PATIENT REGISTRATION

NEW PATIENT: □

SHORELINE NATURAL MEDICINE CLINIC

UPDATE: □

PLEASE PRINT NAME: **DATE:**

Last:_____ First:_____ MI: ___
Address:_____
City: _____ State: _____ Zip: _____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Employer:_____ Occupation: _____
Date of Birth: _____ Sex: Male: □ Female: □
Marital Status: Single: □ Married: □ Widowed: □ Other: □
Emergency Contact and Phone: _____
Email (for newsletter and appointment purposes):_____

PRIMARY INSURANCE:

Insurance Company:_____
Member #_____ Group #_____
Policy Holder's Name:_____
Policy Holder's SS#:_____
Policy Holders' Birth date:_____
Insurance Co. Address:_____
City:_____ State:_____ Zip:_____
Insurance Co. Phone #:_____
Co-Insurance? Copay:

Patient's Relationship to Insured:
Self: □ Spouse: □ Child: □ Other: □

SECONDARY INSURANCE:

Insurance Company: _____
Member #_____ Group # _____
Policy Holder's Name: _____
Policy Holder's SS#: _____
Policy Holders' Birth date: _____
Insurance Co. Address:_____
City:_____ State:_____ Zip:___
Insurance Co. Phone #:_____

Patient's Relationship to Insured:
Self: □ Spouse: □ Child: □ Other: □

If your visit is related to an **AUTO ACCIDENT or WORK INJURY**, please complete the following:

WORK INJURY:

Date of Accident:_____
Employer at the Time of Injury:_____
Insurance company:_____
L&I / claim #: _____
L&I Claim Manager:_____
Claim Manager Phone #:_____

CAR ACCIDENT:

Date of Accident:_____
Employer at the time:_____
Auto Insurance Company:_____
Claim #:_____
Auto Insurance Claim Agent: _____
Agent's Phone #:_____

I AUTHORIZE my insurance company to pay directly to Dr. Fran Pinault / Shoreline Natural Medicine Clinic for my medical care and the release of any medical information necessary to process these claims.
I UNDERSTAND THAT I AM RESPONSIBLE for knowing my insurance coverage for complementary care, including copays, deductables, and responsible portions.
I UNDERSTAND THAT CANCELATION or missed visits without 24 hour notice may result in a missed visit charge.
I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES, describing how my health information may be used and disclosed. The above information is complete and accurate to the best of my knowledge.

SIGNATURE:_____ **DATE:**_____

SHORELINE NATURAL MEDICINE CLINIC

DETAILED PATIENT QUESTIONNAIRE

Name: _____

Today's Date: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY:

*What is your height?*_____ *What is your weight?*_____ *Your age?*_____

Please describe your health concerns for which you are seeking care: Date of onset:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Please list all Surgeries or Hospitalizations: Date:

1. _____ _____
2. _____ _____
3. _____ _____

Please list and scars you have from surgeries, cosmetic procedures, injuries or piercings:

_____

_____

Please list all Medications or Vitamins and doses:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Who is your primary care provider?

_____

Other Specialists you see:

_____

_____

_____

Please list any allergies:

_____

_____

_____

Immunizations: (last date of) Influenza: _____ Tetanus: _____ Other: _____

SOCIAL HISTORY:

Marital Status: Single: □ Married: □ Widowed: □ Partnered: □ Other: □

If in relationship, is it emotionally and physically supportive to you? Yes □ No □

Do you have a "Living Will"? Yes □ No □ Would like information about Health Care Directives or Durable Power of Attorney? Yes □ No □

Please list what you feel is most stressful in your life (work, chemical exposures, stress, lack of rest):

_____

_____

_____

DETAILED HEALTH QUESTIONNAIRE (continued)

Do you smoke tobacco or marijuana? Yes □ No □ If yes, how many cigarettes each day? _____
Please describe your diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
How many ounces of water do you drink daily: _____ Number of fruits, vegetables daily: _____
How many cups of coffee daily: _____ Tea: _____ number of alcoholic drinks _____ daily /weekly
Are you relaxed when you eat? Yes □ No □ You eat out _____ times per week
Do you exercise? Yes □ No □ Type: _____ times per week _____

FAMILY HISTORY: Please indicate which blood relative has experienced:

Breast or Uterine Cancer: _____
Ovarian Cancer: _____
Colon Cancer: _____
Other Cancer: _____
Diabetes: _____
Arthritis: _____
Heart Disease: _____
High Blood Pressure: _____
Mental Illness: _____
Reaction to Anesthesia: _____
Stroke: _____
Tuberculosis: _____

WOMEN: please indicate:

Date of first menses _____
Date of last menses _____
days you bleed _____
day of total cycle _____
Sexual abuse Yes □ No □
Pain with urination Yes □ No □
Pain with intercourse Yes □ No □
Date of last PAP _____
Date of last mammogram _____
Breast lumps Yes □ No
Do you do regular self breast exams? Yes □ No □
Number of pregnancies: _____ Births: _____
Type of birth control _____
Date of last DEXA _____
Satisfied with your sexual experience? Yes □ No □

