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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name:_____Date of Birth:_____

Street:_____Country/City/State/Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____

May we leave a medically related message at home?_____ at work?_____ on cell?_____

Referred by:_____

Emergency contact:_____Phone:_____

Pharmacy:_____Phone:_____

Employer: _____
Marital status: Single / Married / Civil union / Divorced/ other (pls. describe)

Do you have a primary care provider? Y/N Name of other PCP if applicable: _____

Please list your health concerns in order of priority along with other practitioners you may be seeing for the condition:
1. _____
2. _____
3. _____
4. _____

What do you believe is causing your most important health concerns?

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Reason:	Date began:	Dose:

Supplements:	Reason:	Date began:	Dose:

**Please list any drug allergies: _____

PAST MEDICAL HISTORY: PLEASE LIST ANY SURGERIES:

Age or date:	Description:

Patients often desire communication between their healthcare providers. Do we have your permission to communicate verbally and in writing with your other providers regarding your healthcare?

___yes/no___

PAST MEDICAL HISTORY: PLEASE LIST ANY MAJOR ILLNESSES:

Age or date:	Description:

CURRENT HEALTH CONCERNS (Review of Systems): Please check normal or abnormal and briefly explain.

N A

__ __ Constitutional (Energy, weight, body temperature, sleep, general sense of well-being) _____
_____

__ __ Head: headaches, vertigo, injuries etc.)_____

__ __ Vision/eye problems: _____

__ __ Ear/nose/throat/mouth (allergies, infections etc.)_____

__ __ Cardiovascular: (high BP, cholesterol etc.) _____

__ __ Respiratory_____

__ __ Digestive tract issues: (changes in bowel habits, hemorrhoids, bloating, pain, etc.) _____
_____

__ __ Musculoskeletal concerns (arthritis, joint problems, osteoporosis, muscle pain, weakness):_____
_____

__ __ Skin (eczema, infections, rashes, etc.) _____

__ __ Psychological (mood changes, sadness, irritability, anxiety etc.) _____
_____

__ __ Neurological (numbness, tingling, balance problems, memory etc.) _____
_____

__ __ Hormonal issues (diabetes, thyroid problems, menopausal, adrenal etc.) _____
_____

__ __ Blood or lymph issues (current anemia, swollen glands etc.) _____

__ __ Allergies _____

__ __ Others:_____

WOMEN:
Onset of first menses was age___. Periods generally last ___ days and occur every ___ days.
Date of last period _____ Bleeding is __Heavy __Moderate __Light
Do you experience PMS symptoms?_____ List:_____
Are you currently sexually active?_____ Partner(s) is/are __Male __Female
Type of birth control: _____ Are you happy with this method? _____
Are you currently experiencing any gynecological symptoms or problems?_____
_____
Any problems related to sexual function?_____
Do you have a history of sexually transmitted disease?_____ Genital warts?_____
Number of pregnancies?____ Births?____ Abortions?____ Miscarriages?____
Date of last Pap smear: _____ Abnormal Pap History: _____
Do you perform regular breast self exams?_____ Date of last mammogram, if any: _____
If menopausal or premenopausal, list symptoms and concerns:_____

MEN:
Are you currently sexually active?_____ Partner(s) is/are __Male __Female
History of sexually transmitted diseases?_____ Genital warts?_____
Date of last prostate exam?_____ PSA test? _____
Trouble with urination? (frequency, hesitancy, pain, dribbling)_____
Trouble with sexual function/libido?_____ If yes, explain:_____

GENERAL

Please fill in what you can:

	Recent	Past year	Past 5 years
Weight			
Height			
Cholesterol w/HI			
Blood pressure			

If tested in the past 2 years, please check:
_____Thyroid (normal? y/n) ____ Blood sugar (normal? y/n) ____Anemia (normal? y/n) Date of last:
Tetanus shot _____ Colonoscopy _____ (normal? y/n)

FAMILY HEALTH HISTORY: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		

Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

DIET: Please describe a typical day's diet for you, (be honest).

Breakfast	Lunch	Dinner	Snacks (what hour)

SOCIAL HISTORY. Please list sources and amounts of:
Caffeine:_____
Alcohol:_____
Smoking history and amount:_____
Recreational drugs: _____

LIFESTYLE:
What is your vocation? _____
What are your primary sources of stress?_____
_____
How much do you think they impact you life?_____
How many hours do you work per week?_____ Number of play/relaxation hours?_____
What do you do in order to manage stress and take care of yourself?_____
_____
What is your exercise routine?_____
Do you wear seatbelts? Y/N. A bike helmet? Y/N

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have were successfully solved? What would you be able to do? How would you feel?

What specific change(s) are YOU ready to make in order for you vision of health to happen?

What, if any, barriers to this exist? How could you overcome these?

How ready do you feel, on a scale of 1 to 10, to make the changes above?

1 2 3 4 5 6 7 8 9 10
(not sure) (depends how hard it is) (I'll do what it takes!)

The information that you may be provided is presented for educational purposes only. It is not intended as a substitute for the diagnosis, treatment and advice of a qualified, licensed, medical professional. If you have, or have reason to suspect that you may have a medical problem, contact your health care provider immediately. Never disregard professional medical advice or delay seeking professional advice because of something you have read or heard in or office. Information and statements regarding dietary supplements, medications, surgical procedures, and therapies may not necessarily have been evaluated by the Food and Drug Administration and any products, service or information is not intended to diagnose, or cure any disease.

Consent for consultation: I, the undersigned, have voluntarily applied for and agree to participate in a functional medicine balancing program with Michael Turcotte.
Your signature indicates your understanding and acknowledgement of the purpose of your visit and also that the information provided is as accurate as possible. If there are any changes with your health you will let Michael Know as soon as possible.

Please sign your name _____Date_____