Mosaic Natural Health Clinic

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NEW PATIENT REGISTRATION FORM

All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them with your practitioner.

PATIENT INFORMATION / PROFILE

Name:	Date of Birth:	Gender: M F Other
☐ Single ☐ Partnered ☐ Divorced ☐ Other	Number of people in household: children?	
Occupation:	Employer / School:	
Education completed: ☐ High School ☐ Some College ☐ College ☐ Graduate Degree ☐ Other		
Travel Outside US? ☐ Yes ☐ No	Where / When?	
Emergency Contact :	home phone:	
Relationship to patient:	work phone:	
Are you currently under medical care? ☐ No ☐ Yes For:		
Who is your Primary Care Physician (PCP)?		
Clinic Name, Address and phone:		
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible):		
How did you find us? ☐ Insurance Referral: ☐ Physician Referral: ☐ Patient Referral: ☐ Other:		
Referring Physician or Patient Name:		
Have you ever consulted with or been treated by a naturopathic physician, acupuncturist, chiropractor, nutritionist or massage therapist before?	☐ Yes ☐ No (circle those that apply) When? Who?	

HEALTH CONCERNS (please list in order of importance to you)

1.	4.
2.	5.
3.	6.
Are you currently pregnant? ☐ No ☐ Yes Months?	
Is your condition injury or accident related? ☐ No ☐ Yes, auto accident ☐ Yes, work related	
What goals do you have from your visit today and overall?	
What expectations do you have of your physician?	

MEDICATIONS AND SUPPLEMENTS

Medications & dose:	
1.	4.
2.	5.
3.	6.
Supplements (vitamins, herbs, etc):	
1.	4.
2.	5.
3.	6.

Patient Name	Date of Birth:

HEALTH HISTORY

Allergies or Reactions to:	☐Iodine	☐Penicillin / antibiotics	☐Sulfa Drugs	☐Local anesthetics
	☐Aspirin	☐Nuts	☐ Scents	☐Other:
History of serious illness, accidents, hospitalization or operations (description, date):				
Childhood Illnesses:	☐Chicken Pox	☐Measles	☐Mumps	☐Rubella
☐German measles	☐Rheumatic Fever	☐Strep Throat	☐Other:	
Have you ever been touched in a way that made you uncomfortable without your permission?			☐Yes	☐No
Have you ever been physically or emotionally abused?			☐Yes	☐No
Do you have concerns with abuse / violence in your life now?			☐Yes	☐No

REVIEW OF SYSTEMS: Please check if you have or have ever had:

Condition	Never	Past	Current	Physician's Notes
1. General				
Weight loss / gain	☐	☐	☐	Max weight: Min. wt: Current Wt:
Fever / Chills	☐	☐	☐	
Fatigue / Chronic Fatigue	☐	☐	☐	
Heat / Cold Intolerance	☐	☐	☐	
Cold Hands and Feet	☐	☐	☐	
Sweats / Night Sweats	☐	☐	☐	
Thirst	☐	☐	☐	
2. Skin				
Dryness	☐	☐	☐	
Eczema	☐	☐	☐	
Rashes / Itching	☐	☐	☐	
Sores	☐	☐	☐	
Moles	☐	☐	☐	
Hair or nail dryness / changes	☐	☐	☐	
Easy Bruising	☐	☐	☐	
Yellow / Jaundice	☐	☐	☐	
3. Head				
Headache	☐	☐	☐	
Trauma	☐	☐	☐	
4. Eyes				
Blurred Vision	☐	☐	☐	
Corrective Lenses / Contact Lenses	☐	☐	☐	
Double Vision	☐	☐	☐	
Dry Eyes	☐	☐	☐	
Eye Pain	☐	☐	☐	
Glaucoma	☐	☐	☐	
Floaters	☐	☐	☐	
Discharge	☐	☐	☐	
Poor night vision	☐	☐	☐	
5. Ears				
Earaches	☐	☐	☐	
Ringing of Ears	☐	☐	☐	
Hearing Problems	☐	☐	☐	
6. Nose				
Sinus congestion or infection	☐	☐	☐	
Bleeding	☐	☐	☐	
Discharge	☐	☐	☐	
Post Nasal Drip	☐	☐	☐	

