902 SANTA FE MEDICAL OFFICES
Christine Ciavarella, PA-C
902 Santa Fe Avenue
Albany, CA 94706
510-526-5256

Adult Registration Form

Name_____ **Birth date**_____
Home Address_____ **Phone**_____
City, Zip_____ **Phone**_____
Business Address_____ **Phone**_____
Sex M F **Usual Occupation**_____ **Employer**_____
Living Situation ☐ **alone** ☐ **parents** ☐**spouse/partner** ☐ **friend(s)** ☐ **boarding**
Referred by_____
Marital Status ☐ **single** ☐ **partnered/married** ☐ **divorced** ☐ **widowed**
Number of children_____ **Number living with you**_____
Employment Status ☐ **school** ☐ **keeping house** ☐ **work** ☐ **full time** ☐ **part time** ☐ **unemployed** ☐ **disabled** ☐ **retired**
Person to be contacted in case of emergency_____
Address_____ **Phone**_____
Members of household

Name	Age	Relationship

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT: By signing this document, I hereby authorize Christine Ciavarella PA-C to treat me using homeopathic medicines according to the principles of homeopathic practice. I understand and acknowledge the Christine Ciavarella PA-C will base their treatment decisions on the school of homeopathic practice, and if I desire to be treated according to the conventional or allopathic school of medicine, I am free to seek such treatment from another physician. In some cases I may be encouraged or required to do so. I understand that Christine Ciavarella PA-C act as homeopathic specialists and not as primary care providers. I understand that Christine Ciavarella PA-C will make the best effort to treat me but makes no guarantees that their homeopathic treatment will cure me. I certify that the above information is true and give the examining practitioner permission to contact previous practitioners.

I understand that charges will made and hereby agree that I am financially responsible for any such charges.
*Signature*_____ *Date*_____

HEALTH QUESTIONAIRE : Please tick/circle symptoms, which apply to you

- History of Head Injury
- Headaches: frequent or severe or migraine
- Dizzy/ Vertigo
- Blackouts/ Fainting
- Vision Disturbances
- Eye pain/ Itching
- Dry/ watery eyes
- Hearing Problems
- Earaches
- Ringing in ears
- Dental problems
- Sore or bleeding gums
- Hayfever/ allergies
  - *Itching eyes/mouth/ears*
  - *Sneezing/ cough*
  - *Difficulty breathing*
- Nasal congestion
- Nosebleeds
- Frequent Colds
  - *head/ nose/ sinus*
  - *sore throat/ strep throat*
  - *End up in chest*
- Asthma/ Shortness of Breath/ Chronic Cough
- Coughing blood
- Anxious Feeling in Chest
- Chest Pains
- Rapid/ Skipped beats
  - *Anytime/ nighttime*
- Digestive Problems
- Heartburn/ GERDS
- Nausea/ vomiting
- Pain/ bloating
- Frequent belching
- Constipation
  - *Long-standing*
  - *Related to menses*
  - *Use laxatives/enemas etc.*
- Diarrhea/ loose stools
  - *Frequent stools*
  - *How often? _____*
- Rectal Pain/itching
- Rectal bleeding
  - *Hemorrhoids / fissure*
  - *Colitis/Proctitis*

MEN

- Prostate problems
  - *Difficulty starting urine*
  - *Weak or split stream*
  - *Dribbling urine*
- Frequent/ Painful Urination
  - *Night, day, both*
- Bloody/ discolored urine
- Sexual desire
  - *Low / average / high*
  - *Recent change?*
- Warts / Condylomata
- Discharge from Penis
- Painful/swelling testicles

WOMEN

- Frequent Urination
  - *Night, Day, Both*
- Lose urine when cough/laugh
- Menopausal Problems
  - *Hot flashes/ night sweats*
  - *Vaginal dryness*
  - *Emotional distress*
- Age of Menopause___
- Age at First Menses___
- Pre Menstrual Tension
- Irregular Periods
- Profuse bleeding
- Painful Periods
- Type of Pain:
  - *Cramping, stitching*
- Post-menopause bleeding
- Clots: large/small
- Endometriosis
- Fibroid /Ovarian Cysts
- Pelvic/vaginal infection:
  - *acute/ chronic/recurrent*
- Sexual Desire
  - *Low / average / high.*
  - *Recent change?*
- Number of Pregnancies____
- Number of Births_____
- Miscarriages_____
- Premature Births_____
- Cesareans_____
- Abortions_____
- Genital Warts/HPV

