Rising Tide Natural Medicine

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Registration Form

Full Name_____ Date of Initial Visit_____

Social Security Number(SSN)_____ Birth Date_____ Age___

Home Mailing Address_____ Home Phone_____

City,State,Zip_____ E-mail_____

Occupation_____ Cell/Pager Phone_____

Employer_____ Business Phone_____

Business Address_____ Fax_____

Emergency Contact_____ Relation_____

Contact Address_____ Contact Phone_____

Contact Business Address_____ Contact Cell/Bus. Phone_____

Sex: ❑ Male ❑ Female Sexual Orientation: ❑ Celibate ❑ Heterosexual ❑ Homosexual ❑ Bisexual

Marital Status: ❑ Never married ❑ Currently married ❑ Separated ❑ Divorced ❑ Widowed

Living Situation: ❑ Alone ❑ Parents ❑ Spouse ❑ Significant Other ❑ Friend ❑ Boarding

Number Siblings____Number Children____Number Marriages___Number Cohabitants(Live with)_____

Referred by_____ Relation_____

Primary Care Provider (PCP)_____ May we correspond with the referrer? ❑ Yes ❑ No

PCP Address_____ PCP Phone Number_____

Do you have an Advance Directive for Health Care (Living Will)? ❑ Yes ❑ No

If you have any other medical records or test results, please bring them so we can review them or make copies.

Please List Your Primary Health Concerns in Order of Importance or Severity:

1)_____

2)_____

3)_____

4)_____

Please List Your Primary Stresses in Order of Importance or Severity:

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

I understand that I am required to make payment in full at the time of service and insurance reimbursement is my own responsibility. I authorize the release of medical information relative to treatment received to insurance companies responsible for reimbursement.

General Health Questionnaire

Please check if you have experienced the problem currently or recurrently (Yes), severely or frequently in the past (Past), or never (No).

❑ ❑ ❑ Severe/frequent headache
❑ ❑ ❑ Blackouts/fainting spells
❑ ❑ ❑ Dizzy spells/balance loss
❑ ❑ ❑ Double vision
❑ ❑ ❑ See halos/ lights/colors
❑ ❑ ❑ Blurry vision
❑ ❑ ❑ Reduced visual field
❑ ❑ ❑ Eye pain/dryness
❑ ❑ ❑ Itching/watery eyes
❑ ❑ ❑ Vision worsening
❑ ❑ ❑ Wear glasses/contacts
❑ ❑ ❑ Sensitivity to light/color

❑ ❑ ❑ Earaches
❑ ❑ ❑ Hearing problems
❑ ❑ ❑ Fluid from ears
❑ ❑ ❑ Noises in ears
❑ ❑ ❑ Sensitivity to noises

❑ ❑ ❑ Dental problems
❑ ❑ ❑ Sore/bleeding gums
❑ ❑ ❑ Sore tongue
❑ ❑ ❑ Frequent sore throats
❑ ❑ ❑ Swollen neck/glands
❑ ❑ ❑ Difficulty swallowing
❑ ❑ ❑ Hoarse voice

❑ ❑ ❑ Congested nose
❑ ❑ ❑ Running nose
❑ ❑ ❑ Sneezing spells
❑ ❑ ❑ Frequent head colds
❑ ❑ ❑ Frequent nose bleeds
❑ ❑ ❑ Sensitive to smells
❑ ❑ ❑ Poor sense of smell

❑ ❑ ❑ Wheezing or gasping
❑ ❑ ❑ Frequent chest colds
❑ ❑ ❑ Frequent coughing
❑ ❑ ❑ Cough up phlegm
❑ ❑ ❑ Cough up blood
❑ ❑ ❑ Rapid/skipped heartbeats
❑ ❑ ❑ Chest pains
❑ ❑ ❑ Shortness of breath
❑ ❑ ❑ Swollen feet or ankles
❑ ❑ ❑ Cold hands or feet
❑ ❑ ❑ Easy bruising/bleeding
❑ ❑ ❑ Recurring indigestion
❑ ❑ ❑ Frequent belching
❑ ❑ ❑ Nausea
❑ ❑ ❑ Motion sickness

❑ ❑ ❑ Vomiting
❑ ❑ ❑ Bloating/flatulence
❑ ❑ ❑ Pain in abdomen
❑ ❑ ❑ Diarrhea/loose stools
❑ ❑ ❑ Constipation
❑ ❑ ❑ Black stools
❑ ❑ ❑ Gray/white stools
❑ ❑ ❑ Blood in stools
❑ ❑ ❑ Pain in rectum
❑ ❑ ❑ Itching rectum
❑ ❑ ❑ Frequent urination
❑ ❑ ❑ Involuntary loss of urine
❑ ❑ ❑ Burning on urination
❑ ❑ ❑ Brown/black/blood urine
❑ ❑ ❑ Weak urine stream
❑ ❑ ❑ Difficulty starting urine
❑ ❑ ❑ Dribbling after urination
❑ ❑ ❑ Constant urge to urinate