Patient Name	Date of Birth:

7. Mouth / Throat	Never	Past	Current	Physician's Notes (Con't)
Sores	☐	☐	☐	
Bleeding gums	☐	☐	☐	
Cavities / Root canals / toothaches	☐	☐	☐	
Hoarseness	☐	☐	☐	
Sore Throat	☐	☐	☐	
Bitter or Metallic taste in mouth	☐	☐	☐	
8. Lungs				
Asthma	☐	☐	☐	
Difficulty Breathing / Shortness of Breath	☐	☐	☐	
Chest Pain / Tightness in chest	☐	☐	☐	
Cough: Persistent or Bloody	☐	☐	☐	
Wheezing	☐	☐	☐	
Bronchitis	☐	☐	☐	
Emphysema	☐	☐	☐	
Pneumonia	☐	☐	☐	
Tuberculosis	☐	☐	☐	
9. Cardiovascular				
Heart palpitations	☐	☐	☐	
Blood Clots in Legs or Lungs	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Low Blood Pressure	☐	☐	☐	
Swelling (Edema) of hands, feet, legs	☐	☐	☐	
Heart murmurs / Arrhythmias	☐	☐	☐	
Heart Disease	☐	☐	☐	
Heart Attack	☐	☐	☐	
Stroke	☐	☐	☐	
Circulatory Problems (raynauds, etc)	☐	☐	☐	
Varicose Veins	☐	☐	☐	
Pacemaker	☐	☐	☐	
10. Gastrointestinal				
Loss of / Excess Appetite	☐	☐	☐	
Nausea / Vomiting	☐	☐	☐	
Difficulty or pain with swallowing	☐	☐	☐	
Eating Disorders	☐	☐	☐	
Pain with Digestion	☐	☐	☐	
Indigestion / Reflux	☐	☐	☐	
Gas / Bloating	☐	☐	☐	
Constipation	☐	☐	☐	
Diarrhea (with or without blood?)	☐	☐	☐	
Colitis / Crohn's	☐	☐	☐	
Hernia	☐	☐	☐	
Hemorrhoids	☐	☐	☐	
Anal Discomfort	☐	☐	☐	
Blood or Mucus in Stool	☐	☐	☐	
Black tarry or "coffee ground" stools	☐	☐	☐	
Gallbladder Disease	☐	☐	☐	
Hepatitis (type _____)	☐	☐	☐	
High Cholesterol / Lipids	☐	☐	☐	
Liver Disease	☐	☐	☐	
Ulcer	☐	☐	☐	
11. Genitourinary				
Pain with Urination	☐	☐	☐	
Urgency to Urinate	☐	☐	☐	
Frequent Urination	☐	☐	☐	
Wake to Urinate	☐	☐	☐	
Blood in Urine	☐	☐	☐	
Difficulty holding urine (sneeze / cough)	☐	☐	☐	
Kidney disease / Stones	☐	☐	☐	

Patient Name	Date of Birth:

