



Please complete this Patient Registration and History Form, as well as any other requested documents.

**Patient Background**

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ M/F  
First Middle Last  
 Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: \_(\_\_\_\_)\_\_\_\_\_ Work Phone: \_(\_\_\_\_)\_\_\_\_\_ Cell Phone: \_(\_\_\_\_)\_\_\_\_\_  
 Email: \_\_\_\_\_ Best Way To Contact You? \_\_\_\_\_  
 Who can we thank for referring you or how did you hear about us? \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How Long: \_\_\_\_\_  
 Work Status (circle one) Full-Time Part-Time Retired Unemployed Self-Employed Other: \_\_\_\_\_  
 Marital Status (circle one) Single Married Divorced Widowed Other: \_\_\_\_\_ # of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

**Why Are You Seeking Treatment, current condition, or focus of care?**

Please briefly describe: \_\_\_\_\_  
 Date Primary Reason or Symptoms Began: \_\_\_\_\_ Is this a result of an accident or injury? \_\_\_\_\_

**Please indicate your exposure to the following therapies:**

Chiropractic Care:	Y	N	Massage Therapy:	Y	N
Acupuncture:	Y	N	Applied Kinesiology	Y	N
Nutrition/Supplementation:	Y	N	Osteopath Manip.	Y	N
Medicinal Herbs:	Y	N	Other:	_____	
Homeopathy:	Y	N	If yes, date of most recent visit:	_____	

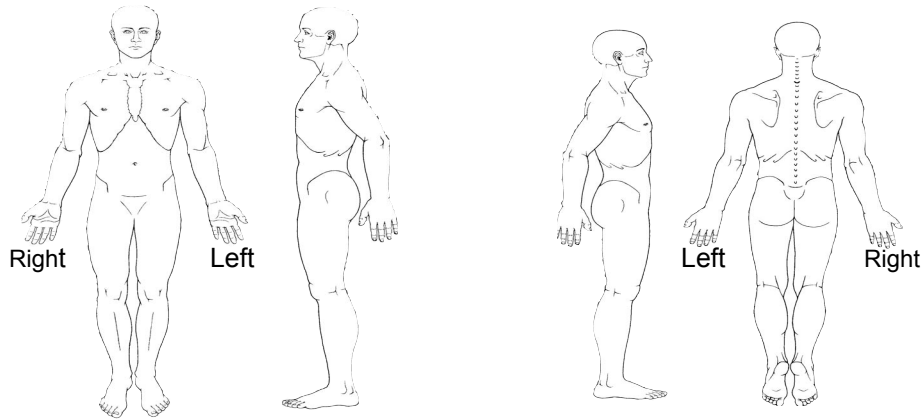
**What are your health goals?**

\_\_\_\_ Remove/Reduce Pain  
 \_\_\_\_ Gain more energy and stamina  
 \_\_\_\_ Fix the cause of the problem  
 \_\_\_\_ Restore health and reduce illness  
 \_\_\_\_ Achieve optimal wholeness

What do you believe is going on or would help? \_\_\_\_\_

**Indicate any of the following areas if applicable on the chart below with following letter/symbol**

- Surgical Scars (S)
- Numbness (N)
- Dull Ache (D)
- Sharp/Stabbing (+)
- Knot (K)
- Burning (B)
- Pins/Needles (P)
- Pain (PN)
- Other: \_\_\_\_\_ (O)



Severity Today:  
1 2 3 4 5 6 7 8 9 10  
 At Best:  
1 2 3 4 5 6 7 8 9 10  
 At Worst:  
1 2 3 4 5 6 7 8 9 10

**Patient Background Continued**

Are you currently under any other care? Y/N If so, please explain/describe: \_\_\_\_\_

Since onset of primary reason for being here, it has gotten: Worse Same Better  
 Does it change (get better or worse) in: Morning Midday Afternoon Night No Pattern

Does anything help or improve your status? Describe: \_\_\_\_\_  
 Do you have any Emotional Stressors that you believe may be related to or affecting your status? Describe: \_\_\_\_\_

Have you been diagnosed with/by a diagnosing professional? Y/N If so please list: \_\_\_\_\_

