
☐	☐	Abdominal pain	
☐	☐	Difficulty swallowing	
☐	☐	Indigestion/Reflux	
☐	☐	Gas/Bloating	
☐	☐	Constipation	
☐	☐	Diarrhea	
☐	☐	Blood/Mucus in stool	
		7. Genitourinary	
☐	☐	Pain with urination	
☐	☐	Urgency/Frequency	
☐	☐	Bladder incontinence	
☐	☐	Excessive thirst	
		8. Musculoskeletal	
☐	☐	Muscle pain	Where?
☐	☐	Joint pain	Where?
		9. Neurological	
☐	☐	Dizziness/Vertigo/Fainting	
☐	☐	Problems with speech/coordination	
☐	☐	Paralysis/Numbness	
☐	☐	Tremors	
		10. Psychological	
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Mood changes	

AND LAST OF ALL

Is there anything else I should know?

Thank you for taking the time to fill out this questionnaire. I look forward to working with you.

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