Patient Registration

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Email: _____

Current Primary Care

Physicians Name: _____

City: _____ State: _____

Please check off the medical condition(s) in which you are here for today:

- ☐ Cancer- What kind? _____ How long? _____
- ☐ PTSD (Post Traumatic Stress Disorder) How long? _____
- ☐ HIV/AIDS How long? _____
- ☐ Hepatitis C or Decompensated Cirrhosis How long? _____
- ☐ Glaucoma How long? _____
- ☐ Multiple Sclerosis How long? _____
- ☐ Cachexia (too thin) or wasting How much weight loss? _____ How long? _____
- ☐ Persistent Muscle Spasms How often? _____ How long? _____
- ☐ Intractable Nausea How often? _____ How long? _____
- ☐ Seizures How often? _____ How long? _____
- ☐ Severe Pain How often? _____ How long? _____
- ☐ Anorexia (Loss of Appetite) How often? _____ How long? _____

Location of pain: _____

Describe the pain: _____

Does the pain travel elsewhere? If so, where? _____

If you have pain, how bad does it get on a scale of 0-10 (10 being the worst) _____

- ☐ Other: (Please describe) _____

☐ How does your medical condition affect your quality of life?

_____

_____

Do you, or have you had any of the following? (Check all that apply)

☐ Diabetes
☐ Arthritis
☐ High blood pressure
☐ Abdominal problems
☐ Muscle cramps
☐ Headaches
☐ Seizures
☐ Syncope
☐ Heart Disease
☐ Lung Disease

Allergies to any medication? Name of medication(s) _____

Have you been losing weight? **YES NO** If yes, how much? _____ Over how long? _____

Is there any chance you are currently pregnant? YES NO

Currently breastfeeding? **YES NO**

SURGERIES (Applicable to reason for visit) _____

_____

MEDICATIONS

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you use illicit drugs? **YES NO**

Do you smoke tobacco? **YES NO** How much/how often? _____

Do you drink alcohol? **YES NO** How much/how often? _____