PATIENT REGISTRATION

Doctor Pia | Your Health and Wellness Doctor

❶ PATIENT DEMOGRAPHIC INFORMATION

Last Name: | First Name: | MI | Date of Birth: | Age: | Sex: ☐ Male ☐ Female

Spouse's First Name: | Nickname: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Minor ☐ Separated ☐ Widowed ☐ Partnered

Mailing Address: | Address Status: ☐ Permanent ☐ Seasonal | Local Home Phone: ( )

City, State, Zip Code: | Best Way to Reach You: ☐ Home ☐ Cell ☐ Work | Cell Phone: ( )

Employment Status: ☐ Retired ☐ Employed ☐ Student ☐ Unemployed | Employer: | Job Title: | Work Phone: ( )

Referred by: ☐ Family ☐ Friend ☐ Health Care Provider ☐ Facebook ☐ Online Search ☐ Other | Specific Referral Source:

Email Address (for invoices): | Would you like to receive my eNewsletter? ☐ Yes ☐ No

❷ IN CASE OF EMERGENCY

Name of local friend or relative: | Relationship to Patient: | Phone: ( )

Name of your family physician: | Phone: ( ) | Name of your OB/GYN | Phone: ( )

❸ GENERAL HEALTH HISTORY

Have you been treated by a Functional Medicine Doctor before? ☐ Yes ☐ No | Date of Most Recent Lab_____

Patient History: Place a mark in the box next to each condition you have or have had in the past. ☐ None Apply ☐ See Attached

☐ Allergies	☐ Corticosteroid Use	☐ High Blood Pressure	☐ Heart Disease	☐ Skin Problems
☐ Anxiety/Depression	☐ Cander	☐ Fatigue	☐ History of Neck Pain	☐ Thyroid Problems
☐ Arthritis	☐ Diabetes	☐ Gall Bladder	☐ History of Back Pain	☐ Weight Gain
☐ Antobiotic Use	☐ Digestive Problems	☐ High Cholesterol	☐ Hormones	☐ Pregnant
☐ Autoimmune	☐ Dizziness	☐ Headaches	☐ Stroke	- # weeks:_____

☐ Family History: ☐ Cancer ☐ Cardiovascular Problems ☐ Diabetes ☐ High Blood Pressure ☐ None Apply

Relevant Incidents:	Description:	Date:
☐ Recent Injuries		
☐ Surgeries		

Number of Births:_____ Number of C-sections:_____

❹ MEDICATIONS

Do you take medications? ☐ Yes ☐ No

If Yes, List Below or ☐ See Attached

4A SUPPLEMENTS

Do You Take Vitamins, Herbs, Supplements or Minerals? ☐ Yes ☐ No

If Yes, List Below or ☐ See Attached

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Patient Name: **Date:**

❺ LIST CURRENT COMPLAINTS:

1.

2.

3.

4.

5.

What Activities Does Discomfort Interfere With?

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

How Often Do You Experience Your Symptoms?

☐ Constantly (76% - 100%) ☐ Frequently (51%- 75%)

☐ Occasionally (26% - 50%) ☐ Intermittently (0 - 25%)

5A MAIN HEALTH GOALS:

1.

2.

3.

4.

5.

What Relevant Tests Have You Had Done?

☐ None ☐ X-rays ☐ MRI ☐ CT Scan ☐ Labs

Who Have You Seen for Symptoms?

☐ No One ☐ M.D. ☐ Physical Therapist

☐ Acupuncturist ☐ Nutritionist

Rate How You Feel Today

☐ 0 No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable Pain

❻ HEALTHY LIVING

What kind of exercise do you do?

When do you exercise? ☐ AM ☐ PM ☐ Lunchtime ☐ Weekends Only | How long is your workout?

Number of fruit servings per day: _____ Breakfast _____ Lunch _____ Dinner _____ Snack

Number of vegetable servings per day: _____ Breakfast _____ Lunch _____ Dinner _____ Snack

Number of 8oz glasses of water per day: 1 2 3 4 5 6 7 8 9 10 | What is your can't live without favorite food? | Diet: ☐ Keto ☐ Vegan ☐ Veggie ☐ Paleo

How Many Times a Week Do You Eat Out? | How Many Times a Week Do You Eat Fast Food?

Number of Alcoholic drinks per week _____ | Number of cups of coffee per day _____ | Number of Sodas per day _____

Hours of sleep per night? 5-6 6-7 7-8 8 or more | Difficult going sleep? ☐ Yes ☐ No | Difficult staying asleep? ☐ Yes ☐ No

Stress (Scale of 1 to 6 with 6 being the highest)

Work	Kids	Friends	Family	Money	Health
1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6

How positive are you? 1 2 3 4 5 6 7 8 9 10 | How healthy do you think you are? 1 2 3 4 5 6 7 8 9 10 | Do you want to lose weight? ☐ Yes ☐ No

❼ PAYMENT AND INVOICING (payment is due at the time of service)

☐ I understand that I must provide 24 hours notice to cancel or reschedule an appointment, and that if I do not, charges will still apply.

The information provided on this form is true to the best of my knowledge, and I will inform you of any changes in my health, demographics or insurance when applicable. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or my insurance company to release information required to process my claims and that, otherwise, it will be kept confidential in accordance with state law.

Patient /Guardian Signature: Date:

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Patient Name: **Date:**

INSTRUCTIONS: Fill in only the circles which apply to you.
●○○MILD symptoms
○●○MODERATE symptoms
○○●SEVERE symptoms
○○○**Leave circles BLANK if they don't apply to you.**

1 2 3 GROUP 1

1 ○○○Acid foods upset
2 ○○○Get chilled often
3 ○○○Pulse speeds after meals
4 ○○○Keyed up - fail to calm
5 ○○○Cut heals slowly
6 ○○○Unable to relax; startles easily
7 ○○○Extremities cold, clammy
8 ○○○Strong light irritates
9 ○○○Heart pounds after retiring
10 ○○○"Nervous" Stomach
11 ○○○Appetite reduced
12 ○○○Fever easily raised
13 ○○○Neuralgia-like pains
14 ○○○Sour stomach often

GROUP 2

15 ○○○Joint stiffness on arising
16 ○○○Muscle-leg-toe cramps at night
17 ○○○Eyelids swollen, puffy
18 ○○○Indigestion soon after meals
19 ○○○Always seems hungry; feels "lightheaded" often
20 ○○○Digestion rapid
21 ○○○Breathing irregular
22 ○○○Difficulty swallowing
23 ○○○Constipation diarrhea alternating
24 ○○○"Slow starter"
25 ○○○Get "chilled infrequently
26 ○○○Perspire easily
27 ○○○Circulation poor, sensitive to cold
28 ○○○Subject to colds, asthma, bronchitis

GROUP 3

29 ○○○Eat when nervous
30 ○○○Excessive appetite
31 ○○○Hungry between meals
32 ○○○Irritable before meals
33 ○○○Get "shaky" if hungry
34 ○○○Fatigue, eating relieves
35 ○○○"Lightheaded" if meals delayed
36 ○○○Heart palpitates if meals missed or delayed
37 ○○○Afternoon headaches
38 ○○○Awaken after few hours of sleep - hard to get back to sleep
39 ○○○Crave candy or coffee in afternoon
40 ○○○Moods of depression - "blues" or melancholy

1 2 3

41 ○○○Abnormal craving for sweets or snacks

GROUP 4

42 ○○○Hands and feet go to sleep easily, numbness
43 ○○○Sigh frequently, "air hunger"
44 ○○○High altitude discomfort
45 ○○○Opens windows in closed rooms
46 ○○○Susceptible to colds and fevers
47 ○○○Afternoon "yawner"
48 ○○○Get "drowsy" often
49 ○○○Swollen ankles, worse at night
50 ○○○Muscle cramps, worse during exercise; get "charley horses"
51 ○○○Shortness of breath on exertion
52 ○○○Dull pain in chest or radiating into left arm, worse on exertion
53 ○○○Bruise easily, "black and blue" spots
54 ○○○Tendency to anemia
55 ○○○"Nose bleeds" frequent
56 ○○○Noises in head or "ringing in ears"
57 ○○○Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

58 ○○○Dizziness
59 ○○○Dry Skin
60 ○○○Burning feet
61 ○○○Blurred vision
62 ○○○Itching skin and feet
63 ○○○Excessive falling hair
64 ○○○Frequent skin rashes
65 ○○○Bitter, metallic taste in mouth in mornings
66 ○○○Bowel movements painful or difficult
67 ○○○Worrier, feels insecure
68 ○○○Feelings queasy; headaches over eyes
69 ○○○Greasy foods upset
70 ○○○Stools light colored
71 ○○○Skin peels on foot soles
72 ○○○Pain between shoulder blades
73 ○○○Use laxatives
74 ○○○Stools alternate from soft to watery

1 2 3

75 ○○○History of gallbladder attacks or gallstones
76 ○○○Dreaming, nightmare type bad dreams
77 ○○○Bad breath (halitosis)
78 ○○○Milk products cause distress
79 ○○○Sensitive to hot weather
80 ○○○Burning or itching anus
81 ○○○Crave sweets

GROUP 6

82 ○○○Loss of taste for meat
83 ○○○Lower bowel gas several hours after eating
84 ○○○Burning stomach sensations, eating relieves
85 ○○○Coated tongue
86 ○○○Pass large amounts of foul-smelling gas
87 ○○○Indigestion ½ - 1 hour after eating; may be up to 3-4 hrs.
88 ○○○Mucous colitis or "irritable bowel"
89 ○○○Gas shortly after eating
90 ○○○Stomach "bloating" after eating

GROUP 7A

100 ○○○Insomnia
101 ○○○Nervousness
102 ○○○Can't gain weight
103 ○○○Intolerance to heat
104 ○○○Highly emotional
105 ○○○Flush easily
106 ○○○Night sweats
107 ○○○Thin, moist skin
108 ○○○Inward trembling
109 ○○○Heart palpitates
110 ○○○Increased appetite without weight gain
111 ○○○Pulse fast at rest
112 ○○○Eyelids and face twitch
113 ○○○Irritable and restless
114 ○○○Can't work under pressure