**Family Diseases (List which family member)**

- |                             |                     |                         |                            |
|-----------------------------|---------------------|-------------------------|----------------------------|
| _____ Alcoholism/Drug Abuse | _____ Eczema        | _____ Miscarriage       | _____ Tumors               |
| _____ Anemia                | _____ Emphysema     | _____ Mumps             | _____ Ulcers               |
| _____ Cancer: _____         | _____ Epilepsy      | _____ Pleurisy          | _____ Vaccination Reaction |
| _____ Cold Sores            | _____ Goiter        | _____ Pneumonia         |                            |
| _____ Deep Vein Thrombosis  | _____ Gout          | _____ Polio             | _____ Other: _____         |
| _____ Detached Retina       | _____ Heart Disease | _____ Rheumatic Fever   | _____                      |
| _____ Diabetes              | _____ Hepatitis     | _____ Seizures/Fainting | _____                      |
| _____ Diverticulitis/IBS    | _____ HIV/AIDS      | _____ Stroke            |                            |

Medications, OTC, Supplements	Reason For Taking	How Long or Date Started

**Patient Review of Systems**

Below answer the questions or circle the number that applies to you. **Leave blank** if it does not apply to you.

- 1 -Mild (occurs once or twice a month)**  
**2 -Moderate (occurs several times a month)**  
**3 -Severe (you are aware of it almost constantly)**

Do you get tired at a particular time? _____	Do you exercise and how often? _____
What kind of food do you prefer? Sweet/Salty/Sour Spicy/Bitter/Tangy	What type of activity do you do? _____
How much water do you consume? _____	Has there been any significant change that has occurred in the last 3 years (marriage, divorce, birth, death, move, job change, etc)? _____
How many hours of sleep do you regularly get? _____	_____
What time do you usually go to bed? _____	_____
What time do you wake up? _____	_____

- |  |   |
|--|---|
| 1 2 3 Acid foods upset (1)                     | 1 2 3 Joint Stiffness after arising (21)            |
| 1 2 3 Get chilled, often (2)                   | 1 2 3 Muscle-leg-toe cramps at night (22)           |
| 1 2 3 "Lump" in throat (3)                     | 1 2 3 "Butterfly" stomach, cramps (23)              |
| 1 2 3 Dry mouth-eyes-nose (4)                  | 1 2 3 Eyes or nose watery (24)                      |
| 1 2 3 Pulse speeds after meal (5)              | 1 2 3 Eyes blink often (25)                         |
| 1 2 3 Keyed up-fail to calm (6)                | 1 2 3 Eyelids swollen, puffy (26)                   |
| 1 2 3 Gag easily (8)                           | 1 2 3 Indigestion soon after meals (27)             |
| 1 2 3 Unable to relax; startles easily (9)     | 1 2 3 Always seems hungry; "lightheaded" often (28) |
| 1 2 3 Extremities cold, clammy (10)            | 1 2 3 Digestion rapid (29)                          |
| 1 2 3 Strong light irritates                   | 1 2 3 Vomiting frequently (30)                      |
| 1 2 3 Urine amount reduced (12)                | 1 2 3 Hoarseness frequently (31)                    |
| 1 2 3 Heart pounds after retiring/resting (13) | 1 2 3 Breathing irregularities (32)                 |
| 1 2 3 "Nervous" stomach (14)                   | 1 2 3 Pulse slow; feels "irregular" (33)            |
| 1 2 3 Appetite reduced (15)                    | 1 2 3 Gagging reflex slow or none (34)              |
| 1 2 3 Cold sweats often (16)                   | 1 2 3 Difficulty swallowing (35)                    |
| 1 2 3 Fever easily raised (17)                 | 1 2 3 Constipation, diarrhea alternating (36)       |
| 1 2 3 Nerve or shooting like pain (18)         | 1 2 3 "Slow starter" getting up, focused, etc (37)  |
| 1 2 3 Staring, blinks little (19)              | 1 2 3 Difficulty cooling down (38)                  |
| 1 2 3 Sour stomach frequent (20)               | 1 2 3 Circulation poor, sensitive to cold (39)      |
| Y N Do you fall asleep when you read           | 1 2 3 Perspire easily (40)                          |
| _____ How many hours can you read              | 1 2 3 Subject to colds, asthma, bronchitis (41)     |

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|--|---|
| 1 2 3 Dark circles/bags under the eyes | 1 2 3 Hair on head thinning all over      |
| 1 2 3 Smelly feet                      | 1 2 3 Slobber, drool or spit when talking |
| 1 2 3 Cracks on the heels of feet      |   |

