

# PATIENT REGISTRATION

## SHORELINE NATURAL MEDICINE CLINIC

NEW PATIENT:

UPDATE:

**PLEASE PRINT NAME:**

**DATE:**

Last: _____	First: _____	MI: _____
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Employer: _____	Occupation: _____	
Date of Birth: _____	Sex: Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Marital Status: Single: <input type="checkbox"/> Married: <input type="checkbox"/> Widowed: <input type="checkbox"/> Other: <input type="checkbox"/>		
Emergency Contact and Phone: _____		
Email (for newsletter and appointment purposes): _____		

**PRIMARY INSURANCE:**

**SECONDARY INSURANCE:**

Insurance Company: _____ Member # _____ Group # _____ Policy Holder's Name: _____ Policy Holder's SS#: _____ Policy Holders' Birth date: _____ Insurance Co. Address: _____ City: _____ State: _____ Zip: _____ Insurance Co. Phone #: _____ Co-Insurance? _____ Copay: _____	Insurance Company: _____ Member # _____ Group # _____ Policy Holder's Name: _____ Policy Holder's SS#: _____ Policy Holders' Birth date: _____ Insurance Co. Address: _____ City: _____ State: _____ Zip: _____ Insurance Co. Phone #: _____
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Patient's Relationship to Insured:  
 Self:  Spouse:  Child:  Other:

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 Self:  Spouse:  Child:  Other:

If your visit is related to an **AUTO ACCIDENT** or **WORK INJURY**, please complete the following:

<p style="text-align: center;"><b>WORK INJURY:</b></p> Date of Accident: _____ Employer at the Time of Injury: _____ Insurance company: _____ L&I / claim #: _____ L&I Claim Manager: _____ Claim Manager Phone #: _____	<p style="text-align: center;"><b>CAR ACCIDENT:</b></p> Date of Accident: _____ Employer at the time: _____ Auto Insurance Company: _____ Claim #: _____ Auto Insurance Claim Agent: _____ Agent's Phone #: _____
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**I AUTHORIZE** my insurance company to pay directly to Dr. Pinault / Shoreline Natural Medicine Clinic for my medical care and the release of any medical information necessary to process these claims.

**I UNDERSTAND THAT I AM RESPONSIBLE** for knowing my insurance coverage for complementary care, including copays, deductables, and responsible portions.

**I UNDERSTAND THAT CANCELLATION** or missed visits without 24 hour notice may result in a missed visit charge.

**I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**, describing how my health information may be used and disclosed. The above information is complete and accurate to the best of my knowledge.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SHORELINE NATURAL MEDICINE CLINIC**  
**DETAILED PATIENT QUESTIONNAIRE**

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

Today's Date: \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU?** \_\_\_\_\_

**MEDICAL HISTORY:**

What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_ Your age? \_\_\_\_\_

Please describe your health concerns for which you are seeking care: \_\_\_\_\_ Date of onset: \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list all Surgeries or Hospitalizations: \_\_\_\_\_ Date: \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list and scars you have from surgeries, cosmetic procedures, injuries or piercings:

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

Please list all Medications or Vitamins and doses:

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

Who is your primary care provider?

\_\_\_\_\_  
Other Specialists you see:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies:

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

Immunizations: (last date of) Influenza: \_\_\_\_\_ Tetanus: \_\_\_\_\_ Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status: Single:  Married:  Widowed:  Partnered:  Other:

If in relationship, is it emotionally and physically supportive to you? Yes  No

Do you have a "Living Will"? Yes  No  Would like information about Health Care Directives or Durable Power of Attorney? Yes  No

Please list what you feel is most stressful in your life (work, chemical exposures, stress, lack of rest):

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

**DETAILED HEALTH QUESTIONNAIRE (continued)**

Do you smoke tobacco or marijuana? Yes  No  If yes, how many cigarettes each day? \_\_\_\_\_

Please describe your diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

How many ounces of water do you drink daily: \_\_\_\_\_ Number of fruits, vegetables daily: \_\_\_\_\_

How many cups of coffee daily: \_\_\_\_\_ Tea: \_\_\_\_\_ number of alcoholic drinks \_\_\_\_\_ daily /weekly

Are you relaxed when you eat? Yes  No  You eat out \_\_\_\_\_ times per week

Do you exercise? Yes  No  Type: \_\_\_\_\_ times per week \_\_\_\_\_

**FAMILY HISTORY: Please indicate which blood relative has experienced: (ex. MGM = maternal grand mother)**

Breast or Uterine Cancer: \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Ovarian Cancer: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_

Colon Cancer: \_\_\_\_\_

Mental Illness: \_\_\_\_\_

Other Cancer: \_\_\_\_\_

Reaction to Anesthesia: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Stroke: \_\_\_\_\_

Arthritis: \_\_\_\_\_

Tuberculosis: \_\_\_\_\_

Thyroid Disease: \_\_\_\_\_

Alzheimer's or Dementia: \_\_\_\_\_

**WOMEN: please indicate:**

Date of first menses \_\_\_\_\_

Date of last menses \_\_\_\_\_

# days (average) you bleed \_\_\_\_\_

# day of total cycle (ex. 28) \_\_\_\_\_

Sexual abuse Yes  No

Pain with urination Yes  No

Pain with intercourse Yes  No

Date of last PAP \_\_\_\_\_

Date of last mammogram \_\_\_\_\_

Breast lumps Yes  No

Do you do regular self breast exams? Yes  No

Number of pregnancies: \_\_\_\_\_ Births: \_\_\_\_\_

Type of birth control \_\_\_\_\_

Date of last DEXA \_\_\_\_\_

Satisfied with your sexual experience? Yes  No

**MEN: please indicate:**

Date of last physical exam \_\_\_\_\_

Date of last PSA \_\_\_\_\_

Last PSA value \_\_\_\_\_

Testicular pain Yes  No

Sexual abuse Yes  No

Penile discharge Yes  No

Slow or thin urine stream Yes  No

Difficulty starting urination Yes  No

Pain with urination Yes  No

Diagnosis of prostatitis Yes  No

Diagnosis of prostate cancer Yes  No

Have you have had a vasectomy Yes  No

Satisfied with your sexual experience? Yes  No

**I. ADRENAL / NEUROTRANSMITTER: please indicate if you experience:**

Fatigue lately \_\_\_\_\_

I do not think well of myself \_\_\_\_\_

Too tired to do usual activities \_\_\_\_\_

I don't enjoy my usual activities \_\_\_\_\_

Difficulty falling asleep \_\_\_\_\_

My mind feels slow, difficult to \_\_\_\_\_

Have restless sleep \_\_\_\_\_

make decisions. \_\_\_\_\_

Wake frequently at night, not \_\_\_\_\_

I feel restless, like I must move \_\_\_\_\_

returning to sleep \_\_\_\_\_

I don't feel very creative now \_\_\_\_\_

Wake early, not returning to sleep \_\_\_\_\_

I don't feel very social now \_\_\_\_\_

I want to sleep more than 8 hours / night \_\_\_\_\_

I wish I were more interested in \_\_\_\_\_

My appetite is low lately \_\_\_\_\_

my family \_\_\_\_\_

My appetite is high lately \_\_\_\_\_

I don't feel like I am having much fun \_\_\_\_\_

I have experienced weight loss lately \_\_\_\_\_

I don't feel inspired to advance \_\_\_\_\_

I have experienced weight gain lately \_\_\_\_\_

my work or earnings \_\_\_\_\_

I often feel sad \_\_\_\_\_

I am afraid I am criticized \_\_\_\_\_

I have difficulty concentrating \_\_\_\_\_

I often feel anxious \_\_\_\_\_

I have difficulty focusing \_\_\_\_\_

I feel something is wrong with me \_\_\_\_\_

I think of dying often \_\_\_\_\_

I have difficulty in work relationships \_\_\_\_\_

Life doesn't have much purpose now \_\_\_\_\_

**PLEASE CHECK IF YOU HAVE OR HAVE EXPERIENCED ANY OF THE FOLLOWING:**

**NEUROLOGICAL:**

Vision changes \_\_\_\_\_  
Dizziness \_\_\_\_\_  
Seizures or convulsions \_\_\_\_\_  
Memory loss \_\_\_\_\_  
Confusion \_\_\_\_\_  
Radiating pain \_\_\_\_\_  
Loss of muscle function \_\_\_\_\_  
Tingling sensation in limbs \_\_\_\_\_  
Burning sensation \_\_\_\_\_  
Migraines \_\_\_\_\_

