Optimal Health
San Francisco

PATIENT REGISTRATION *(Please print clearly)*

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Phone # (home) _____ (work) _____ (cell) _____

Email Address_____ Marital Status: S M D W

Age_____ Date of Birth_____ Time of Birth _____

Employer_____ Type of Work_____

Address _____ City_____ State_____ Zip_____

How were you referred to the doctor? _____

SPOUSE and CHILDREN INFORMATION

Name of spouse_____ Number of children_____ Ages_____

Employer_____ Type of Work _____

Address_____ City_____ State_____ Zip_____

EMERGENCY INFORMATION

(In case of an emergency, the name, address, and phone number of a close relative)

Name_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Relationship_____

Have you ever received chiropractic care? YES NO

If YES, please provide doctor's name._____

Have you ever received acupuncture care? YES NO

If YES, please provide practitioner's name._____

What major complaint(s) caused you to seek treatment here?

	Symptom	Duration	Impact on living/working
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

1. How did it start? ☐ Gradually ☐ Suddenly (accident): Date_____

2. Have you lost any time from work or other activities as a result of this condition?
   ☐ NO ☐ YES, from _____ to _____

4. Frequency of symptoms:
   ☐ Intermittent ☐ Occasional (25%)
   ☐ Infrequent (50%) ☐ Frequent (75%)
   ☐ Constant (100%) ☐ With movement or position

5. Does the pain radiate to other parts of your body? ☐ NO ☐ YES, where?

   _____

6. What makes your pain or condition worse?
   ☐ Bending ☐ Lifting ☐ Standing ☐ Driving
   ☐ Coughing ☐ Pulling ☐ Sitting ☐ Walking
   ☐ Sneezing ☐ Pushing ☐ Other_____

7. What makes your pain or condition better?
   ☐ Cold pack ☐ Hot pack ☐ Rest ☐ Lying down
   ☐ Exercise ☐ Sitting ☐ Standing ☐ Other_____

8. Have you ever had this condition before? ☐ NO ☐ YES, when?

   _____

9. Have you ever had any treatment for this condition? ☐ NO ☐ YES, when?

   _____

   Have you ever been involved in a car and/or motorcycle accident and/or traumatic fall? ☐ NO ☐ YES, when? Please describe.

   _____

   _____

10. Have you ever had any surgery? ☐ NO ☐ YES, when? Please explain.

    _____

11. Do you exercise? ☐NO ☐YES, what type and how often?

_____

12. Do you take vitamins/supplements? ☐NO ☐YES, which one(s) and how often?

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

13. Are you taking any medication or hormones? ☐NO ☐YES (please list below)

Name	Purpose
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

14. Please describe your daily duties (*home or work*) from a physical perspective (e.g., I lift cases of supplies five hours per day and drive a truck three hours per day, *or* I sit at a computer and answer phones eight hours per day).

_____

_____

15. Is your job stressful? ☐NO ☐YES, please explain.

_____

16. What percentage of time do you sit each day? _____% at home _____% at work

17. Are your parents living? ☐YES ☐NO, please list cause of death.

_____

18. Family History. Please indicate if any member of your family has had any of the following illnesses. (*Use these codes: M=Mother, F=Father, B=Brother, S=Sister*)

☐Arthritis	☐Headaches	☐Neck pain
☐Back pain	☐Heart disorder	☐Spinal problems
☐Cancer	☐High blood pressure	☐Stroke
☐Diabetes	☐Intestinal disorder	☐Thyroid dysfunction

Please rate symptoms on a scale from 0-10, where 10 is the worst. NEW PATIENTS: Indicate any symptoms you have experienced in the past 6 months. CURRENT PATIENTS: Indicate any symptoms you're currently experiencing.

___ Energy Low / Normal / High
___ Insomnia
___ Slow to start in morning
___ Energy crash: _____ am/pm
___ Dizzy when standing up quickly
___ Light bothers eyes
___ Weak nails
___ Perspire easily or excessively
___ Splitting Headaches
___ Tired/Sluggish
___ Chills, cold hands/feet, cold bod
___ Require excessive sleep
___ Increase in weight (unexplained)
___ Hair loss and/or thinning
___ Thinning of outer third of eyebro
___ Scalp dryness
___ Mental sluggishness
___ Heart palpitations- skip/flutter
___ Inward trembling
___ Increased pulse at rest
___ Night sweats

___ Twitching around eyes
___ Restlessness
___ Don't remember dreams
___ Nails: spots / weakness
___ Air hunger / frequent sighs
___ Cramps: legs/feet/arms/hands
___ Aches: legs/feet/arms/hands
___ Restless: legs/feet/arms/hands
___ Frequent thirst
___ Shallow rapid breathing
___ Poor muscle endurance
___ Swelling in ankles and wrists

___ Chest congestion
___ Pain on breastbone
___ Breath short on exertion
___ Wheezing
___ Asthma
___ Emphysema
___ Bronchitis
___ Frontal headache
___ Sinus: dry
___ Sinus: post-nasal drip
___ Sinus: stuffy
___ Sneeze frequently
___ Smell / Taste loss
___ Mucous: clear/white/yellow/green/brown
___ Fever
___ Cough: dry / productive
___ Frequent colds/flu
___ Environmental allergies
___ Nightmares

___ Stress
___ Sadness
___ Grief
___ Depression
___ Moodiness
___ Frustration
___ Irritability
___ Anger
___ Worriedness
___ Nervousness
___ Anxiety
___ Panic
___ Crying
___ Fear
___ Shame
___ Guilt

___ Forget names
___ Forget numbers
___ Forget words
___ Forget actions
___ Difficulty focusing / concentrating
___ Sluggish memory

___ Crave sweets
___ Irritable if skipping meals
___ Light-headed if skipping meals
___ Eating relieves fatigue
___ Bouts of blurred vision
___ Fatigued after meals
___ Increased thirst
___ Difficulty losing weight
___ Constant fatigue
___ Dehydrated
___ Slow to heal
___ Low stamina
___ Inability to achieve lean body

___ Sleep quality: poor/fair/good/great
__ Hours in bed; __ hours asleep
___ Interrupted ____ per night
___ Awaken suddenly (jolt)

Appetite: low / normal / high
___ Eat animal protein: ____ /day
___ Eat chocolate: _____ /week
___ Eat spicy foods: _____ /week
___ Eat ice cream: _____ /week
___ Coffee: _____ cups/week
___ Tea: _____ cups/week
___ Juice: _____ per week
___ Soda: _____ per week
___ Beer: _____ per week
___ Wine: _____ per week
___ Liquor: _____ per week
___ Special diet?: _____

___ Eyes: burning/red/dry
___ Excessive tears
___ Eye film/crust in morning
___ Eye floaters
___ Eye stye(s)
___ Itchy eyes
___ Eye aches
___ Blurry vision
___ Tired eyes
___ Eye spots
___ Eyes puffy
___ Dark circles under eyes
___ Ear noise: ring/hiss/pound
___ Ears plugged
___ Ear popping
___ Ear ache(s) / infection(s)
___ Ears itch internally
___ Ear drainage
___ Hearing loss
___ Excessive ear wax
___ Dizziness/vertigo

___ Mouth/Throat blisters
___ Canker sores
___ Bad breath
___ Bleeding gums
___ Receding gums
___ Dental health problems
___ Dry mouth
___ Swelling of glands
___ Difficulty swallowing
___ Sore throat
___ Hoarseness

___ Skin rash
___ Acne
___ Dry/ Itchy skin
___ Nail fungus: mild/mod/severe

___ Chest tension/tightness
___ Chest heaviness
___ Chest/Heart pain
___ Heart palpitations- skip/flutter
___ Heart racing
___ Heart slowing down
___ Sleep apnea
___ Mitral Valve Prolapse
___ Murmur

___ Headaches at base of skull
___ Yellow cast to eyes
___ History of gallbladder attacks
___ Excessively foul-smelling sweat
___ Hormonal imbalances

___ Cardiovascular: ____ /week
___ Weight train: ____/week

Urinate:__ times/day; __times/night
___ Urination urgency
___ Burning/painful urination
___ Cloudy urine
___ Odor in urine
___ Spasm when urinating
___ Urinary Tract Infection (UTI)
___ Kidney pain or infections
___ Frequent urination
___ Urination leakage
___ Pain inside of legs or heels
___ Leg twitching at night
___ Headache side of head

___ Heartburn
___ Indigestion
___ Stomach aches
___ Stomach cramps
___ Nausea / Queasy
___ Bloated after eating
___ Gas / flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
___ Greasy high-fat foods cause distress

