PATIENT REGISTRATION FORM

CIRM Center for Integrative & Regenerative Medicine
10190 Critzer Shop Road, Afton, Virginia 22920
(434) 361-1896
Fax (540) 456-6161
www.cirm1.org

SAVE | PRINT | RESET

PATIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Sex	Social Security #

Address	Apt.#	City	State	Country	Zip Code

Home Phone	Work Phone	Mobile Phone	Email Address

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Spouse's Work Phone:	Spouse's Mobile Phone	Emergency Contact(s)	Emergency Contact Phone(s)

How were you referred to us?

☐ Internet _____
☐ Another Patient (Name): _____
☐ Another Doctor (Name): _____
☐ Other: _____
☐ Our website _____
☐ Another website: _____
☐ Blog: _____

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY — For each member of your family, read down the list and put a check in the boxes that apply. Put one check for each relative having a certain disease, e.g., put 3 checks in Grandparents - Stroke, if 3 of your grandparents suffered strokes. Indicate age only if deceased.

	Father	Mother	Brother(s)	Sister(s)	Spouse	Children	Grandparents	Aunts/Uncles
Age (at death only)								
Cause of Death								
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Allergies / Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Anemia / Blood Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illnesses / Autism	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disease	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism / Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐	☐	☐	☐
Malaria or Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐

PERSONAL HISTORY

Put a check in the box next to any of the following that you now or have ever had:

☐ Measles	☐ Pancreatitis	☐ Venereal disease	☐ Anxiety	☐ Other:
☐ Mumps	☐ Ulcers	☐ Tuberculosis	☐ Depression	
☐ Chicken pox	☐ Diverticulosis	☐ Concussion/Head injury	☐ Serious injury	
☐ Polio	☐ Hernias	☐ Migraines/Headaches	☐ Alcoholism or Drug Abuse	
☐ Diphtheria	☐ Hemorrhoids	☐ Neurological disorders	☐ Nervous breakdown or Psychosis	
☐ Small pox	☐ Bone/Joint disease	☐ Hay fever	☐ Hyperactivity and/or A.D.D.	
☐ Meningitis	☐ Cancer	☐ Frequent Colds	☐ Heart trouble	
☐ Scarlet fever	☐ Seizures/Epilepsy	☐ Neuritis or Neuralgia	☐ Hypertension/High Blood Pressure	
☐ Rheumatic fever	☐ Serious infection	☐ Sciatica	☐ Stroke	
☐ Genetic disease	☐ Malaria	☐ Low Back Pain	☐ Gall Bladder disease	
☐ Chronic Fatigue	☐ Yellow jaundice	☐ Anemia or Blood disease	☐ Rabies	
☐ Chronic Sinusitis	☐ Liver disease/Hepatitis	☐ Diabetes	☐ Reaction to drugs, vaccines, transfusions	
☐ Bronchitis	☐ Skin disorders	☐ Hormonal disorders	☐ To what?	
☐ Pneumonia	☐ Kidney disease or Stones	☐ Thyroid disease	_____	

MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious illness or operation, write in your most recent hospitalization below. Use the reverse side if needed. (Do not include normal pregnancies)

Year	Operation or illness	Physician's Name	City and State

Please list the name and address of any other physicians who have treated you in the past year and the problem for which you were treated (Do not include visits for cold, flus or other minor acutes).

Physician's Name	Address	Problem

MEDICATIONS

Indicate those medicines you are presently taking or which you have taken in the past. Please give the name and dosage of all current medicines.

Present	Past		Present	Past	
☐	☐	Antibiotics	☐	☐	Diabetes medicines
☐	☐	Pain medicine	☐	☐	Arthritis medicines
☐	☐	Diuretics (water pills)	☐	☐	Diet pills
☐	☐	Sedatives	☐	☐	Antacids or laxatives
☐	☐	Blood pressure medicines	☐	☐	Birth control pills
			☐	☐	Hormones
☐	☐	Heart medicines	☐	☐	Antimalarial drugs
☐	☐	Thyroid medicines	☐	☐	Antituberculosis drugs
☐	☐	Aspirin	☐	☐	Allergy desensitization
☐	☐	Vitamins & Herbs	☐	☐	Other

DRUG ALLERGIES

Please list any and all medicines you are allergic to, e.g., penicillin, sulfa drugs, other antibiotics, aspirin, codeine, etc.