MEN: please indicate:

Date of last physical exam _____
Date of last PSA _____
Last PSA value _____
Testicular pain Yes □ No □
Sexual abuse Yes □ No □
Penile discharge Yes □ No □
Slow or thin urine stream Yes □ No □
Difficulty starting urination Yes □ No □
Pain with urination Yes □ No □
Diagnosis of prostatitis Yes □ No □
Diagnosis of prostate cancer Yes □ No □
Have you have had a vasectomy Yes □ No □
Satisfied with your sexual experience? Yes □ No □

I. ADRENAL / NEUROTRANSMITTER: please indicate if you experience:

Fatigue lately _____
Too tired to do usual activities _____
Difficulty falling asleep _____
Have restless sleep _____
Wake frequently at night, not returning to sleep _____
Wake early, not returning to sleep _____
I want to sleep more than 8 hours / night _____
My appetite is low lately _____
My appetite is high lately _____
I have experienced weight loss lately _____
I have experienced weight gain lately _____
I often feel sad _____
I have difficulty concentrating _____
I have difficulty focusing _____
I think of dying often _____
Life doesn't have much purpose now _____
I do not think well of myself _____
I don't enjoy my usual activities _____
My mind feels slow, difficult to make decisions. _____
I feel restless, like I must move _____
I don't fell very creative now _____
I don't feel very social now _____
I wish I were more interested in my family _____
I don't feel like I am having much fun _____
I don't feel inspired to advance my work or earnings _____
I am afraid I am criticized _____
I often feel anxious _____
I feel something is wrong with me _____
I have difficulty in work relationships _____

PLEASE CHECK IF YOU EXPERIENCE ANY OF THE FOLLOWING:

NEUROLOGICAL:

Vision changes ____
Dizziness ____
Seizures or convulsions ____
Memory loss ____
Confusion ____
Radiating pain ____
Loss of muscle function ____
Tingling sensation in limbs ____
Burning sensation ____
Migraines ____

Other: _____

MUSCULOSKELETAL:

Bone deformity ____
Bone loss ____
Joint pain ____
Joint swelling ____
Low back pain ____
Mid back pain ____
Neck pain ____
Numbness or tingling ____
Restless legs, must move ____
Muscle spasms ____
Poor posture ____
Snapping, cracking joints ____
Trigger finger ____

Other: _____

II GASTROINTESTINAL GASTROINTESTINAL – A:

Belching / burping ____
Quickly feel full ____
Low appetite ____
Difficult, small stools ____
History of anemia ____
Loss of taste or odors ____
Pain with eating ____
Heartburn ____
Constipation ____
Difficulty swallowing ____
Diagnosed with GERD ____
Gas just after eating ____
Stomach pain ____

ENDOCRINE:

Diabetes ____
Autoimmune disease ____
Infertility ____
Hypoglycemia ____
Shaky before next meal ____
Faint or low energy between meals ____
Thyroid disease ____

Other: _____

HEAD:

Blurred vision ____
Vision changes ____
Loss of clarity of vision ____
Glaucoma / cataracts ____
Hearing loss ____
Ringing in the ears ____
Nasal congestion ____
Chronic sinusitis ____
Bleeding gums ____
Recurrent sore throat ____
Seasonal allergies ____
Headaches ____
Migraines ____
Hair loss ____
Grinding teeth ____

Other: _____

GASTROINTESTINAL – B:

Bloated feeling after food ____
Nausea or vomiting ____
Frequent bowel movements ____
Alternating constipation / Loose stools ____
Frequent loose stools ____
Brittle hair, nails ____
Undigested food in stool ____
Mucous in stool ____
Dark blood in stool ____
Pain under right ribs ____
Chest of pain at sternum ____

CARDIOVASCULAR:

Chest pain ____
Palpitations ____
Shortness of breath ____
Swelling of feet, ankles ____
High blood pressure ____
Blot clots ____
Anemia ____
Irregular heart beat ____
Mitral valve prolapse ____
Murmur ____

Other: _____

RESPIRATORY:

Cough ____
Asthma ____
Wheezing ____
Shortness of breath ____
Chronic infections ____
Emphysema ____
Recurrent colds ____
Recurrent bronchitis ____

Other: _____

GASTROINTESTINAL –C:

Much flatulence /rectal gas ____
Pencil thin stools ____
Low abdominal pain ____
Fiber aggravates pain ____
Diarrhea ____
Loose stools ____
Abdominal pain ____
Diagnosed with IBS ____
Incontinence /fecal seepage ____
Bright blood in stool ____
Anal itching ____
Mucous in stools ____
Dry, hard stools ____
Incomplete voiding of stool ____