AVILA INTEGRATIVE MEDICINE

Patient Registration

Patient Information

Last Name:	First Name:	Previous Name:
Mailing Address: Apt. #		
City/State/Zip:		
Primary Phone:	Work Phone:	Email Address:
Family Physician:	Date of Birth :	Sex: Male Female
Marital Status:	Social Security #:	
Employer Name:	Emergency Contact:	
Emergency Contact #:	Relationship to patient:	How did you hear about us:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name
Policy Holding Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holders Social Security #:	Policy Holders Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Treatment Authorization

I hereby authorize this office, its staff, and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services preformed on my behalf. Should collections of past due amounts be necessary, I will become responsible for all charges, fees, and attorney fees.

Patient Signature: _____ Date: _____

Consent to Treat a Minor

I(we) being the parents, guardians or custodians of the minor being _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for services and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for the payment of them.

Parent, Guardian, or Custodian Signature: _____ Date: _____

Witness: _____ Date: _____

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Major Complaint

What is your major complaint (Exact Description) _____

_____

_____

_____

Is it related to a fall or accident? (describe) _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

The condition is (circle): Worse Same Better Consistent Recurring

How does this condition interfere with your work or daily routine? _____

When is your condition worse? (circle): Morning Afternoon Evening Night

What aggravates your condition? _____

What relieves your condition? _____

Names of other doctors seen for this condition _____

Name of Hospital (if applicable) _____

Previous diagnosis for this condition _____

Type of previous treatment and/or surgery for this condition _____

Duration of previous treatment for this condition _____

Result of previous treatment (circle): Good Fair Poor Other _____

Please indicate on the diagram the areas where you are experiencing symptoms using the suggested marks below to describe your symptoms:

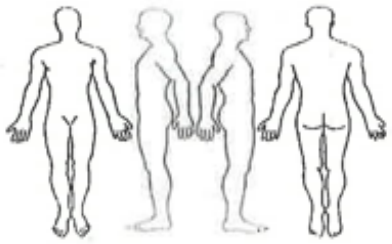
Pain ^^^^

Numbness = = =

Pins & Needles 0 0 0

Burning X X X

Stabbing ////



Using the scale, what is your pain TODAY (please circle):

0 1 2 3 4 5 6 7 8 9 10

No pain ----------Worst Pain Imaginable

Please list your symptoms in order of their severity, most significant or painful symptoms first:

	Symptom(s)	Date
1.	_____	___/___/___
2.	_____	___/___/___
3.	_____	___/___/___
4.	_____	___/___/___
5.	_____	___/___/___

□ Yes □ No Have you received treatment for these symptoms in the past? If yes, please answer the following, beginning with your most recent treatment:

1. Name and location of provider: _____

   Date(s) seen: _____ How many times? _____

   Treatment received: □ Physical therapy/exercise □ Massage □ Chiropractic □ Injections □ Surgery

   □ X-Rays, CT scans, MRI: Which body areas? _____

   □ Prescriptions or medications? (please list): _____

X_____ _____

(Patient Signature) (Date)

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Patient Name: _____ Date: _____

Symptoms

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision - halos

SKIN
- ☐ Bruises easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

Previous/Current Health Conditions
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-Immune Disease
- ☐ Bleeding Disorders
- ☐ Birth Defects
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cervical Whiplash
- ☐ Chemical Dependency
- ☐ Concussion
- ☐ Convulsions
- ☐ Cyst
- ☐ Diabetes
- ☐ Dislocation
- ☐ Ear Infections
- ☐ Electronic Implant
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractured Bone
- ☐ Glaucoma/Cataracts
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Joint replacement
- ☐ Knocked Unconscious
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Metal Screws/Implants
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis/Osteoarthritis
- ☐ Ruptured Spinal Disc
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Slipped Spinal Disc
- ☐ Spinal Surgery
- ☐ Spinal Injections
- ☐ Spinal Taps
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Other Diseases/Problems with the neck and/or back
- ☐ Other _____

Medications

_____
_____
_____

Allergies

_____
_____
_____