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|---|--|
| 1 2 3 Eat when nervous (42)                                       | 1 2 3 Crave candy or coffee in afternoon (53)        |
| 1 2 3 Excessive appetite (43)                                     | 1 2 3 Moods of depression-"blues" or melancholy (54) |
| 1 2 3 Hungry between meals (44)                                   | 1 2 3 Preference for sweets and sugary foods (55)    |
| 1 2 3 Irritable before meals (45)                                 | 1 2 3 Headache if you don't eat regularly            |
| 1 2 3 Get "shaky" if hungry (46)                                  | 1 2 3 Skin tags develop                              |
| 1 2 3 Fatigue, eating relieves (47)                               | 1 2 3 Frequent urination                             |
| 1 2 3 "Lightheaded" if meals delayed (48)                         | 1 2 3 Excessive thirst                               |
| 1 2 3 Heart thumps if meals missed/delayed (49)                   | 1 2 3 Burning urination, acetone breath              |
| 1 2 3 Afternoon headaches (50)                                    | 1 2 3 Thickened, discolored toenails                 |
| 1 2 3 Overeating sweets upsets system/body (51)                   | 1 2 3 Bladder/vagina infections/fungus problems      |
| 1 2 3 Awaken after few hours sleep-hard to get back to sleep (52) | 1 2 3 Thick saliva, mucousy                          |
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|---|--|
| 1 2 3 Hands/feet go to sleep easily/numb (56)                       | 1 2 3 Muscle cramps, worse during exercise; get "charley horses" (65)            |
| 1 2 3 Sigh frequently, "air hunger" (57)                            | 1 2 3 Shortness of breath on exertion (66)                                       |
| 1 2 3 Aware of "breathing heavily" (58)                             | 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion (67)      |
| 1 2 3 High altitude discomfort or sickness (59)                     | 1 2 3 Bruise easily, "black and blue" spots (68)                                 |
| 1 2 3 Opens windows in closed room, feels tight or constricted (60) | 1 2 3 Tendency to anemia (69)  |
| 1 2 3 Susceptible to colds and fevers (61)                          | 1 2 3 "Nose bleeds" frequently (70)  |
| 1 2 3 Afternoon "yawner" (62)                                       | 1 2 3 Noises in head, or "ringing in ears" (71)                                  |
| 1 2 3 Get "drowsy" often (63)                                       | 1 2 3 Tension under breastbone, or feeling of "tightness" worse on exertion (72) |
| 1 2 3 Swollen ankles worse at night (64)                            |  |
| 1 2 3 Hands/feet turn blue/purple, red or white                     |  |
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|--|---|
| 1 2 3 Dizziness (73)                                   | 1 2 3 Pain between shoulder blades (87)                 |
| 1 2 3 Dry skin (74)                                    | 1 2 3 Use laxatives (88)                                |
| 1 2 3 Burning feet (75)                                | 1 2 3 Stools alternate from soft to watery (89)         |
| 1 2 3 Blurred vision (76)                              | 1 2 3 History of gallbladder attacks or gallstones (90) |
| 1 2 3 Itching skin and feet (77)                       | 1 2 3 Sneezing attacks (91)                             |
| 1 2 3 Excessive falling hair (78)                      | 1 2 3 Dreaming, nightmare type bad dreams (92)          |
| 1 2 3 Frequent skin rashes (79)                        | 1 2 3 Bad breath (halitosis) (93)                       |
| 1 2 3 Bitter, metallic taste in mouth in mornings (80) | 1 2 3 Milk products cause distress (94)                 |
| 1 2 3 Headache with bad taste in mouth                 | 1 2 3 Sensitive to hot weather (95)                     |
| 1 2 3 Bowel movements painful or difficult (81)        | 1 2 3 Burning or itching anus (96)                      |
| 1 2 3 Worrier, feels insecure (82)                     | 1 2 3 Crave sweets (97)                                 |
| 1 2 3 Feeling queasy; headache over eyes (83)          | 1 2 3 Varicose veins or hemorrhoids                     |
| 1 2 3 Greasy foods upset (84)                          | 1 2 3 Wakes up between 1 to 3 AM                        |
| 1 2 3 Stools light-colored (85)                        | 1 2 3 Pain behind or inside the knee                    |
| 1 2 3 Skin peels on foot soles (86)                    | Y N Do you wake up tired after a full nights rest       |
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|---|---|
| 1 2 3 Loss of taste for meat (98)                     | 1 2 3 Indigestion 1/2-1 hour after eating; may be up to 3-4 hours (103) |
| 1 2 3 Lower bowel gas several hours after eating (99) | 1 2 3 Mucous colitis or "irritable bowel" (104)                         |
| 1 2 3 Burning stomach sensation, eating relieves(100) | 1 2 3 Gas shortly after eating (105)                                    |
| 1 2 3 Coated tongue (101)                             | 1 2 3 Stomach "bloating" after eating (106)                             |
| 1 2 3 Pass large amounts of foul-smelling gas (102)   |   |
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|---|--|
| 1 2 3 Dizziness (150)                                 | 1 2 3 Over-sexually aroused                  |
| 1 2 3 Headaches (151)                                 | 1 2 3 Exercise or stress makes tired/fatigue |
| 1 2 3 Hot flashes (152)                               |  |
| 1 2 3 Increased blood pressure (153)                  | 1 2 3 Weakness, dizziness (157)              |
| 1 2 3 Female: Hair growth on face or body (154)       | 1 2 3 Chronic fatigue (158)                  |
| 1 2 3 Sugar in urine (not diabetes) (155)             | 1 2 3 Low Blood Pressure (159)               |
| 1 2 3 Female: Masculine tendencies (156)              | 1 2 3 Nails weak, ridges appear (160)        |
| 1 2 3 Male: feminine tendencies                       | 1 2 3 Tendency to hives (161)                |
| 1 2 3 Insensitivity to light (always have sunglasses) | 1 2 3 Arthritic tendencies (162)             |

