Date: _____ Account#: _____

Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital status: ☐ Single ☐ Married ☐ Widowed Sex: ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Street Address: _____ (Apt# _____)

City: _____ State: _____ Zip Code: _____ SS# _____ - _____ - _____

Home: (____) _____ Work phone: (____) _____ Ext_____ Cell phone: (____) _____

Date of Birth: _____ (month) / _____ (day) / _____ (year)

Employer/Name of School _____ ☐ Full Time ☐ Part Time

Spouse's name: _____ (last name) _____ (first name) _____ (initial) Spouse's Work Phone: (____) _____

How do you wish to be addressed? _____ Social Security # _____- _____-_____

PATIENT'S REFERRAL INFORMATION

(please circle one)

Referred by: _____ If referred by a friend, may we thank her or him? YES NO

Name(s) of other physician(s) who care for you: _____

_____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number (home): (_____) _____ Phone number (work): (_____) _____

Full Payment must be made at the time of visit.

Date: _____ Your Signature: _____

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card

Patient Name _____ Date of Birth _____

PAST MEDICAL HISTORY

Have you ever had any of the following illnesses? If so, please indicate with a check.

Measles_____	Mumps _____	Chicken Pox _____	Malaria _____	Pneumonia _____
Meningitis _____	Tuberculosis _____	Diptheria _____	Asthma _____	Heart Disease _____
Hypertension _____	Diabetes _____	Tonsillitis _____	Jaundice _____	

Please list any surgeries you have had : _____

_____

Menstrual Cycle:

Age of onset? _____ Periodicity? _____ Type? _____ Duration? _____

Pain? _____ L.M.P.? _____

Have you had any of the following? If so, how many?

Children _____ Miscarriages _____ Abortions _____

Habits:

Do you drink alcohol? Yes No If so, how much? _____

Do you smoke? Yes No If so, how much? _____

Do you drink coffee? Yes No If so, how much? _____

Do you drink tea? Yes No If so, how much? _____

Do you exercise? Yes No If so, how much? _____

How many meals do you eat per day? _____

How much water do you drink daily? _____

How many hours of sleep do you get? _____

How many bowel movements do you have daily? _____

FAMILY MEDICAL HISTORY

Father: Living _____ Deceased _____ Age: _____

Mother: Living _____ Deceased _____ Age: _____

Siblings: How many? _____

Have any family members had any of the following? If so, please indicate with a check.

Hypertension _____ Diabetes _____ Obesity _____ Asthma _____ Heart Disease _____ Cancer _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & PERMISION TO SHARE HEALTH INFORMATION

I have received a copy of the _____ Notice of Privacy Practices this day.
Yes ☐ No ☐

PATIENT SIGNATURE: _____
AUTHORIZED REPRESENTATIVE (Title): _____

DATE: _____

☐ Received, but refuses to sign

_____

_____

STAFF SIGNATURE: _____ DATE: _____

NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize _____ to disclose my health information to the following persons:
Persons to be notified (name, address, phone #)

1. _____
2. _____
3. _____

PATIENT SIGNATURE: _____
AUTHORIZED REPRESENTATIVE (Title): _____

Date: _____

NUTRITION EVALUATION
(To be completed by patient)

Name _____ (Last / First / Initial) Date _____

Address _____ Occupation _____

City _____ State _____ Zip _____

The following information will be helpful in the assessment and management of your particular problem areas.

Present Weight _____ Desired Weight _____ Height (no shoes) _____

Birth Weight _____ Weight at 18 yrs _____ Weight 1 yr ago _____

What is the main reason for your decision to lose weight? _____

_____

_____

When did you begin gaining excess weight? (give reasons, if known) _____

_____

_____

Previous diets you have followed:

Type?	When?	Results?

Describe your typical eating habits:

Breakfast	Lunch	Dinner
Time of day:	Time of day:	Time of day:
Where:	Where:	Where:
With whom:	With whom:	With whom:

Snack habits: (candy, cake, pastry, chips, sodas, ice cream, others)

What?	When?	How much?

Why do you have snacks at these times? Please answer in your own words (e.g. hunger, boredom, coffee break, etc.)

_____

_____

Food allergies _____ Food dislikes _____

Who plans meals? _____ Cooks? _____ Shops? _____ Is a list used? _____

How often do you eat at a restaurant? _____

How often do you eat "Fast Foods"? _____

Do you drink alcohol? _____ What? _____ How much daily? _____ Weekly? _____

Do you drink coffee/tea? _____ How much daily? _____

Do you smoke? _____ What? _____ How much daily? _____

Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

Foods you crave most _____ When? _____

Do you eat before going to bed? _____ What? _____

What are your worst food habits? _____

_____

_____

This information will help us determine your caloric expenditure:

Describe your usual energy level: _____

_____

Are your physical activities restricted for any medical reasons? _____

_____

Do you exercise? _____ Type? _____ How often? _____

Describe other sports and physical activities: _____

_____

Time spent watching TV: _____ (hours per week.)

In the following chart, please indicate the degree of overweight in your family:

Family Member	Age	Degree of overweight			
		None	Slight	Mod.	Very
Spouse					
Son(s)					
Daughter(s)					

Family Member	Age	Degree of overweight			
		None	Slight	Mod.	Very
Father					
Mother					
Brother(s)					
Sister(s)					