Rapha Integrative Family Clinic
Patient Registration Form

Please PRINT, Sign AND complete ALL sections below. Thank You.

Patient Information	Gender: ☐Male ☐Female			
Last Name	First Name	Middle Initial	Date of Birth	
Address:	City:	State:	Zip:	
Home Phone	Day Phone	Cell Phone	E-Mail	SSN
Preferred Language:	Race:	Ethnicity:		
Marital Status	☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Life Partner			
Preferred Method of Contact	☐Mail ☐Phone ☐Cell Phone ☐Texting			
Responsible Party	Parent or legal guardian who resides with patient	Gender: ☐Male ☐Female		
Last Name	First Name	Middle Initial	Date of Birth	
Address:	City:	State:	Zip:	
Home Phone	Day Phone	Cell Phone	E-Mail	SSN
Marital Status	☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Life Partner			
Preferred Method of Contact	☐Mail ☐Phone ☐Cell Phone ☐Texting	Relationship to patient		
Emergency Contact	(If different from responsible party)			
Last Name	First Name	Middle Initial	Relationship to patient:	
Address:	City:	State:	Zip:	
Home Phone	Day Phone	Cell Phone	E-Mail	
Insurance Information	Please present insurance card(s) to the front desk.			
Primary Insurance Name				
Name of Policy Holder	Date of Birth	Relationship to insured	☐ Self ☐ Spouse ☐ Child ☐ Other	
Policy Number:		Group Number:		
Secondary Insurance Name (If Applicable)				
Name of Policy Holder	Date of Birth	Relationship to insured	☐ Self ☐ Spouse ☐ Child ☐ Other	
Policy Number:		Group Number:		

FINANCIAL AGREEMENT: I hereby give lifetime authorization for payment of insurance benefits to be made directly to Rapha Integrative Family Clinic for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ I fully understand this agreement and consent will continue until cancelled by me in writing.
Initial

_____ I authorize Rapha Integrative Family Clinic to render necessary medical treatment to the above named minor or whom I am the parent or legal guardian.

SIGNATURE: _____ **DATE:** _____

* Parent Signature if patient is under 18: _____ Date: _____

NAME (Please print): _____ **RELATIONSHIP:** _____

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Current Heath Concerns	
1.	2.
3.	4.

Goals/Expectations

Health Care Providers	Please list your current medical doctor/primary care provider or other health care professionals (chiropractor, acupuncturist, counselor, etc.).
☐ None. ☐ I would like to establish primary care here.	1.
2.	3.

Preferred Pharmacy	Name: Address: Phone: Fax:

Medication	☐ I do not take any medications.
Medication Name	**Dosage**

Allergies	☐ No Known Allergies (* Medication/Food/Animal/Insect or any Treatment)
1.	
2.	
3.	
4.	
5.	

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Medical History	☐ No past Medical History

Please check if you have ever experienced any of the following conditions, and year of onset.

Condition	Year	Condition	Year
□ High Blood Pressure		□ Cancer Type:	
□ Diabetes		□ Acid Reflux	
□ High Cholesterol		□ Peptic ulcer/stomach pain	
□ Angina/chest pain		□ Heart Attack/heart disease	
□ Anxiety		□ Stroke	
□ Depression		□ Thyroid disease	
□ Asthma		□ Benign prostatic hypertrophy	
□ Atrial fibrillation		□ Migraine headaches	
□ Arthritis		□ Hepatitis □ A □ B □ C	
□ Blood clots/DVT		□ Liver Disease	
□ Anemia		□ Osteoporosis/osteopenia	
□ Seizure disorder		□ Gallbladder disease	
□ COPD (Emphysema)		□ Kidney disease	
□ MVA/other Traumas			

Surgeries and/or Hospitalization History	☐ No Surgical History	☐ No Hospitalization History
1.	2.	
3.	4.	

Health Maintenance	Please check if you have had any of the following exams & provide the date of the last exam.