GROUP 7B

115 ○○○Increase in weight
116 ○○○Decrease in appetite
117 ○○○Fatigue easily
118 ○○○Ringing in ears
119 ○○○Sleepy during day

Patient Name: **Date:**

1 2 3
120 ○○○Sensitive to cold
121 ○○○Dry or scaly skin
122 ○○○Constipation
123 ○○○Mental sluggishness
124 ○○○Hair coarse, falls out
125 ○○○Headaches upon arising, wear off during day
126 ○○○Slow pulse, below 65
127 ○○○Frequency of urination
128 ○○○Impaired hearing
129 ○○○Reduced initiative

GROUP 7C
130 ○○○Failing memory
131 ○○○Low blood pressure
132 ○○○Increased sex drive
133 ○○○Headaches, "splitting or rending" type
134 ○○○Decreased sugar tolerance

GROUP 7D
135 ○○○Abnormal thirst
136 ○○○Bloating of abdomen
137 ○○○Weight gain around hips or waist
138 ○○○Sex drive reduced or lacking
139 ○○○Tendency to ulcers, colitis
140 ○○○Increased sugar tolerance
141 ○○○Women; menstrual disorders
142 ○○○Young girls; lack of menstrual functions

GROUP 7E
143 ○○○Dizziness
144 ○○○Headaches
145 ○○○Hot flashes
146 ○○○Increased blood pressure
147 ○○○Hair growth on face or body (female)
148 ○○○Sugar in urine (not diabetes)
149 ○○○Masculine tendencies (female)

GROUP 7F
150 ○○○Weakness, dizziness
151 ○○○Chronic fatigue
152 ○○○Low blood pressure
153 ○○○Nails weak, ridged
154 ○○○Tendency to hives

1 2 3
155 ○○○Arthritic tendencies
156 ○○○Perspiration increase
157 ○○○Bowel disorders
158 ○○○Poor circulation
159 ○○○Swollen ankles
160 ○○○Crave salt
161 ○○○Brown spots or bronzing of skin
162 ○○○Allergies - tendency to asthma
163 ○○○Weakness after cold, influenza
164 ○○○Exhaustion - muscular and nervous
165 ○○○Respiratory disorders

GROUP 8
166 ○○○Apprehension
167 ○○○Irritability
168 ○○○Morbid fears
169 ○○○Never seems to get well
170 ○○○Forgetfulness
171 ○○○Indigestion
172 ○○○Poor appetite
173 ○○○Craving for sweets
174 ○○○Muscular soreness
175 ○○○Depression; feelings of dread
176 ○○○Noise sensitivity
177 ○○○Acoustic hallucinations
178 ○○○Tendency to cry without reason
179 ○○○Hair is coarse and/or thinning
180 ○○○Weakness
181 ○○○Fatigue
182 ○○○Skin sensitive to touch
183 ○○○Tendency toward hives
184 ○○○Nervousness
185 ○○○Headaches
186 ○○○Insomnia
187 ○○○Anxiety
188 ○○○Anorexia
189 ○○○Inability to concentrate; confusion
190 ○○○Frequent stuffy nose; sinus infections
191 ○○○Allergy to some foods
192 ○○○Loose joints

MUSCULO-SKELETAL
193 ○○○Low back pain
194 ○○○Pain between
195 ○○○Neck pain
196 ○○○Arm pain

1 2 3
197 ○○○Joint Pain / Stiffness
198 ○○○Walking problems
199 ○○○Difficult Chewing
200 ○○○Clicking jaw
201 ○○○General Stiffness

NERVOUS SYSTEM
202 ○○○Nervous
203 ○○○Numbness
204 ○○○Paralysis
205 ○○○Dizziness
206 ○○○Forgetfulness
207 ○○○Confusion / Depression
208 ○○○Fainting
209 ○○○Convulsions
210 ○○○Cold / Tingling Extremities
211 ○○○Stress

FEMALE ONLY
212 ○○○Very easily frustrated
213 ○○○Premenstrual tension
214 ○○○Painful menses
215 ○○○Depressed feelings before menstruation
216 ○○○Menstruation excessive and prolonged
217 ○○○Painful breasts
218 ○○○Menstruate too frequently
219 ○○○Vaginal discharge
220 ○○○Hysterectomy / ovaries removed
220 ○○○Menopausal hot flashes
220 ○○○Menses scanty or missed
220 ○○○Acne, worse at menses
220 ○○○Depression of long standing

MALE ONLY
220 ○○○Prostate trouble
220 ○○○Urination difficult or dribbling
220 ○○○Night urination frequent
220 ○○○Depression
220 ○○○Pain on inside of legs or heels
220 ○○○Feeling of incomplete bowel evacuation
220 ○○○Lack of energy
220 ○○○Migrating aches and pains
220 ○○○Tire too easily
220 ○○○Avoids activity
220 ○○○Leg nervousness at night
220 ○○○Diminished sex drive