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 ❑ Part Time ❑ Retired ❑ Disabled ❑ School ❑ Home Maker ❑ Unemployed ❑ College ❑ High School ❑ G.E.D. ❑

Other Family Members Seen Here:

How did you Hear about Us:

LIVING SITUATION (Check those that apply) HEIGHT: WEIGHT: GENDER:

Alone ❑ Parents ❑ Spouse ❑ Friends ❑ Cohabiting ❑ Boarding ❑ Divorce ❑ Separated ❑ Widow ❑

EMAIL ADDRESS:

FINANCIAL RESPONSIBILITY & INSURANCE INFORMATION				
Person responsible for bill:				
NAME OF INSURANCE COMPANY:				Home phone no.:
				( )
Are you Covered by Insurance:	❑ Yes	❑ No	Group #:	
Policy #	**Co-payment**	**ID#**		Employer phone no.:
				( )
I WILL BE PAYING TODAY BY:	**CASH ❑**	**CHECK ❑**	**CREDIT CARD ❑**	

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:

IN CASE OF EMERGENCY

HEALTH QUESTIONAIRE

IF YOU HAVE RECENTLY BEEN BOTHERED WITH THESE PROBLEMS *CHECK YES*

YES NO

- ☐ ☐ Frequent or Severe Headaches
- ☐ ☐ Neck Pains
- ☐ ☐ Neck Lumps or Swelling
- ☐ ☐ Loss of Balance
- ☐ ☐ Dizzy Spells
- ☐ ☐ Blackouts/Fainting
- ☐ ☐ Wear Glasses
- ☐ ☐ Blurry Vision
- ☐ ☐ Eyesight Worsening
- ☐ ☐ See Double
- ☐ ☐ See Halos or Lights
- ☐ ☐ Eye Pains or Itching
- ☐ ☐ Watering Eyes
- ☐ ☐ Hearing Difficulties
- ☐ ☐ Earaches
- ☐ ☐ Running Ears
- ☐ ☐ Noises in Ears
- ☐ ☐ Dental Problems
- ☐ ☐ Sore or Bleeding Gums
- ☐ ☐ Sore Tongue
- ☐ ☐ Congested Nose
- ☐ ☐ Running Nose
- ☐ ☐ Sneezing Spells
- ☐ ☐ Head Colds
- ☐ ☐ Nosebleeds
- ☐ ☐ Sore Throat
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Hoarse Voice
- ☐ ☐ Wheezing or Gasping
- ☐ ☐ Frequent Coughing
- ☐ ☐ Cough up Phlegm
- ☐ ☐ Cough up Blood
- ☐ ☐ Chest Colds
- ☐ ☐ Rapid or Skipped Heartbeats
- ☐ ☐ Chest Pains
- ☐ ☐ Shortness of Breath w/ Normal Activity
- ☐ ☐ swollen feet or ankles

YES NO

- ☐ ☐ Recurring Indigestion
- ☐ ☐ Frequent Belching
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Pain in Abdomen
- ☐ ☐ Bloated Abdomen
- ☐ ☐ Constipation
- ☐ ☐ Loose Bowels
- ☐ ☐ Black Stools
- ☐ ☐ Grey or Whitish Stools
- ☐ ☐ Pain in Rectum
- ☐ ☐ Itching Rectum
- ☐ ☐ Blood with Stools
- ☐ ☐ Frequent Urination
- ☐ ☐ Involuntary Escape of Urine
- ☐ ☐ Burning on Urination
- ☐ ☐ Brown, Black or Bloody Urine
- ☐ ☐ Weak Urine Stream
- ☐ ☐ Difficulty Starting Urine
- ☐ ☐ Constant urge to Urinate

(MEN ONLY)

- ☐ ☐ **Burning or Discharge**
- ☐ ☐ **Lumps or Swelling on Testicles**
- ☐ ☐ **Painful Testicles**

(WOMEN ONLY)

- ☐ ☐ **A Missed Period**
- ☐ ☐ **Menstrual Problems**
- ☐ ☐ **Bleeding Between Periods**
- ☐ ☐ **Tension or Pain before Periods**
- ☐ ☐ **Heavy Bleeding**
- ☐ ☐ **Bearing Down Feeling**
- ☐ ☐ **Vaginal Discharge**
- ☐ ☐ **Genital Irritation**
- ☐ ☐ **Pain on Intercourse**
- ☐ ☐ **Swelling or Lumps in Breasts**
- ☐ ☐ **Painful Breasts**
- _____ **Number of Pregnancies**

- _____ **Caesareans**
- _____ **Number of Births**
- _____ **Miscarriages**
- _____ **Premature Births**
- _____ **Abortions**

YES NO

- ☐ ☐ Aching Muscles or Joints
- ☐ ☐ Swollen Joints
- ☐ ☐ Back or Shoulder Pains
- ☐ ☐ Weakness in Arms or Legs
- ☐ ☐ Painful Feet
- ☐ ☐ Trembling
- ☐ ☐ Numbness
- ☐ ☐ Leg Cramps
- ☐ ☐ Skin Problems
- ☐ ☐ Scalp Problems
- ☐ ☐ Itching or Burning Skin
- ☐ ☐ Bruise Easily
- ☐ ☐ Nervousness or Anxiety
- ☐ ☐ Nervous with Strangers
- ☐ ☐ Nail Biting
- ☐ ☐ Difficulty making Decisions
- ☐ ☐ Lack of Concentration
- ☐ ☐ Absent Minded/Loss of Memory
- ☐ ☐ Lonely or Depressed
- ☐ ☐ Frequent Crying
- ☐ ☐ Hopeless Outlook
- ☐ ☐ Difficulty Relaxing
- ☐ ☐ Worry a Lot
- ☐ ☐ Frightening Dreams or Thoughts
- ☐ ☐ Feeling of Desperation
- ☐ ☐ Shy or Sensitive
- ☐ ☐ Dislike Criticism
- ☐ ☐ Angered Easily
- ☐ ☐ Annoyed by Little Things
- ☐ ☐ Family Problems
- ☐ ☐ Problems at Work

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YES	NO		YES	NO	
☐	☐	Sexual Difficulties	☐	☐	Armpits or Groin Swelling
☐	☐	Change of Sexual Energy	☐	☐	Unusual Fatigue or Weariness
☐	☐	Considered Suicide	☐	☐	Difficulty Sleeping
☐	☐	Sought Psychiatric Help	☐	☐	Motion Sickness
☐	☐	Loss or Gain in Weight	☐	☐	Excessive Sweating
☐	☐	Loss of Appetite	☐	☐	Night Sweats
☐	☐	Always Hungry	☐	☐	Hot Flashes
☐	☐	Frequently feel warmer or Colder than Others	☐	☐	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
☐	COFFEE	_____	☐	CORTISONE	_____	☐	TRANQUILIZERS	_____
☐	SMOKE	_____	☐	THYROID	_____	☐	MEDICINAL HERBS & TEAS	_____
☐	ALCOHOL	_____	☐	LAXATIVES	_____	☐	BIRTH CONTROL PILLS	_____
☐	ASPIRIN	_____	☐	HORMONES	_____			
☐	VITAMINS	_____	☐	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:*	