



Patient Registration Form

Personal Information	Today's date: _____
Name: _____ Sex: _____ Date of Birth: _____ Age: _____	
Address: _____ SSN: _____	
City: _____ State: _____ Zip: _____	
Best Phone: _____ Alternate Phone: _____ Marital Status: _____	
E-Mail Address: _____	
Emergency Contact Person: _____ Relationship: _____ Phone #: _____	
Employer: _____ Occupation: _____ Work Phone: _____	
Referred to this office by: _____ Learned about Holistique Medical Center from: _____	

Insurance Information
Primary Ins.: _____ Group #: _____ Subscriber #: _____
Subscriber: _____ Relationship: _____ Insured's DOB: _____

Health Problems – Please list your main health problems, duration, and current treatments
1. _____
2. _____
3. _____
4. _____

Diet and Nutrition
List foods excluded from diet: _____
Vegetarian? _____ For how many years? _____ Vegan? _____ % of raw food in diet: _____
Do you buy organically grown foods? _____
Recreational Drug Use? _____ If yes, what and how long: _____
Drink Alcohol? _____ Daily amount: _____ Drink coffee or soft drinks? _____ Daily amount: _____
Drink Juice: _____ Daily Amount: _____ Cigarette or chew tobacco: _____ Daily amount: _____
How many glasses of water do you drink per day? _____ Are you constipated? _____
Do you exercise regularly? _____ How often? _____ What type? _____

24-hour Diet – Please indicate the foods and drinks you normally take for each meal.
Breakfast _____
Snack _____
Lunch _____
Snack _____
Dinner _____



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Personal History – Check all that applies			
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychological disorders
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cardio vascular disease	<input type="checkbox"/> Heart disorders	<input type="checkbox"/> Obesity
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Colitis	<input type="checkbox"/> Herpes genitalis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin disorders
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drug addiction	<input type="checkbox"/> Liver disorders	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Gastrointestinal disorders	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
			<input type="checkbox"/> Venereal disease
Other: _____			

Medical History
Last physical exam: _____ Do you have a living will? _____ If yes, please furnish our office w/ a copy.
Previous hospitalizations/major illnesses/surgeries: _____
Known Allergies: _____ Blood Type: _____
Medication taken in the last <u>two</u> months: _____
Medication & Supplements: _____
Significant dental work (Type and date): _____
Significant psychological trauma: _____
Occupational stress (chemical, physical, psychological) _____

Family History	Age if living	Age at death	Health concerns	Immunizations and Dates	
Mother				MMR	
Father				Polio	
Sibling (S/B)				Pertussis	
Sibling (S/B)				Tetanus	
Children (D/S)				Hepatitis B	

Family Health History - for all blood relatives, please indicate who has the following			
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cardio vascular disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychological disorders
<input type="checkbox"/> Allergies	<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart disorders	<input type="checkbox"/> Obesity
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes genitalis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin disorders
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug addiction	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastrointestinal disorders	<input type="checkbox"/> Liver disorders	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Breast cancer		<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer			<input type="checkbox"/> Venereal disease
Other: _____			