Inphinite Wellness

Patient Registration and Personal History

Patient Full Name: _____ **DOB:** _____ **Age:** _____ **Sex:**

☐ female ☐ male **Marital Status:** ☐ single ☐ married ☐ separated ☐ divorced **Home Phone:**

_____ **Cell Phone:** _____ **Work Phone:**

_____ **Other Phone:** _____ **Email Address:**

_____ **Address:**

_____ **City, State,**

Zip: _____ **Immediate**

Family (list members of household with their ages):

Spouse: _____ _____

_____ _____

_____ _____

Education (check highest achieved): ☐ grade school ☐ high school ☐ college ☐ other

Occupation: _____ **Employer:** _____

Referred By: _____

Responsible Party (if not patient):

Full Name: _____Sex: _____ Age: _____

Relationship to Patient: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email

Address: _____

Chief Complaint: _____

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Past Health

Childhood Illnesses: ☐ measles ☐ German measles ☐ chicken pox ☐ mumps ☐ other

Vaccinations: ☐ smallpox ☐ tetanus ☐ DPT ☐ polio ☐ measles ☐ German measles ☐ other Have you had any vaccination reactions, if so please explain: _____

Hospitalizations (use back of page if needed):

Date Diagnosis Treatment Hospital _____ _____

_____ _____ _____ _____

_____ _____

Past Health Problems (check if you have experienced any of the following):

☐ asthma ☐ hay fever ☐ other lung disease ☐ head or spinal injuries ☐ thyroid disease ☐ other

GI disease ☐ seizures or fainting ☐ kidney disease ☐ prostate trouble ☐ female trouble ☐

sinusitis ☐ arthritis

☐ heart disease ☐ high blood pressure ☐ muscle disease ☐ psychiatric disorder ☐ cancer ☐ diabetes ☐ ulcer ☐

hepatitis ☐ rheumatic fever

Family History (include parents, grandparents, brothers, sisters, etc.):

☐ high blood pressure ☐ diabetes ☐ cancer ☐ stroke ☐TB

☐ asthma ☐ hives ☐ hay fever ☐ rashes ☐ other

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Present Health

Present Health Problems (check any you have had in the past 4-6 weeks):

☐ weight loss ☐ tremors ☐ problems with teeth/gums ☐ poor appetite ☐ too much appetite ☐ cough ☐ insomnia ☐ serious headaches ☐ shortness of breath ☐ loss of energy ☐ chest pain ☐ tight chest ☐ night sweats ☐ dizziness ☐ hair loss ☐ poor coordination ☐ sore throat ☐ chills ☐ earaches ☐ swollen feet/ankles ☐ rapid pulse ☐ fainting ☐ sores that don't heal ☐ localized weakness ☐ increased thirst ☐ blood loss

Alcohol Use: ☐ none ☐ moderate ☐ need to cut down

Street Drugs: ☐ none ☐ moderate ☐ need to cut down

Cigarettes: ☐ none ☐ moderate ☐ need to cut down

Medications (list those taken in the past 3 months):

Name of medicine and dose Why do you take this? _____

_____ _____

_____ _____

_____ Do you have any history of reacting to medications, if so please explain: _____

_____

Vitamins/Supplements:

Name of vitamin or supplement Why do you take this? _____

_____ _____

_____ _____

_____

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Check if bothered by any of the following:

Eyes: ☐ itching ☐ swelling ☐ burning ☐ discharge ☐ excess tearing

Ears: ☐ itching ☐ fullness ☐ popping ☐ frequent infections

Nose: ☐ sneezing ☐ itching ☐ discharge ☐ mouth breathing ☐ runny nose

Throat: ☐ soreness ☐ postnasal discharge ☐ itching palate ☐ AM mucus

Chest: ☐ cough ☐ pain wheezing ☐ sputum ☐ shortness of breath

Skin: ☐ rash ☐ eczema ☐ psoriasis ☐ whelps ☐ cosmetics

Fumes: ☐ gasoline ☐ kerosene ☐ diesel ☐ fuel ☐ hairspray ☐ perfumes ☐ paints ☐ chemicals ☐ deodorants ☐ detergents ☐ paints ☐ insecticides

Fibers: ☐ cotton ☐ synthetics ☐ wool ☐ other _____ *Animal*

Dander: ☐ horses ☐ cats ☐ dogs ☐ other _____ *Insects:* ☐ bees ☐ spiders ☐ fleas ☐ other _____ *Weather:* ☐ muggy weather ☐ changes in weather ☐ cold ☐ heat ☐ air conditioning *Seasonal Allergies:* ☐ flowers ☐ weeds ☐ trees ☐ grasses ☐ poison oak ☐ dust

☐ affected more in Spring ☐ affected more in Fall ☐ Spring and Fall are equally the same *Food Allergies*

(list any food which bothers you): _____

_____

Misc.: ☐ mold ☐ newspapers ☐ latex gloves ☐ smoke ☐ alcohol

Others: _____

_____