❑ ❑ ❑ Aching muscles/joints
❑ ❑ ❑ Swollen joints
❑ ❑ ❑ Facial pain
❑ ❑ ❑ Scalp/neck pain
❑ ❑ ❑ Shoulder/arm pain/weak
❑ ❑ ❑ Hand/finger pain/weak
❑ ❑ ❑ Back pain/weakness
❑ ❑ ❑ Rib pain
❑ ❑ ❑ Hip/leg pain/weakness
❑ ❑ ❑ Foot/toe pain/weakness
❑ ❑ ❑ Paralysis

❑ ❑ ❑ Skin growths/Warts
❑ ❑ ❑ Skin rashes/Acne
❑ ❑ ❑ Itching/burning skin
❑ ❑ ❑ Hair/nail problems
❑ ❑ ❑ Perspiration/night sweats
❑ ❑ ❑ Fever/chills
❑ ❑ ❑ Hot flashes

❑ ❑ ❑ Fatigue/weariness
❑ ❑ ❑ Nervous/anxious
❑ ❑ ❑ Nervous with strangers
❑ ❑ ❑ Nail biting
❑ ❑ ❑ Difficulty relaxing
❑ ❑ ❑ Worry a lot
❑ ❑ ❑ Overwhelmed
❑ ❑ ❑ Sensitive or shy
❑ ❑ ❑ Trouble making decisions
❑ ❑ ❑ Lack of concentration
❑ ❑ ❑ Poor memory/forgetful

❑ ❑ ❑ Frequent crying
❑ ❑ ❑ Lonely/depressed
❑ ❑ ❑ Hopeless outlook
❑ ❑ ❑ Considered suicide
❑ ❑ ❑ Considered homicide
❑ ❑ ❑ Difficulty sleeping
❑ ❑ ❑ Persistent thoughts
❑ ❑ ❑ Frightening thoughts
❑ ❑ ❑ Nightmares
❑ ❑ ❑ See things not there
❑ ❑ ❑ Hear voices
❑ ❑ ❑ Dislike criticism
❑ ❑ ❑ Annoyed at small events
❑ ❑ ❑ Easily angered
❑ ❑ ❑ Sexual difficulties
❑ ❑ ❑ Change in sexual desire
❑ ❑ ❑ Family problems
❑ ❑ ❑ Relationship problems
❑ ❑ ❑ Problems with work

MEN

❑ ❑ ❑ Burning/discharge
❑ ❑ ❑ Lumps/swelling testicles
❑ ❑ ❑ Painful testicles
❑ ❑ ❑ Erection problems
❑ ❑ ❑ Premature ejaculation

WOMEN (or mother if patient is a child)

❑ ❑ ❑ Swelling/lumps in breasts
❑ ❑ ❑ Painful breasts
❑ ❑ ❑ Genital irritation
❑ ❑ ❑ Vaginal discharge
❑ ❑ ❑ Bearing down feeling
❑ ❑ ❑ Problems before periods
❑ ❑ ❑ Painful periods
❑ ❑ ❑ Bleeding between period
❑ ❑ ❑ Miss period(not pregnant)
❑ ❑ ❑ Light periods
❑ ❑ ❑ Heavy periods
❑ ❑ ❑ Irregular periods
❑ ❑ ❑ Pain on intercourse
❑ ❑ ❑ Infertility problems
❑ ❑ ❑ Pregnancy complications
❑ ❑ ❑ Birth complications
❑ ❑ ❑ Postpartum complications

_____Number of pregnancies
_____Number of births/ cesareans
_____Number of premature births
_____Number of miscarriages
_____Number of abortions
_____Number of abnormal paps

Medical History

Please include even if the person is now deceased. Change column headings to adjust for your family's composition.

	You	Father	Mother	Sibling	Sibling	Sibling	Child	Child	Child	Grand-Parent	Grand-Parent
Allergies	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Anemia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Arthritis/Gout	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Bleeding/Bruising	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Cancer/Tumors	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Convulsions/Epilepsy	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Drinking/Drug problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Eczema	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Heart trouble	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Hepatitis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
HIV Positive/AIDS	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Infections frequently	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Kidney/Bladder problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Mental illness	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Migraines	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Periods abnormal	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Psoriasis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Pneumonia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Polio	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Prostate problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Rheumatic fever	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Stomach/Intestinal problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Tuberculosis/PPD+	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Ulcers	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Venereal disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Weight gain/loss problems	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Other Familial Conditions: _____

Allergies (including medications): _____

Hospitalizations/Surgeries:

Month/Year_____Type of Illness/Operation_____

Month/Year_____Type of Illness/Operation_____

Month/Year_____Type of Illness/Operation_____

Month/Year_____Type of Illness/Operation_____

Month/Year_____Type of Illness/Operation_____

Immunizations (note any adverse reactions):

❑ MMR_____

❑ DPT_____

❑ Hepatitis_____

❑ Polio_____

❑ Typhoid_____

❑ Other_____

Please estimate the type and amount you currently or regularly consume (may use other side):

Blood Pressure/Heart Meds: _____

Birth Control/Hormone Replacement: _____

Cortisone/Prednisone: _____

Laxatives: _____

Pain Meds/Analgesics: _____

Sedatives/Tranquilizers: _____

Stimulants: _____

Alcohol: _____

Beer: _____

Coffee: _____

Cigarettes: _____

Cigars/Chew: _____

Vitamins: _____