- Back Pain;
  - *Neck, Mid-back, low back*
- Character of Back Pain:
  - *ache/sore/spasm/cramp*
- Sciatica: left, right
- History Back Injury
- Muscular Pain: Arms/legs
- Joint Pain or Swelling
- Swollen hands or feet
- Restless Hands/Feet
- Jerking of Limbs
- Twitching of Muscles
- Biting Nails
- Problems with Nails
- Feet hot
  - *uncover at night*
- Feet Perspire, odor
- Skin problems
  - Eczema/Psoriasis
  - Acne: teen/adult
  - Rash

Sleep Problems

Wake Unrefreshed

Hard to fall asleep

Hard to stay asleep

Frequent waking

Time_____

Bad Dreams

Sleep Position

Sides, left, right, abdomen,

Back, Knee to chest

Night Sweats

Head, neck, chest, back

Irritable

Hold it in

With Myself

With Others

Impatient

If people are being stupid

If people are inefficient

If people move too slowly

In traffic

Critical/Judgmental

Of myself/others

Easily Angered

Hold it in

Let it out

Scream/Throw things

Hit/injure people or animals

Jealousy is a problem for me

Fastidious/Perfectionist

order/cleanliness

being on time

work/school assignments

Difficulty: social situations

Difficulty making Decisions

Fears:

Heights/ Dark / Water

Claustrophobia /Cancer/ Animals

Other _____

Anxiety/ Worries

Generalized

State of the world

Family/Children/Spouse

Business/Money

Natural Disasters

Robbers

Violence/Rape

Speaking in Public

Health

History of depression

Sadness

Weeping:

easily/often/at slightest thing

not in front of people

not in years/never

Grief

loss of a loved one

loss of relationship

loss of business/possessions

wish to die

Considered/Attempted suicide

Considered Therapy

Other concerns or special situations_____

_____

_____

_____

Generalities

Complaints occur predominantly on one side or part of body: Left/Right/Upper/Lower

Time of day you feel the worst: *morning, mid-afternoon, early afternoon, late afternoon, early evening, late evening, night*

Do you feel: *Warmer/Colder than most others*

Do you wear: *More/Less Clothes than most others*

Do you have a strong preference for certain seasons or weather:

Summer, winter, fall, spring, Hot, Cold, Cold Damp, Humid, Foggy, Overcast, Windy, Fresh Air

Do you have a dislike for certain seasons or weather:

Summer, winter, fall, spring, Hot, Cold, Damp, Humid, Foggy, Overcast, Windy, Fresh Air, Drafts

Are there certain foods that you crave? _____

Are there certain foods you cannot stand?_____

Current Therapies:

Regular Medical, Acupuncture, Herbs/Vitamins, Chiropractic, Osteopathy, Massage, Psychic Healing,

*Other*_____

How many other health practitioners do you see at this time? _____

Do you use: **Amount**

Coffee_____
Cigarettes_____
Alcohol_____
Aspirin_____

Please list any drug allergies

_____
_____
_____
_____

Please list all medications and supplements

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Print the names of your relatives, living or dead, in the list at the left. Place an (X) in the appropriate column for any illnesses that you or the relatives listed at the left have had.

	Allergies	Anemia	Arthritis/Gout	Asthma	Bleeding/Bruising problems	Cancer or Tumors	Convulsions/Epilepsy	Diabetes	Drinking or Drug problem	Eczema	Emphysema	Heart Trouble	Hepatitis	High Blood Pressure	Frequent Infections	Kidney or Bladder problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia	Polio	Prostate Problems	Rheumatic Fever	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease	Weight Problems
You																														
Father																														
Mother																														
Siblings																														
Children																														
G. Parents																														

Last Three Hospitalizations (except normal pregnancies)

	Hospitalization	Hospitalization	Hospitalization
Type of operation or illness			
Month and year hospitalized			
Name of hospital			
City and State			

If you have had any of the following tests or immunizations place an (X) next to the appropriate box and, if you can, give the year you last had them.

Year	Test
_____	☐ Chest x-ray
_____	☐ Kidney x-ray (Pyelogram)
_____	☐ G.I.series
_____	☐ Colon x-ray
_____	☐ Gallbladder x-ray (Cholecystogram)
_____	☐ Electrocardiogram
_____	☐ T.B. test
_____	Mammogram

Year	Immunizations
_____	☐ Tetanus
_____	☐ Tetanus/Pertussis
_____	☐ Polio
_____	Gardasil/HPV
_____	☐ Flu
_____	☐ ChickenPox
_____	☐ Measles,Mumps,Rubella
_____	Hepatitis A and/or B