TESTS AND IMMUNIZATIONS

Check those tests and immunizations which you have had. Enter the year when you last were given the tests or shots.

Year		Year		Year	
	☐ Chest X-Ray		☐ Colonoscopy/Sigmoidoscopy		☐ DPT
	☐ Kidney X-Ray		☐ PAP smear		☐ Tetanus
	☐ G.I. Series		☐ Nutritional Analysis		☐ Flu shot
	☐ Colon X-Ray		☐ Polio series		☐ Pneumonia shot
	☐ Electrocardiogram		☐ Measles, mumps, rubella		☐ Other
	☐ TB test		☐ HIV vaccine		
	☐ CT or MRI scan		☐ Ultrasound		

HEALTH FACTORS

Please check those items below that apply:

Yes	No	Do you drink or use?		Yes	No	
☐	☐	Coffee?	__ cups/day	☐	☐	Do you use an electric blanket?
☐	☐	Tea?	__ cups/day	☐	☐	Do you have silver-mercury amalgams in your mouth?
☐	☐	Sodas?	__ cans/day	☐	☐	Do you exercise regularly? If yes, how much?
☐	☐	Beer?	__ cans/day	☐	☐	Do you meditate regularly?
☐	☐	Wine?	__ glasses/day	☐	☐	Do you use "recreational" drugs, e.g. cocaine, LSD, marijuana, etc.?
☐	☐	Other alcohol?	__ glasses/day	☐	☐	Have you any known environmental sensitivities or past or present toxic chemical exposure? If yes, please describe:
☐	☐	Cigarettes?	__ packs/day			
☐	☐	Cigars?	__ cigars/day			
☐	☐	Pipe?	__ bowls/day			
☐	☐	Chew tobacco?				
☐	☐	Snuff?				

Please describe your emotional nature and personality characteristics, especially the major issues in your life.

HEALTH QUESTIONNAIRE

If you have recently been bothered with these problems, check YES.

Yes	No		Yes	No		Yes	No	
☐	☐	frequent or severe headache	☐	☐	recurring indigestion	☐	☐	swollen joints
☐	☐	neck pains	☐	☐	frequent belching	☐	☐	back or shoulder pains
☐	☐	neck lumps or swelling	☐	☐	nausea	☐	☐	weakness in arms or legs
☐	☐	loss of balance	☐	☐	vomiting	☐	☐	painful feet
☐	☐	dizzy spells	☐	☐	pain in abdomen	☐	☐	trembling
☐	☐	blackouts/fainting	☐	☐	bloated abdomen	☐	☐	numbness
☐	☐	wear glasses	☐	☐	constipation	☐	☐	leg cramps
☐	☐	blurry vision	☐	☐	loose bowels	☐	☐	skin problems
☐	☐	eyesight worsening	☐	☐	black stools	☐	☐	scalp problems
☐	☐	see double	☐	☐	gray or whitish stools	☐	☐	itching or burning skin
☐	☐	see halos or lights	☐	☐	pain in rectum	☐	☐	bruise easily
☐	☐	eye pains or itching	☐	☐	itching rectum	☐	☐	nervousness or anxiety
☐	☐	watering eyes	☐	☐	blood in stools	☐	☐	nervous with strangers
☐	☐	hearing difficulties	☐	☐	frequent urination	☐	☐	nail biting
☐	☐	earaches	☐	☐	involuntary escape of urine	☐	☐	difficulty making decisions
☐	☐	running ears	☐	☐	burning on urination	☐	☐	lack of concentration
☐	☐	noises in ears	☐	☐	brown, black or bloody urine	☐	☐	absentminded/loss of memory
☐	☐	dental problems	☐	☐	weak urine stream	☐	☐	lonely or depressed
☐	☐	sore or bleeding gums	☐	☐	difficulty starting urine	☐	☐	frequent crying
☐	☐	sore tongue	☐	☐	constant urge to urinate	☐	☐	hopeless outlook
☐	☐	congested nose	**(MEN ONLY)**			☐	☐	difficulty relaxing
☐	☐	running nose	☐	☐	burning or discharge	☐	☐	worry a lot
☐	☐	sneezing spells	☐	☐	lumps or swelling on testicles	☐	☐	frightening dreams or thoughts
☐	☐	head colds	☐	☐	painful testicles	☐	☐	feeling desperation
☐	☐	nosebleeds	**(WOMAN ONLY)**			☐	☐	shy or sensitive
☐	☐	sore throat	☐	☐	a missed period	☐	☐	dislike criticism
☐	☐	difficulty swallowing	☐	☐	menstrual problems	☐	☐	angered easily
☐	☐	hoarse voice	☐	☐	bleeding between periods	☐	☐	annoyed by little things
☐	☐	wheezing or gasping	☐	☐	tension or pain before periods	☐	☐	family problems
☐	☐	frequent coughing	☐	☐	heavy bleeding	☐	☐	problems at work
☐	☐	cough up phlegm	☐	☐	bearing down feeling	☐	☐	sexual difficulties
☐	☐	cough up blood	☐	☐	vaginal discharge	☐	☐	considered suicide
☐	☐	chest colds	☐	☐	genital irritation	☐	☐	sought psychiatric help
☐	☐	rapid or skipped heartbeats	☐	☐	pain on intercourse	☐	☐	loss or gain in weight
☐	☐	chest pains	☐	☐	swelling or lumps in breasts	☐	☐	often feel warmer or colder than others
☐	☐	shortness of breath with normal activity	☐	☐	painful breasts	☐	☐	loss of appetite
☐	☐	swollen feet or ankles			____ # of pregnancies	☐	☐	always hungry
☐	☐	aching muscles or joints			____ # of births	☐	☐	armpits or groin swelling
					____ miscarriages	☐	☐	unusual fatigue or weariness
					____ premature births	☐	☐	difficulty sleeping
					____ cesareans	☐	☐	fever or chills
					____ abortions	☐	☐	motion sickness
						☐	☐	excessive sweating
						☐	☐	night sweats
						☐	☐	hot flashes

Comments or Special Problems:

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Contract for Integrative & Regenerative Medical Services

Dear Patient:

Integrative & Regenerative Medicine are distinct, specialized types of medical services apart from allopathic or conventional medical practice. Due to the unique office visit and the extraordinary amount of time and effort required by Dr. Fleisher to conduct the Integrative & Regenerative Medical examination and interview, the charge may not be adequately reimbursed by health insurance.

Please note: We are currently restricted from billing for Integrative & Regenerative Medical services to Medicare, Medicaid, Blue Cross/Blue Shield and other health insurers. Also, Medicare and Medicaid patients cannot personally file for reimbursement from Medicare and Medicaid.

You will be fully responsible for the payment of fees at the time that Integrative & Regenerative Medical services are rendered. An invoice with the appropriate coded billing information will be provided for submittal to your insurance company for your reimbursement.

Please sign the following statement, which will serve as a billing contract for Integrative & Regenerative Medical services.

"I understand that I am responsible for the full payment of fees for Integrative & Regenerative Medical consultations at the time that services are rendered."

Signed:_____ Print Name: _____

Patient, Parent or Guardian

Please be aware that typing in your name is a legal e-signature and is enforceable as a handwritten signature.

Date:_____

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Patient Acknowledgement of Receipt/Review of the Notice of Privacy Practices

PATIENT NAME: _____

By signing this form, I am acknowledging my receipt and/or review of the posted Notice of Privacy Practices of the Center for Integrative & Regenerative Medicine.

I have been given the right to review the Notice of Privacy Practices prior to signing this form.

Signature of Patient or Legal Guardian ***Please be aware that typing in your name is a legal e-signature and is enforceable as a handwritten signature.***	Print Name of Legal Guardian (if applicable)
Print Name of Patient	Date

Please kindly complete and return the Patient Registration Form to:
info@cirm1.org or fax to: 540-456-6161