12. Musculoskeletal	Never	Past	Current	
Muscle pain / spasm / strain	☐	☐	☐	
Joint pain / sprain	☐	☐	☐	
Arthritis (type:)	☐	☐	☐	
Back Problems (type:)	☐	☐	☐	
Broken Bones	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Weakness	☐	☐	☐	
Trauma / Swelling	☐	☐	☐	
13. Endocrine				
Diabetes	☐	☐	☐	
Thyroid disease	☐	☐	☐	
Goiter	☐	☐	☐	
Tremor	☐	☐	☐	
Hormone Therapy	☐	☐	☐	
14. Blood / Lymphatic				
Anemia	☐	☐	☐	
Bleeding tendencies	☐	☐	☐	
Blood Transfusions	☐	☐	☐	
Swollen Lymph nodes	☐	☐	☐	
Blood / Lymph disease or cancer	☐	☐	☐	
15. Allergic / Immune				
HIV / AIDS	☐	☐	☐	
Cancer / Chemotherapy	☐	☐	☐	
Autoimmune (scleroderma, hashimotos, lupus, etc)	☐	☐	☐	
Hay fever / Asthma / Eczema	☐	☐	☐	
Drug Allergies	☐	☐	☐	
Food Allergies	☐	☐	☐	
Environmental / Animal allergies	☐	☐	☐	
16. Neurologic				
Epilepsy / Seizures / Convulsions	☐	☐	☐	
Fainting	☐	☐	☐	
Dizziness / Vertigo	☐	☐	☐	
Problems with speech	☐	☐	☐	
Problems with walking / coordination	☐	☐	☐	
Paralysis / weakness	☐	☐	☐	
Numbness	☐	☐	☐	
Multiple Sclerosis	☐	☐	☐	
17. Psychologic				
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
Chemical Dependency	☐	☐	☐	
Phobias	☐	☐	☐	
Memory Loss	☐	☐	☐	
Mood Changes	☐	☐	☐	
Psychiatric Care	☐	☐	☐	

Patient Name	Date of Birth:

Sexual Health Information

Are you currently sexually active? ☐No ☐Yes	With: ☐Men	☐Women	☐Both	
Have you been sexually active with:	☐Men	☐Women	☐Both	☐Neither
☐Current ☐Past	☐Bisexual	☐Bisexual	☐Prostitute	☐IV drug user
Are you satisfied with your sex life?	☐No ☐Yes	Do you practice safer sex?	☐No	☐Yes
Do you have need for birth control?	☐No ☐Yes			
Method of birth control currently used		Number of sexual partners this year?		
STDs ☐HIV ☐Herpes ☐HPV/ Warts	☐Gonorrhea	☐Chlamydia	☐Syphilis	☐Hepatitis
Notes:				

Male Health Information

Condition	Never	Past	Current	Physician's Notes
Difficult Urination	☐	☐	☐	
Testicular Pain / Swelling	☐	☐	☐	
Impotence / Sexual difficulties	☐	☐	☐	
Prostate problems	☐	☐	☐	
Notes:				

Female Health Information

Menstrual History			Obstetric History		
Age at first period			Have you ever been pregnant	☐No	☐Yes
Date last menstrual period began			Age at first pregnancy		
Periods regular?	☐No	☐Yes	Number of pregnancies		
Days between periods			Number of living children		
Length of flow			Number of stillbirths		
Heaviness of flow			Number of miscarriages	When in pregnancy?	
Color of flow			Number of tubal pregnancies		
Clots (size? Sm, Med, Lg)	☐No	☐Yes	Number of abortions	When in pregnancy?	
Pain with ovulation?	☐No	☐Yes	Number of Cesarean sections		
Pain with Menses?	☐ No	☐Yes	Date of last pregnancy		
Menopause?	☐No	☐Yes	Difficulty conceiving	☐No	☐Yes
			Difficulty with pregnancy	☐No	☐Yes
PMS Symptoms:	☐None	☐Bloating/swelling	Difficulty with labor or delivery	☐No	☐Yes
☐Breast Tenderness	☐Acne	☐Mood Swings	Difficulty with breast feeding	☐No	☐Yes
☐Digestive changes	☐Fatigue	☐Headache	Future OB plans	☐No	☐Yes
☐Other					