Other: \_\_\_\_\_

**MUSCULOSKELETAL:**

Bone deformity \_\_\_\_\_  
Bone loss \_\_\_\_\_  
Joint pain \_\_\_\_\_  
Joint swelling \_\_\_\_\_  
Low back pain \_\_\_\_\_  
Mid back pain \_\_\_\_\_  
Neck pain \_\_\_\_\_  
Numbness or tingling \_\_\_\_\_  
Restless legs, must move \_\_\_\_\_  
Muscle spasms \_\_\_\_\_  
Poor posture \_\_\_\_\_  
Snapping, cracking joints \_\_\_\_\_  
Trigger finger \_\_\_\_\_

Other: \_\_\_\_\_

**GASTROINTESTINAL – A:**

Belching / burping \_\_\_\_\_  
Quickly feel full \_\_\_\_\_  
Low appetite \_\_\_\_\_  
Difficult, small stools \_\_\_\_\_  
History of anemia \_\_\_\_\_  
Loss of taste or odors \_\_\_\_\_  
Pain with eating \_\_\_\_\_  
Heartburn \_\_\_\_\_  
Constipation \_\_\_\_\_  
Difficulty swallowing \_\_\_\_\_  
Diagnosed with GERD \_\_\_\_\_  
Gas just after eating \_\_\_\_\_  
Stomach pain \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Autoimmune disease \_\_\_\_\_

**ENDOCRINE:**

Infertility \_\_\_\_\_  
Hypoglycemia \_\_\_\_\_  
Shaky before next meal \_\_\_\_\_  
Faint or low energy  
between meals \_\_\_\_\_  
Thyroid disease \_\_\_\_\_

Other: \_\_\_\_\_

**HEAD:**

Blurred vision \_\_\_\_\_  
Vision changes \_\_\_\_\_  
Loss of clarity of vision \_\_\_\_\_  
Glaucoma / cataracts \_\_\_\_\_  
Hearing loss \_\_\_\_\_  
Ringing in the ears \_\_\_\_\_  
Nasal congestion \_\_\_\_\_  
Chronic sinusitis \_\_\_\_\_  
Bleeding gums \_\_\_\_\_  
Recurrent sore throat \_\_\_\_\_  
Seasonal allergies \_\_\_\_\_  
Headaches \_\_\_\_\_  
Migraines \_\_\_\_\_  
Hair loss \_\_\_\_\_  
Grinding teeth \_\_\_\_\_

Other: \_\_\_\_\_

**GASTROINTESTINAL – B:**

Bloated feeling after food \_\_\_\_\_  
Nausea or vomiting \_\_\_\_\_  
Frequent bowel movements \_\_\_\_\_  
Alternating constipation /  
Loose stools \_\_\_\_\_  
Frequent loose stools \_\_\_\_\_  
Brittle hair, nails \_\_\_\_\_  
Undigested food in stool \_\_\_\_\_  
Mucous in stool \_\_\_\_\_  
Dark blood in stool \_\_\_\_\_  
Pain under right ribs \_\_\_\_\_  
Chest of pain at sternum \_\_\_\_\_  
Chest pain \_\_\_\_\_  
Palpitations \_\_\_\_\_

**CARDIOVASCULAR:**

Shortness of breath \_\_\_\_\_  
Swelling of feet, ankles \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Blot clots \_\_\_\_\_  
Anemia \_\_\_\_\_  
Irregular heart beat \_\_\_\_\_  
Mitral valve prolapse \_\_\_\_\_  
Murmur \_\_\_\_\_

Other: \_\_\_\_\_

**RESPIRATORY:**

Cough \_\_\_\_\_  
Asthma \_\_\_\_\_  
Wheezing \_\_\_\_\_  
Shortness of breath \_\_\_\_\_  
Chronic infections \_\_\_\_\_  
Emphysema \_\_\_\_\_  
Recurrent colds \_\_\_\_\_  
Recurrent bronchitis \_\_\_\_\_

Other: \_\_\_\_\_

**GASTROINTESTINAL – C:**

Much flatulence /rectal gas \_\_\_\_\_  
Pencil thin stools \_\_\_\_\_  
Low abdominal pain \_\_\_\_\_  
Fiber aggravates pain \_\_\_\_\_  
Diarrhea \_\_\_\_\_  
Loose stools \_\_\_\_\_  
Abdominal pain \_\_\_\_\_  
Diagnosed with IBS \_\_\_\_\_  
Incontinence /fecal seepage \_\_\_\_\_  
Bright blood in stool \_\_\_\_\_  
Anal itching \_\_\_\_\_  
Mucous in stools \_\_\_\_\_  
Dry, hard stools \_\_\_\_\_  
Incomplete voiding of stool \_\_\_\_\_