- 1 2 3 Increase in weight (122)
- 1 2 3 Fatigues easily (124)
- 1 2 3 Ringing in the ears (125)
- 1 2 3 Sleepy during the day (126)
- 1 2 3 Have cold hands and/or feet
- 1 2 3 Sensitivity to cold (127)
- 1 2 3 Wants or prefers warm weather
- 1 2 3 Impaired hearing (135)
- 1 2 3 Poor circulation
- 1 2 3 Dry, chapped, flaky or scaly skin (128)
- 1 2 3 Cracks that bleed in hands or feet
- 1 2 3 Frequent use of lotions to soothe skin
- 1 2 3 Wounds or cuts heal slowly (7)
- 1 2 3 Bruise easily or visibly
- 1 2 3 Reduced initiative (136)
- 1 2 3 Nails are brittle or easily crack
- 1 2 3 Hair grows slowly
- 1 2 3 Infrequent need for haircuts or shaving
- 1 2 3 Hair coarse body/head or falls out (131)
- 1 2 3 Headaches upon arising, wear off or decrease during the day (132)
- 1 2 3 Mental sluggishness (130)
- 1 2 3 Change in hair loss amount
- 1 2 3 Increase cholesterol or fat in blood
- 1 2 3 Weight change, loss or gain
- 1 2 3 Frequency of urination (134)
- 1 2 3 Feels or looks puffy or swollen
- 1 2 3 Decreased energy levels
- 1 2 3 Decreased appetite (123)
- 1 2 3 Weight gain that is difficult to lose
- 1 2 3 Constipation (129)
- 1 2 3 Slow pulse rate, below 65 (133)
- 1 2 3 Irregular menstrual periods
- 1 2 3 Miscarriages
- 1 2 3 Insomnia (107)
- 1 2 3 Nervousness (108)
- 1 2 3 Can't gain weight (109)
- 1 2 3 Intolerance to heat (110)
- 1 2 3 Prefers cool or cold weather
- 1 2 3 Highly emotional (111)
- 1 2 3 Flush or turns red easily (112)
- 1 2 3 Night sweats (113)
- 1 2 3 Thin, moist/oily skin (114)
- 1 2 3 Inward trembling or shaky (115)
- 1 2 3 Increased appetite without weight gain (117)
- 1 2 3 Pulse fast at rest (118)
- 1 2 3 Eyelids and face twitch (119)
- 1 2 3 Irritable and restless (120)
- 1 2 3 Can't work under pressure (121)
- 1 2 3 Poor balance
- 1 2 3 Increase heart rate or aware of heart (116)
- 1 2 3 Shortness of breath

- 1 2 3 Failing memory (137)
- 1 2 3 Low blood pressure (138)
- 1 2 3 Increased sex drive (139)
- 1 2 3 Headaches "splitting or rending" type (140)
- 1 2 3 Random Headaches without a pattern
- 1 2 3 Decreased sugar intolerance (141)
- 1 2 3 Abnormal thirst (142)
- 1 2 3 Bloating of abdomen (143)
- 1 2 3 Weight gain around hips or waist (144)
- 1 2 3 Sex drive reduced or lacking (145)
- 1 2 3 Tendency to ulcers, colitis (146)
- 1 2 3 Increased sugar tolerance (147)
- 1 2 3 Women: menstrual disorders (148)
- 1 2 3 Young girls: lack of menstrual function (149)
- 1 2 3 Symptoms worse at night or when its dark out

