

## REGISTRATION INFORMATION

IT IS IMPORTANT TO COMPLETE THIS INFORMATION IN ORDER TO PROVIDE YOU WITH THE HIGHEST STANDARD OF CARE.  
YOUR COOPERATION IS APPRECIATED. PLEASE PRINT.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ (D/M/Y) Sex M / F

Address: \_\_\_\_\_  
\_\_\_\_\_

E-mail Address: \_\_\_\_\_

Telephone #: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

May we leave messages relating to your visits? Y / N

Emergency contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

Relation: \_\_\_\_\_

Other health care provider(s) (e.g. MD, DC): \_\_\_\_\_

How did you hear about our Clinic? \_\_\_\_\_

What are your primary health concerns? (List in order of importance)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have a chronic illness(es), indicate its duration since onset:

Who diagnosed your illness(es)? When? \_\_\_\_\_

What specialists have you seen? (Indicate the year of consultation) \_\_\_\_\_

If you are a female are you currently pregnant? YES / NO

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

Tick as applicable: HETEROSEXUAL HOMOSEXUAL BISEXUAL

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.) Provide the name, dosage and duration of use.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list past medications, use the reverse of this page if you need more space:

\_\_\_\_\_ [ ] Tick if continued on reverse

Have you been treated with antibiotics frequently in the past/present?

Do you frequently use any of the following? (Circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol (amount per week) \_\_\_\_\_

Tobacco (form and amount per day) \_\_\_\_\_

Caffeine (form and amount per day) \_\_\_\_\_

Recreational drugs (what and how often) \_\_\_\_\_

Please indicate what immunizations you have had (note any adverse reactions).

DPT (DIPHTHERIA, PERTUSSIS, TETANUS)	HAEMOPHILUS INFLUENZA B	HEPATITIS A
TETANUS BOOSTER; WHEN? _____	"FLU"	HEPATITIS B
MMR (MEASLES, MUMPS, RUBELLA)	POLIO	SMALLPOX

**MEDICAL HISTORY (PLEASE CHECK ONLY THOSE THAT PERTAIN TO YOU PERSONALLY)**

ALCOHOL ABUSE	EPILEPSY	MONONUCLEOSIS
ALLERGIES	FEMALE GYNECOLOGICAL PROBLEMS	OSTEOPOROSIS
ANEMIA	GALLSTONES	OVERWEIGHT
ARTHRITIS	GOUT	PLEURISY
ASTHMA	GUM/TEETH PROBLEMS	PNEUMONIA
BACK, MUSCLE, JOINT PAIN	HAY FEVER	PSYCHOLOGICAL PROBLEMS
BLADDER/URINARY PROBLEMS	HEART ATTACK	RHEUMATIC FEVER
BOWEL DISEASE	HEART PROBLEMS	RHEUMATISM
CANCER	HIGH BLOOD PRESSURE	SKIN PROBLEMS
CANDIDA	HIVES	STROKE
CHRONIC FATIGUE	HYPOGLYCEMIA	SUICIDE
CHRONIC SINUSITIS	INFLUENZA	THYROID PROBLEMS
CHRONIC SWOLLEN GLANDS	KIDNEY PROBLEMS	TUBERCULOSIS
CONSTIPATION	LIVER PROBLEMS	ULCERS
DEPRESSION	LUNG PROBLEMS	VENEREAL DISEASE
DIABETES	MALARIA	OTHER (PLEASE LIST):
ECZEMA	MEASLES	

**FAMILY HISTORY (REFER TO ABOVE LIST FOR HEALTH CONDITIONS)**

FAMILY MEMBER	AGE	HEALTH CONDITION(S). IF DECEASED, PLEASE INDICATE CAUSE AND AGE AT DEATH
MOTHER		
FATHER		
SIBLINGS		
CHILDREN		
MATERNAL GRANDPARENTS		
PATERNAL GRANDPARENTS		
OTHER		

**DIET**

Do you have any food allergies or intolerances? Please list. \_\_\_\_\_

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? \_\_\_\_\_

Describe a typical day's diet:

Breakfast \_\_\_\_\_  
Lunch \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snacks \_\_\_\_\_  
Beverages (and total quantity per day) \_\_\_\_\_

**ENVIRONMENT**

Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Do you exercise regularly? Y / N

What do you do for exercise, how much, how often? \_\_\_\_\_

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated? \_\_\_\_\_

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

Is there anything that you feel is important that has not been covered? \_\_\_\_\_

**CHRONOLOGICAL HEALTH HISTORY:** This will help establish trends in one's health that may be relevant to current health concerns. Please indicate any accidents, illnesses, broken bones, falls, hospitalization (e.g. surgeries), and include any emotional traumas (e.g. deaths, loss of jobs, divorces, etc).

Year 0-10 \_\_\_\_\_

Year 11-20 \_\_\_\_\_

Year 21-30 \_\_\_\_\_

Year 31-40 \_\_\_\_\_

Year 41-50 \_\_\_\_\_

Year 51-60 \_\_\_\_\_

Year 61-70 \_\_\_\_\_

Year 71-80 \_\_\_\_\_

Year 80+ \_\_\_\_\_

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.**