PATIENT REGISTRATION

SHORELINE NATURAL MEDICINE CLINIC

NEW PATIENT: ☐
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:	**SECONDARY INSURANCE:**
Insurance Company:___________________	Insurance Company: ___________________
Member #________________Group #______	Member #________________Group # ______
Policy Holder's Name:_________________	Policy Holder's Name: _________________
Policy Holder's SS#:__________________	Policy Holder's SS#: __________________
Policy Holders' Birth date:_____________	Policy Holders' Birth date: _____________
Insurance Co. Address:________________	Insurance Co. Address:________________
City:______________State:_____ Zip:_____	City:______________State:________Zip:___
Insurance Co. Phone #:________________	Insurance Co. Phone #:________________
Co-Insurance? Copay:	
Patient's Relationship to Insured:	Patient's Relationship to Insured:
Self: ☐ Spouse: ☐ Child: ☐ Other: ☐	Self: ☐ Spouse: ☐ Child: ☐ Other: ☐

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

WORK INJURY:	**CAR ACCIDENT:**
Date of Accident:______________________	Date of Accident:______________________
Employer at the Time of Injury:__________	Employer at the time:___________________
Insurance company:____________________	Auto Insurance Company:________________
L&I / claim #: _________________________	Claim #:______________________________
L&I Claim Manager:____________________	Auto Insurance Claim Agent: ____________
Claim Manager Phone #:________________	Agent's Phone #:________________________

I AUTHORIZE my insurance company to pay directly to Dr. 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

Name: ____________________

DETAILED PATIENT QUESTIONNAIRE

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:

____

____

____

____

____

____

____

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____

____

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: (ex. MGM = maternal grand mother)**

Breast or Uterine Cancer: ______________________

Ovarian Cancer: ______________________

Colon Cancer: ______________________

Other Cancer: ______________________

Diabetes: ______________________

Arthritis: ______________________

Thyroid Disease: ______________________

Heart Disease: ______________________

High Blood Pressure: ______________________

Mental Illness: ______________________

Reaction to Anesthesia: ______________________

Stroke: ______________________

Tuberculosis: ______________________

Alzheimer's or Dementia: ______________________

WOMEN: please indicate:

Date of first menses _______________

Date of last menses _______________

days (average) you bleed _______________

day of total cycle (ex. 28) _______________

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 HAVE OR HAVE EXPERIENCED 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: ____________________

ENDOCRINE:

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: ____________________

CARDIOVASCULAR:

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 – 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 ____
Diabetes ____
Autoimmune disease ____

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 ____
Chest pain ____
Palpitations ____

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 ___