Vaginitis Symptoms:	Never	Past	Current	Risk Factors		
Discharge	☐	☐	☐	History of Abnormal paps	☐No	☐Yes
Irritation / Itching	☐	☐	☐	Did your mother take DES?	☐No	☐Yes
Vaginal dryness	☐	☐	☐	Did your mother ever miscarry?	☐No	☐Yes
Odor	☐	☐	☐	Do you do self breast exams?	☐No	☐Yes
Pain with sex	☐	☐	☐	Long term Hormone Replacement?	☐No	☐Yes
Trichomoniasis	☐	☐	☐			
Bacteria (BV)	☐	☐	☐			
Yeast	☐	☐	☐			

Notes:

Patient Name	**Date of Birth:**

Family History

Mother:	☐Living	☐Deceased	Cause	Age:
Father:	☐Living	☐Deceased	Cause	Age:
Siblings:	Number living:	Number deceased:	Causes / Ages:	
Children:	Number living:	Number deceased:	Causes / Ages:	

Has any family member had:	**Yes**	**Which Relative(s) & Age of Onset**	**Physician's Notes**
Diabetes	☐		
Severe allergies	☐		
Stroke	☐		
Heart Disease	☐		
Heart Attack	☐		
Blood clots in lungs or legs	☐		
High Blood Pressure	☐		
High Cholesterol	☐		
Kidney Disease	☐		
Osteoporosis	☐		
Hepatitis	☐		
Thyroid problems	☐		
Colitis / Crohn's	☐		
HIV / AIDS	☐		
Tuberculosis	☐		
Birth Defects	☐		
Drinking or Drug problems	☐		
Breast Cancer	☐		
Colon Cancer	☐		
Ovarian Cancer	☐		
Uterine Cancer	☐		
Other Cancer:	☐		
Mental Illness/Depression	☐		
Alzheimer's	☐		
Other:	☐		
	☐		

Social & Lifestyle

Habits	**Yes**	**No**	**Details**	**Notes**
Current Tobacco Use	☐	☐	Packs per day:	
Past Tobacco Use	☐	☐	Packs per day:	
Quit?	☐	☐	When?	
Alcohol consumption Types:	☐	☐	Per day? Per week?	
Recreational Drug Use	☐	☐	Type:	
Ever been treated for drug or alcohol abuse	☐	☐	When?	
Seat Belt Use	☐	☐		
Caffeine Use (coffee, tea, cola)	☐	☐	Cups per day? Type?	
Regular Exercise? Types:	☐	☐	How much?	
Health Hazards at home / work?	☐	☐		
Social				
Happy with relationship status?	☐	☐		
Do you have a good support network of family and friends?	☐	☐	Who?	
What is your predominant emotion?				
Lifestyle				
Do you enjoy your work?	☐	☐	Hours per week:	
Stress Level	☐Low	☐Medium	☐High	
Stress source	☐Money	☐Job	☐Family/ Relationship	
What do you do to relive stress?				

Patient Name	**Date of Birth:**

Sleep	**Yes**	**No**	**Details**	
Problems falling asleep?	☐	☐		
Problems staying asleep?	☐	☐		
Do you wake rested in the am?	☐	☐		
Usual bed time / rising time:		Hours of sleep daily:		
Dreams?				
Diet				
Do you follow a particular Diet?				
Known food allergies / intolerances?				
What is a typical breakfast for you?				
Typical Lunch?				
Typical Dinner?				
Snacks?	Dessert / Treats?			
How much water do you drink per day?				

EXAM AND IMAGING HISTORY (Indicate date, doctor's name or place of most recent)

Physical Exam		HIV test	
Pap Smear		Chest X-ray	
Mammogram		EKG	
Colonoscopy		STD screen	
Prostate check		Cholesterol screen	
TB test		Bone density check	

IMMUNIZATION HISTORY

Immunization	**Date**	**Boosters**
Tetanus – Diphtheria		
Measles-Mumps-Rubella (MMR)		
Varicella		
Hepatitis A		
Hepatitis B		
Flu shot		
Other:		

_______________________________________ ______________

Patient Signature *Date*

_______________________________________ ______________

Signature of Physician *Date reviewed with patient*