Thank you so much for taking the time to fill out this paperwork. We understand it is lengthy but it is our mission to understand your individual history, needs and goals in order to get you feeling your best!

# PATIENT REGISTRATION

Today's Date _____ First Name _____ Last Name _____

Date of Birth _____ Marital Status _____ Age _____ SS# _____

Street Address _____

City_____ State_____ Zip_____

Phone (Home) _____ Work _____

Mobile _____ Email _____

Occupation _____ Employer _____

Spouse First Name _____ Spouse Last Name _____ Date of Birth _____

Employer _____ SS# _____

Legal Guardian Name (if applicable) _____

Relationship to Patient _____ Phone _____

# PERSONAL HEALTH HISTORY AND SELF REFLECTION INVENTORY

Primary Care Provider _____ Phone _____

Please list all physicians that you see. (Please include mental health professionals)

| Name | Specialty, or condition that is being treated |
|---|---|
| | |
| | |
| | |
| | |
| | |

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).

| Approximate Date(s) of Treatment | Name of Therapist or Treatment Facility | Type of Treatment (e.g. Reiki, Qi Gong, Sand Tray) | Reason for Treatment | Beneficial Experience? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## WHAT HEALTH ISSUES DO YOU WANT TO FOCUS ON DURING THIS VISIT?

## PAST MEDICAL HISTORY

List any major past illnesses, hospitalizations (include year or date if known).

| | Date | | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## PAST SURGICAL HISTORY

List any past surgeries (and what year/date).

| | Date | | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## FAMILY HISTORY

Have your close relatives had any of the following? Write the relative (parent, brother or sister, child, grandparent, uncle, and/or aunt) and age of diagnosis (if known).

Heart attack, angina _____

High blood pressure _____

Diabetes _____

Cancer (list type) _____

Rheumatoid Arthritis _____

Mental health disorder _____

Stroke _____

High cholesterol _____

Thyroid disease _____

Crohn's or Ulcerative Colitis _____

Asthma _____

Other Autoimmune Disease _____

## PHARMACEUTICALS AND SUPPLEMENTS

Do you have Medication allergies? ❑ Yes ❑ No If yes, please list:

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## PLEASE LIST ALL PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS YOU TAKE REGULARLY

Please include all supplements, vitamins or herbal products.

| Medicine/ Supplement | Frequency | Dose |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

## PLEASE OUTLINE YOUR USE OF THE FOLLOWING, PAST OR PRESENT

| Product: | Current Use? Yes/No | Quantity Per Day | Quantity Per Week | Past Use? Yes/No | Do others have concern about your usage? |
|---|---|---|---|---|---|
| Tobacco | | | | | |
| Alcohol | | | | | |
| Recreational Drugs | | | | | |
| Caffeine | | | | | |

## REVIEW OF SYMPTOMS

Please check no or yes for the following **current** symptoms (**within past 3 months**)

| **GENERAL** | **YES** | **NO** | **GASTROINTESTINAL** | **YES** | **NO** |
|---|---|---|---|---|---|
| Fever | | | Diarrhea | | |
| Sweats at night | | | Constipation | | |
| Hot flashes | | | Indigestion/heartburn | | |
| Temperature intolerance | | | Nausea/Vomiting | | |
| Fatigue | | | Blood in stool | | |
| Sleep difficulties | | | Bloating | | |
| Daytime sleepiness | | | Pain | | |
| Unplanned weight change | | | **GENITOURINARY** | **YES** | **NO** |
| **SKIN** | **YES** | **NO** | Pain or burning on urination | | |
| Rash | | | Frequent urination | | |
| **EYES** | **YES** | **NO** | Waking to urinate more than once at night | | |
| Pain | | | Urinary incontinence | | |
| Redness | | | Decreased sexual desire | | |
| Vision Changes | | | Pain with intercourse | | |
| Dryness | | | Sexually Transmitted Diseases | | |
| Dark circles under eyes | | | Fertility Issues | | |
| **EAR, NOSE, THROAT** | **YES** | **NO** | **MEN:** | **YES** | **NO** |
| Hearing loss | | | Erectile dysfunction | | |
| Ringing in ears | | | **WOMEN:** | **YES** | **NO** |

| | | | | | |
|---|---|---|---|---|---|
| Dizziness or vertigo | | | Heavy menstrual bleeding | | |
| Bleeding gums | | | Painful menstrual periods | | |
| Nosebleeds | | | Irregular menstrual bleeding | | |
| **BREAST** | **YES** | **NO** | **MUSCULOSKELETAL** | **YES** | **NO** |
| Breast Pain | | | Generalized or all-over pain | | |
| Masses and or Lumps | | | Joint pain | | |
| Nipple discharge | | | Stiffness | | |
| Skin changes | | | Joint swelling | | |
| **CARDIOVASCULAR** | **YES** | **NO** | Joint redness | | |
| Chest pain | | | Back or neck pain | | |
| Heart murmur | | | **NEUROLOGICAL** | **YES** | **NO** |
| Irregular heartbeat (palpitations) | | | Abnormal gait (Trouble Walking) or falls | | |
| Leg swelling or edema | | | Headache severe and/or frequent | | |
| **PULMONARY** | **YES** | **NO** | Seizures | | |
| Wheezing or shortness of breath | | | Muscle weakness, TIA or stroke | | |
| Chronic cough | | | Fainting or loss of consciousness | | |
| **HEMATOPOIETIC** | **YES** | **NO** | Localized numbness, tingling, neuropathy | | |
| Swollen lymph glands | | | **PSYCHOLOGICAL** | **YES** | **NO** |
| Blood clots | | | Anxiety | | |
| Excessive bleeding | | | Depression | | |
| Anemia | | | Memory loss | | |
| | | | Mood swings | | |

## REVIEW OF SYSTEMS

Were you born vaginally or via C-section? ❑ Vaginally ❑ C-section

Were you breastfed? ❑ Yes ❑ No If yes, for how long? _____

Frequent use of antibiotics as a child? ❑ Yes ❑ No

If yes, how frequently and for how long? _____

## CHILDHOOD HISTORY

Did you have frequent ear/nose/throat infections as a child? ❑ Yes ❑ No

History of Tonsillectomy? ❑ Yes ❑ No

History of Ear Tubes? ❑ Yes ❑ No

## TRAUMA HISTORY

Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ❑ Yes ❑ No

If yes, is this an active issue in your life that you would like to address while you are here? ❑ Yes ❑ No

## EXERCISE

What forms of exercise and movement do you enjoy? _____

On a scale of 1-10 (10 being high), how satisfied are you in the area of exercise? _____

Please describe your usual physical activity:

| Activity | How often | How long each time |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## SLEEP

How many hours of sleep do you usually get each night? _____

Describe any issues you have with sleep. _____

## FOOD

Please list any food allergies or sensitivities:

| Foods | Reaction | Foods | Reaction |
|---|---|---|---|
| | | | |
| | | | |

Please list everything you ate in the last 24 hours.

| |
|---|
| Morning: |
| Afternoon: |
| Evening: |
| Snacks: |

Do you currently or have you ever had a problem with weight or eating? ❑ Yes ❑ No

If yes, please describe: _____

Are you comfortable with your relationship with food? ❑ Yes ❑ No

Do you feel knowledgeable about your nutritional needs? ❑ Yes ❑ No

What percentage of your food is home-cooked? _____

Do you crave sugar, coffee, cigarettes or have any other addictions? ❑ Yes ❑ No

If yes, which do you crave and how often? _____

## EMPLOYMENT

Are you currently ❑ employed? ❑ retired? ❑ working at home? ❑ care-taking? ❑ disabled?

❑ unemployed?

Indicate your past occupation if applicable: _____

On a scale of 1-10 (10 being high), how satisfied are you in the area of employment? _____

Why? _____

Do you anticipate any work changes in the near future (Retirement, etc.)? _____

_____

## EDUCATION

How many years of education do you have?

❑ No high school diploma

❑ High School or equivalent diploma

❑ Education beyond high school, but have not completed college bachelor's degree

❑ College degree

❑ Graduate or professional degree

## RELATIONSHIPS

Relationship status: _____ If married or partnered, what is your relationship length? _____

What are your living arrangements? _____ Number of children and ages: _____

Are you sexually active? ❑ Yes ❑ No Are you happy with your sexual life? ❑ Yes ❑ No

Which relationship(s) fulfill and/or empower you? _____.

Who or what drains your energy? _____

On a scale of 1-10 (10 being high), how satisfied are you in the area of relationships? _____

On a scale of 1-10 (10 being high), how hard do you feel it is to express your emotions? _____

## SPIRITUALITY

What things or activities bring you your greatest joy and meaning? What inspires you?

_____

_____

What things create the greatest challenges for you?

_____

_____

What makes you feel connected to the larger world? Describe your spiritual or religious practices if any (i.e., meditation, prayer, time in nature, worship attendance, etc.). _____

_____

On a scale of 1-10 (10 being high), how satisfied are you in the area of spirituality? _____

## RELAXATION

Rate the amount of stress in your life: ❑ None ❑ A Little Bit ❑ Moderate ❑ Quite a Lot ❑ Extreme

How well do you manage stress? ❑ Not at All ❑ A Little Bit ❑ Moderate ❑ Quite well ❑ Excellent

What are the main sources of stress in life? (Personal, professional, financial etc.) _____

_____

What are your methods of coping with the stress in your life? _____

_____

On a scale of 1-10 (10 being high), how satisfied are you in the area of relaxation? _____

## WHAT ARE YOUR HEALTH GOALS?

What are your overall goals for improving your health and your life? _____

_____

_____

## PHYSICAL ENVIRONMENT

Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)?

_____

Have you had hazardous environmental or occupational exposures? If yes, please describe.

_____

## HOW DID YOU LEARN ABOUT US?

- ❑ Website/Internet search
- ❑ Print/Media
- ❑ Direct mail
- ❑ Physician (please specify): _____
- ❑ At an event (please specify): _____
- ❑ Other (please specify): _____
- ❑ Health care provider (non-MD)
- ❑ another patient
- ❑ an individual (non-patient)

I understand that I am financially responsible for all services rendered by Mandala Integrative Medicine. All payments must be made at the time of service.

Patient signature _____ Date _____