Women Only:

Exams	Date	Exams	Date
□ Complete physical		□ GYN Exam	
□ Eye Exam		□ PAP smear	
□ Blood work up		History of abnormal PAP? Y/N	
□ EKG □ Echocardiogram		□ Mammogram	
□ FOBT (stool card for hidden blood) □ Colonoscopy		□ Breast Exam	
Vaccine (year): □ Influenza □ Pneumococcal □ Tetanus		□ DEXA scan	

Family Medical History	Please check if any family member has had any of the following conditions. □ Adopted

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Diagnosis	Mother	Father	Sister	Brother	Other	Other
High Blood Pressure						
High Cholesterol						
Diabetes						
Cancer/ Indicate Type:						
Stroke/Heart Attack						
Asthma/ Eczema/Hay fever						
Celiac Disease						
Allergies						
Thyroid Disease						
Blood Disease						
Osteoporosis						
Kidney disease						
Depression						
Mental illness						
Alzheimer's						
Tuberculosis						
Genetic Disorder						
Other (Please describe):						

Social History	
Current Occupation	
# of children (if any)	Female/s: Male/s:
Tobacco Use	□ Yes □ No □ Former □, Year Started: , Quit: Current packs/day:
Alcohol Use	□ Never □ Yes □ No □ Former/Year Quit: Type: □ Beer □ Liquor □ Wine □ Other:
Exercise/Activity	Level: □Vigorous □ Moderate □ Sedentary Times per week/month: Type of exercise:
Caffeine Use	□ Coffee ___ cups per day/week/month □ Tea □ Sodas □ Tablets □ Chocolates □ Other
Diet	I eat □ breakfast □ lunch □ dinner □ snack Describe if you have any foods that disagree with you/ or that you avoid (meats, etc.).
Stress	Rate level of stress (10=high, 1=low): Top stressors, if any:

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Review of Symptoms Circle Yes if experience within the last 1 month

Constitutional
- Good Recent Health Yes No
- Recent Weight Change Yes No
- Night sweats, Fever Yes No
- Fatigue Yes No

Cardiovascular
- Chest pain Yes No
- Palpitations Yes No
- Heart Trouble Yes No
- Swelling hands/ feet Yes No
- Lightheaded/ dizziness Yes No

Musculoskeletal
- Muscle pain/cramps Yes No
- Stiffness/Swelling Joints Yes No
- Trouble walking Yes No

Respiratory
- Shortness of Breath Yes No
- Cough Yes No
- Wheezing/Asthma Yes No
- Difficulty Breathing Yes No
- Sleep Apnea Yes No

Skin
- Rashes or itching Yes No
- Abnormal Nails Yes No
- Dry Skin Yes No
- Discolored Skin Yes No
- Body Odor/Excessive Sweat Yes No

Eyes
- Wear glasses/contacts Yes No
- Blurred/double vision Yes No
- Eye Disease/Injury Yes No
- Eye Pain Yes No

Allergies
- Food Allergies Yes No
- Hay Fever Yes No
- Chemical Sensitivity Yes No
- Insomnia Yes No

Endocrine
- Excessive thirst/urination Yes No
- Hair loss or unusual growth Yes No
- Cold hands/feet Yes No
- Hormone Problems Yes No

Urinary
- Blood in urine Yes No
- Pain/ Burning w/ urination Yes No
- Kidney Stones Yes No
- Recurrent Bladder Infections Yes No
- Difficulty with voiding Yes No

Ears/Nose/Throat/Mouth
- Hearing loss or ringing Yes No
- Sinus problems Yes No
- Sore throat/voice change Yes No

Neurological
- Frequent Headaches Yes No
- Paralysis or Tremors Yes No
- Seizures Yes No
- Numbness or Tingling Yes No

Male/Female
- Menstrual Problems Yes No
- Sexual Problems Yes No
- Testicle/Ovary Pain Yes No
- Infertility Yes No
- Breast Concerns (lumps, discharge/ pain) Yes No

Hemotologic/Lymphatic
- Anemia Yes No
- Bruise Easily Yes No
- Slow to Heal Yes No
- Enlarged Glands Yes No

Psychiatric
- Depression Yes No
- Anxiety/Panic Attacks Yes No
- Confusion/Memory Loss Yes No
- Suicidal Ideation/Attempts Yes No

Digestion
- Indigestion/Belching/Reflux Yes No
- Nausea/Vomiting Yes No
- Early Fullness Yes No
- Gas/Bloat Yes No
- Diarrhea Yes No
- Constipation Yes No
- Abdominal Pain Yes No
- Hemorrhoids Yes No
- Rectal Bleeding Yes No
- Mucous in Stool Yes No
- Abnormal Stool Color Yes No

OTHER CONCERNS NOT NOTED ABOVE:	**Women Only** Last menses start date: Birth Control Type? Age at Menopause: # of pregnancies/miscarriage/abortion: / / /

Provider's initial:
Date Reviewed: