

PARTNERS IN HOLISTIC HEALTH, Inc.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's LAST NAME:		FIRST:		MIDDLE:	
Street address:				Cell phone no.:	Home phone no.:
				()	()
Birth Date	Age	City:	State:	ZIP Code:	
/ /					
Occupation:		Employer:		Work phone no.:	
				()	
Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> School <input type="checkbox"/> Home Maker <input type="checkbox"/> Unemployed <input type="checkbox"/> College <input type="checkbox"/> High School <input type="checkbox"/> G.E.D. <input type="checkbox"/>					
Other Family Members Seen Here:					
How did you Hear about Us:					
LIVING SITUATION (Check those that apply)		HEIGHT:	WEIGHT:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	
Alone <input type="checkbox"/> Parents <input type="checkbox"/> Spouse <input type="checkbox"/> Friends <input type="checkbox"/> Cohabiting <input type="checkbox"/> Boarding <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/>					

EMAIL ADDRESS:

FINANCIAL RESPONSIBILITY & INSURANCE INFORMATION

Person responsible for bill:					
NAME OF INSURANCE COMPANY:				Home phone no.:	
				()	
Are you Covered by Insurance:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Group #:		
Policy #	Co-payment	ID#		Employer phone no.:	
				()	
I WILL BE PAYING TODAY BY: CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD <input type="checkbox"/>					

Make Checks to: PARTNERS IN HOLISTIC HEALTH

GENERAL INFORMATION

Members of Household	Age	RELATIONSHIP
1)		
2)		
3)		
4)		

Have you been Hospitalized? Yes No **If Yes:** Recently? Yes No How Many Times? _____

Give the following information for the last times you have been hospitalized starting with the most recent (Except Normal Pregnancies)

***** PLEASE INCLUDE TYPE OF OPERATION OR ILLNESS & LOCATION OF HOSPITALISATION *****

HOSPITALISATION (1)	HOSPITALISATION (2)	HOSPITALISATION (3)

Do you have worrisome financial problems? : Yes No : Do you have transportation problems getting here? : Yes No

IF YES PLEASE EXPLAIN:

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HEALTH QUESTIONNAIRE

IF YOU HAVE RECENTLY BEEN BOTHERED WITH THESE PROBLEMS CHECK YES

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent or Severe Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Lumps or Swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Balance |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizzy Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Blackouts/Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear Glasses |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurry Vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyesight Worsening |
| <input type="checkbox"/> | <input type="checkbox"/> | See Double |
| <input type="checkbox"/> | <input type="checkbox"/> | See Halos or Lights |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Pains or Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Watering Eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | Earaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Running Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Noises in Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore or Bleeding Gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore Tongue |
| <input type="checkbox"/> | <input type="checkbox"/> | Congested Nose |
| <input type="checkbox"/> | <input type="checkbox"/> | Running Nose |
| <input type="checkbox"/> | <input type="checkbox"/> | Sneezing Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Head Colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore Throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarse Voice |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing or Gasping |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Coughing |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough up Phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough up Blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid or Skipped Heartbeats |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath w/ Normal Activity |
| <input type="checkbox"/> | <input type="checkbox"/> | swollen feet or ankles |

- | YES | NO | |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Recurring Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Belching |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Abdomen |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloated Abdomen |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Loose Bowels |
| <input type="checkbox"/> | <input type="checkbox"/> | Black Stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Grey or Whitish Stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Rectum |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching Rectum |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood with Stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Involuntary Escape of Urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning on Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Brown, Black or Bloody Urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak Urine Stream |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Starting Urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Constant urge to Urinate |
| (MEN ONLY) | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning or Discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Lumps or Swelling on Testicles |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Testicles |
| (WOMEN ONLY) | | |
| <input type="checkbox"/> | <input type="checkbox"/> | A Missed Period |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Between Periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Tension or Pain before Periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavy Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Bearing Down Feeling |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital Irritation |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain on Intercourse |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling or Lumps in Breasts |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Breasts |
| <input type="checkbox"/> | <input type="checkbox"/> | Number of Pregnancies |

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Caesareans |
| <input type="checkbox"/> | <input type="checkbox"/> | Number of Births |
| <input type="checkbox"/> | <input type="checkbox"/> | Miscarriages |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature Births |
| <input type="checkbox"/> | <input type="checkbox"/> | Abortions |
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Aching Muscles or Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Back or Shoulder Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in Arms or Legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Trembling |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg Cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Scalp Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching or Burning Skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness or Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous with Strangers |
| <input type="checkbox"/> | <input type="checkbox"/> | Nail Biting |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty making Decisions |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of Concentration |
| <input type="checkbox"/> | <input type="checkbox"/> | Absent Minded/Loss of Memory |
| <input type="checkbox"/> | <input type="checkbox"/> | Lonely or Depressed |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Crying |
| <input type="checkbox"/> | <input type="checkbox"/> | Hopeless Outlook |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Relaxing |
| <input type="checkbox"/> | <input type="checkbox"/> | Worry a Lot |
| <input type="checkbox"/> | <input type="checkbox"/> | Frightening Dreams or Thoughts |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling of Desperation |
| <input type="checkbox"/> | <input type="checkbox"/> | Shy or Sensitive |
| <input type="checkbox"/> | <input type="checkbox"/> | Dislike Criticism |
| <input type="checkbox"/> | <input type="checkbox"/> | Angered Easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Annoyed by Little Things |
| <input type="checkbox"/> | <input type="checkbox"/> | Family Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems at Work |

Continued Next Page

YES	NO			Sexual Difficulties	YES	NO			Armpits or Groin Swelling
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			Change of Sexual Energy	<input type="checkbox"/>	<input type="checkbox"/>			Unusual Fatigue or Weariness
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			Considered Suicide	<input type="checkbox"/>	<input type="checkbox"/>			Difficulty Sleeping
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			Sought Psychiatric Help	<input type="checkbox"/>	<input type="checkbox"/>			Motion Sickness
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			Loss or Gain in Weight	<input type="checkbox"/>	<input type="checkbox"/>			Excessive Sweating
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>			Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			Always Hungry	<input type="checkbox"/>	<input type="checkbox"/>			Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			Frequently feel warmer or Colder than Others	<input type="checkbox"/>	<input type="checkbox"/>			Fever or Chills

Place an (X) in the appropriate column for any illnesses that you or your relatives have had!

	You	Father	Mother	Sib	Sib	Sib	Grand Ma	Grand Pa	Kids	Kids	Kids	ILLNESSES
1												Allergies
2												Anemia
3												Arthritis/Gout
4												Asthma
5												Bleeding/Bruising problems
6												Cancer or Tumors
7												Convulsion/Epilepsy
8												Diabetes
9												Drinking or Drug Problems
10												Eczema
11												Emphysema
12												Heart Trouble
13												Hepatitis
14												High Blood Pressure
15												Frequent Infections
16												Kidney or Bladder Problems
17												Mental Illnesses
18												Migraines
19												Abnormal Periods
20												Psoriasis
21												Pneumonia
22												Polio
23												Prostate Problems
24												Rheumatic Fever
25												Stomach or Intestinal Disease
26												Stroke
27												Thyroid Problems
28												Tuberculosis
29												Ulcers
30												Venereal Disease
31												Weight Problems

DO YOU USE

YES	Amount	YES	Amount	YES	Amount
<input type="checkbox"/>	COFFEE _____	<input type="checkbox"/>	CORTISONE _____	<input type="checkbox"/>	TRANQUILIZERS _____
<input type="checkbox"/>	SMOKE _____	<input type="checkbox"/>	THYROID _____	<input type="checkbox"/>	MEDICINAL HERBS & TEAS _____
<input type="checkbox"/>	ALCOHOL _____	<input type="checkbox"/>	LAXATIVES _____	<input type="checkbox"/>	BIRTH CONTROL PILLS _____
<input type="checkbox"/>	ASPIRIN _____	<input type="checkbox"/>	HORMONES _____		
<input type="checkbox"/>	VITAMINS _____	<input type="checkbox"/>	OTHER DRUGS _____		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

ADDRESS:

RELATIONSHIP:

Cell Phone no:
()

Home Phone No:
()

TESTS & IMMUNIZATIONS

If you have had any of the following tests or immunizations, check what applies and, if you can, give the year that you last had them:

YEAR	TEST	YEAR	IMMUNIZATIONS
	C.A.T. SCAN		HEPATITUS
	ULTRASOUND		M.M.R.
	M.R.I.		MEASLES
	CHEST X RAY		MUMPS
	KIDNEY X-RAY (PYELOGRAM)		TETANUS
	G.I. SERIES		POLIO
	COLON X-RAY (BARIUM ENEMA)		TYPHOID
	GALLBLADDER X-RAY (CHOLECYSTOGRAM)		FLU
	ELECTROCARDIOGRAM		BAD REACTION TO SHOTS
	OTHER X-RAYS		
	T.B. TEST		

Other Doctors or Therapists involved in your care? (Please include phone number)

1)

2)

Any other concerns or comments about your health and well being; Mentally, Emotionally or Physically:

POLICIES

THE FOLLOWING SERVICE SHARGES WILL BE ASSESSED:

Missed Appointment Charge -----Current Office Visit Charges.

1.5% Interest Per Month on any past due balances

\$20 bounced check Charge

Charges may also be made for appointments cancelled without 24 hours advance notice.

Your health care is being provided by Partners in Holistic Health, Inc., an Arizona Corporation. By signing below, you agree that in the event of any claim that you may have relating to your health care, your claim is against the corporation and not against individuals who are shareholders and/or employees of the corporation.

We must emphasize that as your health care provider, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on pages 1 and 2 and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

SIGNATURE

The above information is true to the best of my knowledge. I understand I am financially responsible for any balance.

Patient/Guardian signature

Date: