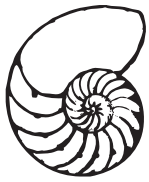

Pacific Coast Osteopathy

New Patient Registration Form

Patient's Name Birthdate

Social Security Number

Address

City State Zip

Home Phone ( ) Cell Phone ( )

Work Phone ( ) Email Address

Married ☐ Single☐ Divorced ☐ Legal Partnership ☐

Employer

Employer Address

City State Zip

Primary Care Physician Name

Primary Care Physician Phone ( )

Referred By

Reviewed By Dr. _____Date:_____

Patient's Name _____

Past Medical History
Check Conditions you have or have had in the past:

❑AIDS/HIV	❑Diabetes	❑Measles
❑Allergies	❑Dizziness	❑Migraines
❑Anxiety	❑Epilepsy/Seizures	❑Multiple Sclerosis
❑Appendicitis	❑Glaucoma	❑Osteoarthritis
❑Asthma	❑Heart Disease	❑Pneumonia
❑Back Pain	❑Hepatitis	❑Polio
❑Bleeding Disorder	❑Herpes	❑Rheumatoid Arthritis
❑Cancer	❑Hypertension	❑Skin Disease
❑Cholesterol	❑Kidney Disease	❑Thyroid Issues
❑Depression	❑Liver Disease	❑Other

Explain Other: _____

_____

_____

Family History
Check Conditions of your grandparents, parents or siblings and indicate with a letter such as: Mother M Father F Sister S Brother B Grandmother GM and Grandfather GF

Example: ☑ Diabetes *GM*

❑AIDS/HIV	❑Diabetes	❑Mental Disease
❑Allergies	❑Dizziness	❑Migraines
❑Anxiety	❑Epilepsy/Seizures	❑Multiple Sclerosis
❑Appendicitis	❑Glaucoma	❑Osteoarthritis
❑Asthma	❑Heart Attack	❑Pneumonia
❑Alcoholism	❑Heart Disease	❑Rheumatoid Arthritis
❑Back Pain	❑Hepatitis	❑Skin Disease
❑Bleeding Disorder	❑Herpes	❑Stroke
❑Cancer	❑Hypertension	❑Thyroid Issues
❑Cholesterol	❑Kidney Disease	❑Tuberculosis
❑Depression	❑Liver Disease	❑Other

Explain Other:

_____

_____

Reviewed By Dr. _____Date:_____

Patient's Name _____

Hospitalizations

Date/Reason

Traumas
(Include Car Accidents, Sports Accidents, Childhood Accidents, Mental Trauma's, Emotional Traumas)

Date/Description

Never Well Since (My health has never been the same since….)

Reviewed By Dr. _____Date:_____

Patient's Name _____

Social History

Tobacco Use:

☐ Daily Smoker, Packs Per Day_____
☐ Former Smoker: Date Quit _____
☐ Occasional Smoker Quantity_____

Alcohol Consumption:

☐ Daily Alcohol, Type_____
☐ Former Daily Alcohol, Date Quit_____
☐ Occasional Alcholol, Drinks per Week_____

Drug Use:

☐Daily Use, Type_____
☐Former Use, Date Quit _____
☐Occasional Drug Use, Type and Frequency_____

Sexual Activity:

☐Currently Sexually Active, Partners: ☐Male ☐Female ☐Both
☐Not Currently Sexually Active

Type of Birth Control or Safe Sex Practice _____
Lifetime Number of Partners _____

Diet/Nutrition (check those that apply and indicate how much)

☐ Coffee Drinks per Day _____
☐ Energy Drinks per Day _____
☐ Fast Food Meals per Week _____
☐ Chocolate Amount per Week_____
☐ Water Amount per Day _____

Reviewed By Dr. _____Date:_____

Patients Name _____

Describe Your Typical Diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Lifestyle

Describe what types of physical activity you do:

Type/Amount Per Week

_____

_____

_____

_____

_____

_____

Reviewed By Dr. _____Date:_____