



Acct. Number: _____

Health History & Patient Registration

Please Write or Print clearly

Holistic Health is a state of well-being in which an individual's body, mind, emotions and spirit are in tune with the natural, cosmic and social environment.

Holistic Medicine is defined as a system of health care which emphasizes personal responsibility, and fosters a cooperative relationship among all those involved, leading toward optimal attunement of body, mind, emotions and spirit.

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The following questionnaire, although somewhat long and detailed, is an invaluable source of information about you as a unique person. It will allow your practitioner to know the Total you, not just you as a collection of symptoms of an illness.

If for any reason you object to filling out any or all of it, you may leave that part blank and provide your practitioner with that information about yourself that you feel comfortable sharing.

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released except when you have authorized Village Health to do so.

SCENT FREE POLICY: As a courtesy to our more sensitive patients, our office is a scent-free zone. Please refrain from wearing perfumes or fragrances to your visits at the Village.

.....
Would you be willing to sign a release to obtain medical records from your previous doctor(s) and hospital(s) if this information would be helpful in your treatment? No Yes If Yes, then sign below.

AUTHORIZATION FOR MEDICAL INFORMATION

My signature below authorizes you to release any and all information in regard to any manner of treatment rendered to me, including blood tests, X-rays, findings and diagnoses. A copy of this authorization is as valid as an original.

Signature

Date

.....
Name: _____ Birth date: _____ / _____ / _____ Age: _____

Mailing Address: _____ City: _____ Zip: _____

Telephone—Home: _____ Work: _____ Cell: _____
Okay to Leave Discreet Message: No Yes

E-mail Address: _____ How often do you check e-mail? _____

Local Emergency Contact— Name: _____ Telephone: _____

How did you hear about Village Health? _____

What are your primary concerns regarding your health? _____

Medical History

Blood Type: _____

Allergies: Are you allergic to...

Any medication or Drug? **NO** **YES** If yes, which ones? _____

Any food? **NO** **YES** If yes, which ones? _____

Anything carried in the air? **NO** **YES** If yes, what? _____

Physicians & Healers:

Please list all healers, helpers or therapies with which you are currently or were previously involved?

Name: _____ Specialty _____ Location _____

Date of last physical exam: _____ Date of last lab work: _____

Have you ever had any abnormal lab work findings? Yes No If so, what? _____

Medications: Prescription or Over the Counter; Topical or Oral

Please list all medicine/drugs you are taking

Name _____ Dose _____ How Often _____ How long have you been taking it? _____

Supplements: Vitamins, minerals, herbs or similar health products

Please list any supplements you are currently taking:

Name _____ Dose _____ How Often _____ How long have you been taking it? _____

Please mark (x) for all conditions that apply now. Put a (p) for past conditions .

Measles		Drainage from Ears		Diarrhea	
Polio or Meningitis		Ear pain		Constipation	
Mumps		Ear Infections		Abdominal Pain	
Chicken Pox		Runny Nose		Blood from Bowels	
Whooping Cough		Nasal Congestion		Gas, Belching	
Scarlet Fever or Scarlentina		Sneezing		Hemorrhoids/Anal Itching	
Diphtheria		Nasal Bleeding		Rectal Pain	
Smallpox		Sinus Infection		Jaundice	
Gonorrhea or Syphilis		Bleeding Gums		Enlarged Liver or Spleen	
Rheumatic Fever		Silver Dental Fillings		Gallstones	
Hepatitis		Difficulty Swallowing		Urinary	
Rheumatoid Arthritis		Swollen Glands		Pain with Urination	
Osteoarthritis		Pharyngitis / Tonsillitis		Difficulty Urinating	
Colitis or other bowel disease		Sore throat		Urgency to Urinate	
Diabetes		Thyroid Disorder		Blood in Urine	
Cardiovascular Disease		Goiter		Side Pain (flank)	
Cancer		Hair, Skin & Nails		Frequent Urination	
High or Low Blood Pressure		Hives or Eczema		Urinary Tract Infection	
Bleeding Disorder		Frequent Infections or Boils		Kidney Infection	
Anemia		Rashes		Musculoskeletal	
Chemical or Drug Poisoning		Itching		Any bone or joint disease	
Epilepsy/Seizures		Change in Hair/Skin/Nails		Neuritis or Neuralgia	
Neurological Disorder		Poor Healing Time		Bursitis, Sciatic or Lumbago	
General Symptoms		Respiratory		Numbness	
Heat or Cold Intolerance		Pneumonia		Neck Pain	
Excessive Thirst		Bronchitis		Back Pain	
Fuzzy Thinking/Memory Loss		Pleurisy		Arm Pain	
Fever/chills		Difficulty Breathing w/Exercise		Leg Pain	
Fatigue		Shortness of Breath w/Resting		Joint Pain or Swelling	
Weakness		Hay Fever or Asthma		Muscle Cramping	
Night Sweats		Cough/Phlegm		Bone Pain/Infection	
HEENT (Head, Eyes, Ears, Nose & Throat)		Coughing Up Blood		Broken or Cracked Bones	
Headaches/Migraine		Tuberculosis		Sprains	
Concussion or Head Injury		Cardiac		Dislocations	
Loss of Consciousness		Heart Attack		Mental Health	
Change in Vision		Chest Pain		Nervous Breakdown	
Drainage from eyes		Heart Palpitations		Mental Illness	
Itchy Eyes		Heart Murmur		Depression	
Eye pain		Stroke		Hallucinations	
Eye Infections		Gastrointestinal		Passing Out	
Change in Hearing		Parasites		Seizures	
Ringling in Ears		Nausea		Anxiety	
Dizziness/Vertigo		Vomiting		Suicidal Thoughts	

If you are currently in pain, please rate the intensity by circling a number on the scale below:

Pain Scale: minor-1 2 3 4 5 6 7 8 9 10-severe

Do you have any pain in your: Neck Midback Lower Back

(if yes, complete the rest of this section.)

When did it start? _____

What do you think is the cause? _____

Describe the pain: Sharp/Stabbing Burning Throbbing Shooting

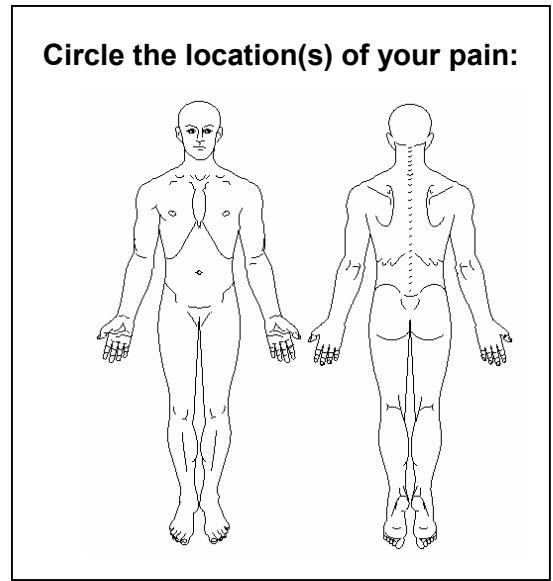
Tingling Dull Numb Sore Aches Weak

Other _____

How often does the pain occur? _____

Indicate the intensity of the pain at its **LOWEST & HIGHEST** level:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 **(Worst Pain Ever)**



What makes your problem better? Nothing Lying Down Standing Walking Sitting Movement

Exercise Inactivity/Rest Other _____

What makes your problem worse? Nothing Lying Down Standing Walking Sitting Movement

Exercise Inactivity/Rest Other _____

Can you perform your daily home activities: Yes Only with help Not at all

Describe your job requirements: Mainly Sitting Light Labor Heavy Labor

Can you perform your daily work activities: Yes, all activities Only some Not at

Have you been treated for this recently? If so, what type of treatment? _____

Have you ever been treated for the same/similar problem? When? _____

What self-treatment have you tried? _____

Have you had any operations? If so, when and for what reason? _____

Have you ever been in a motor vehicle accident? Y N If yes, when? _____ Were you hurt? Y N

Please briefly describe the accident: _____

Please describe any other serious injuries you have had. Please provide a year and a description of what body part was hurt, and what care, if any, you received: _____

Female	
Breast Tenderness	
Discharge from Nipple	
Hot Flashes/Night Sweats	
Vaginal Dryness	
Mood Changes w/Cycle	
Changes in Menstruation	
Painful Intercourse	

Last Menstrual Period _____ Age at onset _____
 Duration _____ Frequency _____
 Currently Pregnant: How Many Weeks? _____
 # of Pregnancies _____ # of Childbirths _____
 Birth Control: Type _____

Male	
Testicle pain	
Discharge from penis	
Prostate Infection	
Prostate Enlargement	
Split Stream	
Hydrocele	
Varicocele	

Year of your last **TETANUS** shot: _____
 Indicate any **SURGERIES** or **HOSPITALIZATIONS** you have had: **NONE**
 Appendix Tonsils Hernia Gallbladder
 Uterus Tubes Tied Heart Oral
 List Other _____

Do you **SMOKE**? Yes No Previously
 Packs per day _____ For _____ Years
 Do you drink **ALCOHOL**? Yes No Previously
 Drinks per week _____ What type? _____
 Do you drink **COFFEE**? Yes No Previously
 Cups per day _____ For _____ Years
 Caffeinated Decaffeinated
 Do **YOU** have any concerns about your **ALCOHOL/DRUG** use?
 Yes No
 Has **ANYONE ELSE** ever expressed concerns about your
ALCOHOL/DRUG use? Yes No
 How much **WATER** do you drink a day? _____
 Current Height: _____
 Current Weight: _____ Weight 1 year ago _____
 Max Weight: _____ When: _____
Do you consider yourself:
 Underweight Overweight Just Right Ideal Weight _____
 Unintentional weight loss or gain of 10 pounds or more in the last
 three months: No Yes
Check the following statements that apply:
 Occasionally or frequently skip meals
 Crave sweets or carbohydrates
 Crave stimulants, such as caffeine or soft drinks?
Sleep Habits
 Sleep well, wake up rested Difficulty falling asleep
 Wake up frequently How often a night? _____
 Wake up to urinate How often a night? _____
 What time do you generally wake up in the morning? _____
 What time do you generally go to bed? _____
 Do you **DREAM**? Yes No
 Themes? _____
 Re-occurring? _____

Family Medical History

How is the health of your mother? _____
 How is the health of your father? _____
 How is the health of your siblings? _____
 How is the health of people living with you (spouse, children, partner, roommates) _____

Has any blood relative ever had:	Who?
Cancer <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
Tuberculosis <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
Heart Trouble <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
High Blood Pressure <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
Stroke <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
Epilepsy <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
Mental Illness <input type="checkbox"/> NO <input type="checkbox"/> YES	_____
Suicide <input type="checkbox"/> NO <input type="checkbox"/> YES	_____

Personal Information

Current Relationship Status: _____ How long? _____

Children? _____ Where do they live? _____

Occupation: _____ How many hours per week? _____

Education: Years High School _____

Years College _____ Focus of study _____

Years Post Grad _____ Focus of study _____

Trade School _____ Focus of study _____

Currently a student? NO YES If yes, where? _____

Religious or spiritual affiliations: _____

Current stress management and self-care activities: _____

Please list any hobbies, recreational or leisure time activities you like to participate in: _____

Previous counseling experience—Please include Psychiatric Hospitalizations, Drug/Alcohol Programs & Self Help Groups: _____

Describe your Strengths: _____

.....
Briefly Describe Your Family of Origin: Reflect briefly on the strengths and challenges in your family of origin, the impact of family-of-origin experiences on your adult relationships, and strengths and growth areas in your current significant relationships (with spouse, children, siblings, parents, etc.). This should not be a "family history" but rather a summary of themes you have observed in your family experience, past and present.

Check you Current Level of Work or Lifestyle:

- Level 1-Very Light Work:** sitting, standing, driving, reading, computer, etc.
- Level 2-Light Work:** Light housework, labor, child-care, mechanic, some sitting, etc.
- Level 3-Moderate Work:** heavy gardening, housework, labor, no sitting, etc.
- Level 4-Heavy Work:** Heavy manual labor, construction, digging, etc.

