Welcome to Kim Brown Wellness

Patient Registration *Confidential*

Today's date: _____ Age _____ Birth date: ____/____/____

Patient's name _____

Address _____

City _____ State _____ Zip code _____

Cell phone _____

Sex: M/F Marital status: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Partnered

Referred by _____

Patient's employer _____ Occupation _____

Spouse/guardian's name _____ Birth date: ____/____/____

Cell phone _____

Emergency contact (name) _____

Emergency contact (relationship) _____

Emergency contact (cell) _____

Payment required at time of service. I will be paying today by …

☐ CASH ☐ CHECK ☐ MASTERCARD/VISA

_____ _____

Patient signature here Guardian's signature if patient is a minor Today's date

Help Me Get To Know You

Please bring any current labs to your appointment

Personal Information

Name _____ Referred by _____

Today's date: _____ Age _____ birth date: ____/____/____

Marital status: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Partnered

Children _____

Occupation _____

General health Information

Height _____ Weight _____

Blood pressure ____/____ Date last taken _____

Family physician _____

What are the problems or concerns you would like to address? _____

_____

_____

_____

Was there a time/event in your life that triggered the problem(s)? _____

_____

_____

_____

Does anything make your symptoms better or worse? _____

_____

_____

_____

Diagnostic studies/ procedures you've had

Biopsy _____ Of what? _____ Date _____ Results _____

Blood Tests _____ Date _____ Where? _____

Bone Density _____ Date _____ Results? _____

Colonoscopy _____ Date _____ Results? _____

Mammogram _____ Date _____ Results? _____

PAP _____ Date _____ Results? _____

PSA _____ Date _____ Results? _____

Vaccines

Flu _____ Date _____

Pneumonia _____ Date _____

Shingles _____ Date _____

Tetanus _____ Date _____

HPV _____ Date _____

Other _____ Date _____

Other _____ Date _____

Other _____ Date _____

Medications

	Name	Dose	Frequency	Duration
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Supplements/vitamins

	Name	Dose	Frequency	Duration
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Allergy or adverse reactions to medication or latex

	Substance	Reaction
1.		
2.		
3.		
4.		
5.		

Surgical history

	Surgery	Date	Reason for surgery
1.			
2.			
3.			
4			
5.			

Dermatologic

☐ Yes ☐ No Do you have a chronic skin condition?
☐ Yes ☐ No Hair falling out?
☐ Yes ☐ No Do your nails split easily?

Headaches

☐ Yes ☐ No Tension?
☐ Yes ☐ No Migraines?

Endocrine

☐ Yes ☐ No Do you suffer from fatigue?
☐ Yes ☐ No Do you have insomnia?
☐ Yes ☐ No Do you obtain 8 hours of sleep each night?
☐ Yes ☐ No Do you have a hard time falling asleep?
☐ Yes ☐ No Do you have a hard time staying asleep?
☐ Yes ☐ No Have you had thyroid trouble?
☐ Yes ☐ No Have you been diagnosed with metabolic syndrome or insulin resistance?

Cardiovascular

☐ Yes ☐ No Do you have asthma?
☐ Yes ☐ No Do you get short of breathe climbing stairs?
☐ Yes ☐ No Have you had a heart attack?
☐ Yes ☐ No Have you had an abnormal EKG?
☐ Yes ☐ No Does your heart race or skip?
☐ Yes ☐ No Do you have high blood pressure

Urinary

☐ Yes ☐ No At night, do you usually have to get up to urinate?
☐ Yes ☐ No Have you ever had kidney stones? # _____

Gastrointestinal

☐ Yes ☐ No Have you been treated for ulcers?

Check symptoms that apply

☐ Heartburn	☐ Flatulence	☐ Abdominal pain
☐ Bloating	☐ Diarrhea	☐ Stomach aches
☐ Use of laxatives	☐ Gallbladder trouble	☐ Contipation
☐ Mucus In stools	☐ Other_____	☐ Other_____

Neurology

☐ Yes ☐ No Have you had head injuries?

☐ Yes ☐ No Have you ever had seizures?

☐ Yes ☐ No Are there times when you have trouble thinking clearly or explaining what you mean?

Skeletal

☐ Yes ☐ No Do you have arthritis? type?_____

☐ Yes ☐ No Do you have frequent muscle spasms?

☐ Yes ☐ No Do you experience restless legs?

Women only

Premenopause/menopause symptoms

Check all symptoms you are currently experiencing

- ☐ hot flashes
- ☐ night sweats
- ☐ mood swings
- ☐ low libido or ability to orgasm
- ☐ vaginal dryness
- ☐ irregular or absent menstrual cycle

First day of your last menstrual period? _____

a. How many **days** is your menstrual cycle?_____ **# days**

b. Menstrual flow lasts _____ **total # days**

c. Abnormally heavy _____ # days

- ☐ Yes ☐ No Do you have heavy bleeding?
- ☐ Yes ☐ No Do you have heavy &/or painful menstrual cycles?
- ☐ Yes ☐ No Have you been diagnosed with PCOS? (Polycystic Ovarian Syndrome)
- ☐ Yes ☐ No Are you currently using contraceptives?

  If "yes" what method? _____
- ☐ Yes ☐ No Are you trying to get pregnant?
- ☐ Yes ☐ No Have you had a miscarriage? #_____
- ☐ Yes ☐ No Have you had complication(s) with pregnancy?

  Describe: _____

  _____

  How many times have you been pregnant? _____
- ☐ Yes ☐ No Are you sexually active?
- ☐ Yes ☐ No Is intercourse painful?
- ☐ Yes ☐ No Are you experiencing abnormal vaginal discharge?
- ☐ Yes ☐ No Has your libido decreased from previously?

Men only

- ☐ Yes ☐ No Discharge from penis?
- ☐ Yes ☐ No Do you have a decrease In libido?
- ☐ Yes ☐ No Are your erections less strong?
- ☐ Yes ☐ No Inability to achieve or sustain an erection?

Immediate family Please complete to the best of your ability.

What is your ethnicity? _____

					Paternal		Maternal	
	Mother	Father	Brother	Sister	Grandfather	Grandmother	Grandfather	Grandmother
Age if living								
Age at death								
Cause of death								
Weight problems								
Tobacco use								
Alcohol use								
Mental Illness								
Cancer								
Diabetes								
Hypertension								
Heart problems								
High Cholesteral								
Thyroid disease								
Ulcers								
Arthritis								
Osteoporosis								
Other								

Personal habits

☐ Yes ☐ No Do you smoke? If "yes", how many per day?_____
Age when started?_____

☐ Yes ☐ No Do you use any other type of tobacco? Kind?_____

☐ Yes ☐ No Do you drink alcohol? # per week?_____

☐ Yes ☐ No Do you use recreational drugs? What?_____

☐ Yes ☐ No Is your hostility easily aroused?

☐ Yes ☐ No Do you feel depressed or lonely?

☐ Yes ☐ No Do you have crying spells?

☐ Yes ☐ No Do you eat 3 meals a day?

☐ Yes ☐ No Do you snack?

☐ Yes ☐ No Do you diet?

☐ Yes ☐ No Do you crave certain foods? What?_____

What do you do to cope with stress?_____

_____

_____

_____

_____

Thank you for taking your time to help me get to know you!