- 1 2 3 Apprehension (173)
- 1 2 3 Irritability (174)
- 1 2 3 Morbid fears (175)
- 1 2 3 Never seems to get well (176)
- 1 2 3 Forgetfulness (177)
- 1 2 3 Indigestion (178)
- 1 2 3 Poor appetite (179)
- 1 2 3 Cravings for sweets (180)
- 1 2 3 Muscular soreness (181)
- 1 2 3 Depression; feeling of dread (182)
- 1 2 3 Noise sensitivity (183)
- 1 2 3 Acoustic hallucinations (184)
- 1 2 3 Tendency to cry without reason (185)
- 1 2 3 Hair is coarse and/or thinning (186)
- 1 2 3 Weakness (187)
- 1 2 3 Fatigue (188)
- 1 2 3 Skin sensitive to touch (189)
- 1 2 3 Tendency towards hives (189)
- 1 2 3 Nervousness (191)
- 1 2 3 Headache (192)
- 1 2 3 Insomnia (193)
- 1 2 3 Anxiety (194)
- 1 2 3 Anorexia (195)
- 1 2 3 Inability to concentrate (196)
- 1 2 3 Frequent stuffy nose; sinus infections (197)
- 1 2 3 Allergy to some foods (198)
- 1 2 3 Loose joints (199)

**Females Only**

- 1 2 3 Very easily fatigued (200)
- 1 2 3 Premenstrual tension (201)
- 1 2 3 Painful menses (202)
- 1 2 3 Depressed feelings (203)
- 1 2 3 Menstruation excessive and prolonged (204)
- 1 2 3 Painful breasts (205)
- 1 2 3 Menstruate too frequently (206)
- 1 2 3 Vaginal discharge (207)
- 1 2 3 Hysterectomy/ovaries removed (208)
- 1 2 3 Menopausal hot flashes (209)
- 1 2 3 Menses scanty or missed (210)
- 1 2 3 Acne, worse at menses (211)
- 1 2 3 Depression of long standing (212)
- 1 2 3 Headache worse/starts with menses

**Males Only**

- 1 2 3 Prostate trouble (213)
- 1 2 3 Urination difficulty or dribbling (214)
- 1 2 3 Night urination frequent (215)
- 1 2 3 Depression (216)
- 1 2 3 Pain on inside of legs or heels (217)
- 1 2 3 Feeling of incomplete bowel evacuation (218)

- 1 2 3 Lack of energy (219)
- 1 2 3 Migrating aches and pains (220)
- 1 2 3 Tire too easily (221)
- 1 2 3 Avoids activity (222)
- 1 2 3 Leg nervousness at night (223)
- 1 2 3 Diminished sex drive (224)

**HIPAA & CONSENT**

We would like you to know how our office will be using your information and the rights that you have as a patient here regarding your records. Before we begin with your healthcare needs we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1. The patient understands and agrees to allow An Even Vida Clinic to use their patient information for the purpose of treatment, payment, and health care operations.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their patient information. Our office will not release any of your records without your written permission
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the consent has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known to An Even Vida Clinic to assure that your records are not readily available to those who do not need them.
6. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations the physician has the right to refuse care.

***I agree to the above HIPPA/Consent Initial*** \_\_\_\_\_

**PATIENT BILLING INFORMATION & CONSENT FOR PROFESSIONAL SERVICES**

I understand that all payments are due to An Even Vida Clinic at the time services are rendered. All bills are due and payable in full at date of service.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. *An initial visit usually consists of a consultation and exam (\$199) and usually lasts approximately an hour. If your situation calls for longer than an hour your fee will be adjusted accordingly, for further pricing contact the office.*

An Even Vida Clinic is NOT responsible for submitting claims to ANY insurance entity included but not limited to health, auto, worker's compensation or personal injury. If I intend to submit receipts acquired at An Even Vida Clinic to an insurance entity I must notify the front desk before payment.

***I agree to the above fee schedule Initial*** \_\_\_\_\_

**WE MISS YOU WHEN YOU MISS YOUR APPOINTMENT**

We kindly ask that any changes or cancellations are made 24 hours prior to your appointment. A notice of less than 24 hours impacts our opportunity to serve other patients. Simply give the office a ring when you need to modify, change, or cancel an appointment. Our office coordinator is a scheduling guru.

We understand "life happens," and you may miss an appointment without notice. However, if you miss multiple appointments, we reserve the right to charge a fee of up to 100% of the cost of the scheduled services. We also reserve the right to ask for pre-payment via credit card to book future appointments.

If copies of medical records are needed, a charge of \$10.00 for copy charge and an additional 10 cents per page over 15 pages will be billed to you.

*I have read and understand how my patient information will be used and how the payments are due, and I agree to these policies and procedures. Please sign before your appointment.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date