___ Swollen/distended/bloody anus
___ Burning anus
___ Itchy/stinging anus
___ Achy anus

Bowel movements: ____ per day
___ Regular
___ Incomplete
___ Skip days: ___ per (week/month)
___ Sluggish bowels every: ____ days
___ Cramps in abdomen
___ Taking laxatives
___ Using suppositories
___ Enemas
___ Colonics
___ Pain with bowel movements
___ Irritable Bowel Syndrome
___ Chron's Disease
Color of feces: light / dark _____
Fecal consitency:
___ Normal
___ Soft
___ Hard
___ Pebble-like
___ Dry
___ Ribbon-like
___ Bulky
___ Mucous
___ Diarrhea
___ Constipation

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Women only:

Last menstrual period: _____

Length of menses: _____

____ Regular cycle
____ Irregular cycle
____ Early (fewer than 28 days)
____ Late (more than 28 days)
____ Skip cycle
____ Flow: Light / Moderate / Heavy
____ Cramps: Mild / Moderate / Severe
____ Clotting / Spotting
____ Headache on side of head
____ Sex drive: Flat / Low / Normal
____ Low abdominal puffiness
____ Fluid retention: Face / Hands / Feet
____ Mood swings/irritability/depression
____ Tired during cycle
____ Menopausal: natural / surgical
____ Hot flashes

Women only (cont.):

____ Ovarian pain
____ Breasts tender around cycle
____ Acne around cycle: pre/mid/post
____ Birth control pill / patch
____ Facial hair growth
____ Dark nipple hair
____ Hair growing up towards belly button
____ Skin crawling
____ Breast discharge
____ Breasts shrinking
____ Breast feeding
____ Breast surgery
____ Vaginal burning
____ Vaginal itchiness
____ Dry Vagina
____ Discharge: clear/white/yellow/green/brown
____ Pain with intercourse

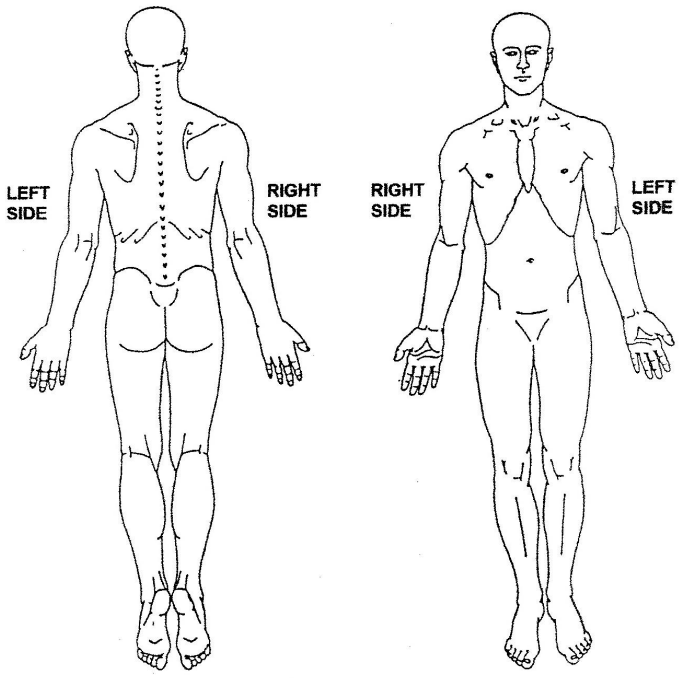
Men only:

____ Sex drive: Flat / Low / Normal
____ Decreased morning erections
____ Decreased fullness erections
____ Inability to concentrate
____ Episodes of depression
____ Decreased physical stamina
____ Sweating attacks
____ More emotional than in past
____ Weight gain (unexplained)

ALL Patients: Indicate where you are experiencing the symptoms listed below by circling the area on the body diagram.

Pain (P) / Stiffness (S) / Swelling (SW) / Aching (A) / Numbness (N) / Tingling (T) Burning (B):

____ Head
____ Face
____ Neck
____ Trapezius
____ Upper back
____ Shoulders
____ Arms
____ Elbows
____ Wrists
____ Hands
____ Mid back
____ Low back
____ Sacral iliac
____ Hips
____ Buttocks
____ Legs
____ Knees
____ Ankles
____ Feet
____ Other: _____



The above information is accurate and complete to the best of my knowledge. I have disclosed all past and present medical information, with the understanding that it is important for proper and accurate diagnosis.

I agree to receive mandatory practice notices and optional patient education (twice monthly) electronic communications at the email address given above. If I don't want to receive optional patient education, I will be able to Opt-Out.

I agree to pay in full the charges incurred by myself for services rendered at the time of each visit. NOTE: If for any reason this request cannot be met, arrangements must be made in advance with the doctor.

Patient's Signature: _____

Date:_____

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