Check your Current Level of Exercise:

- None**
- Level A-Light Exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- Level B-Moderate Exercise:** 2-3 times per week, vigorous pace, weights, fast running, etc.
- Level C-Heavy Exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

Check your Exercise Frequency and Schedule

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 min or more duration per workout
- 30-45 min or more duration per workout
- Less than 30 min
- Use of personal trainer
- Member of fitness club
- Own exercise equipment
- Walk: days per week _____
- Run, jog, bike, other aerobic: days per week _____
- Weight lift: days per week _____
- Stretch: days per week _____
- Yoga: days per week _____
- Other: _____ days per week _____

Stress Habits

Check Which Apply:

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

- Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents? No Yes
- Do you suffer from insomnia/sleep disorders? No Yes
- Do you often abruptly awake from sleep? No Yes
- Do you suffer from depression/mood swings? No Yes

Stress Reduction

I'd like to:

- Be happier
- Be less depressed
- Be less moody
- Be less indecisive
- Be more focused
- Think more clearly
- Improve my memory
- Learn how to reduce stress
- Learn how to meditate

Balanced Eating

Check Which Apply:

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt Restriction
- Fat Restriction
- Starch/carbohydrate restriction
- Diet Program: If so, Name of Diet _____
- Total calorie restriction

Specific food restrictions of:

- dairy wheat eggs
- Soy corn all gluten
- Other _____

Servings per day:

- Fruits (citrus, melon, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____
- Water _____

What Percentage of your food is home cooked? _____

Where do you get the rest from? _____

Eating Frequency

Check Which Apply:

- Skip breakfast or other meals
- Three meals a day
- Two meals a day
- One meal a day
- Graze-small frequent meals How many a day? _____
- Generally eat on the run

Energy-Vitality

I'd like to:

- Have more energy
- Have longer endurance
- Have more motivation
- Sleep better
- Be less tired after lunch
- Feel more vital
- Regain vitality and vigor of my younger years
- Get less colds and flu
- Get rid of allergies
- Not use so many over the counter drugs
- Stop using laxatives
- Be free of pain

Body Composition

I'd like to:

- Be stronger
- Be thinner
- Be more muscular
- Burn more body fat
- Be more flexible
- Lose weight

Longevity

I'd like to:

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier lifestyle
- Change from a "treating-illness" orientation to a creating wellness lifestyle

Insurance Information

Primary Insurance Information

Insurance Company Name: _____
Insurance Company Phone Number: _____
Patient Name: _____ Patient DOB: ____/____/____
Insured's Name: _____ Insured's DOB: ____/____/____
ID#: _____ Phone #: _____
Group #: _____ Effective Date: ____/____/____

Automobile Accident Information

Describe the accident: _____
Claim # _____ Date of injury: _____
Insurance Company _____ Co.'s Phone # _____
Insurance Company Address: _____
Is this your auto insurance, or a third party's insurance? _____
MINE Name of third party

Worker's Compensation Information

Your employer when injured: _____
Claim Number: _____ Date of injury: _____
Insurance Company _____ Co.'s Phone # _____
Insurance Company Address: _____

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE **Unless your practitioner is a preferred provider on your insurance plan**

Village Health accepts cash, personal check (in-state only), VISA, MasterCard, Discover and American Express. There is a \$25 service charge for returned checks.

INSURANCE: We bill your primary insurance company as a courtesy to you. You are expected to pay in full at the time of service. As a service to you, our customers, we will submit an insurance claim to your primary insurance company with the reimbursement to come directly to you. You are responsible for filing with your secondary insurance company after receiving notice from your primary about what is covered.

At the time of service you will receive a receipt that includes all the information necessary for submitting claims to your insurance company for yourself.

If you need assistance or have questions, please contact the front office between 9:00 a.m. and Noon or 2:00pm and 6:00pm, Monday through Friday at 684-3988. Appointments are available for detailed financial consultation when necessary.

EXCEPTION: If your practitioner is a preferred provider on your insurance plan, we will accept your co-pay and bill your primary insurance the balance.

Date

Signature