KHALSA INTEGRATIVE MEDICINE, LLC

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PATIENT REGISTRATION

Patient Information:

First Name	Middle Initial	Last Name	Date of Birth	Sex
				Male ❑ Female ❑

Social Security Number	Home Phone Number	Work Phone Number	Cell Phone Number
	( )	( )	( )

Home Address	City	State	Zip

Marital Status	Home e-mail address:
Married ❑ Unmarried ❑ Divorced ❑ Widowed ❑	
Employer/ School	Best Time and Place to Reach You:
Employer Address	City / State / Zip

Emergency Contact (Friend or Relative):

Name	Relationship	Phone Numbers	
Home Address	City	State	Zip

Reason for Today's Visit:

_____

_____

_____

Have you had any of the following symptoms recently?

Fever ❑ Cold Feeling or Chills ❑ Sweating ❑ Coughing ❑ Sneezing ❑
Insomnia ❑ Anxiety ❑ Depression ❑ Irritability ❑ Fatigue ❑
Pain ❑ If so, where: _____

Diarrhea/Loose Stool ❑ Constipation ❑ Abnormal Urination ❑
Abnormal Appetite ❑ Gastric Reflux ❑ Nausea ❑

Other Recent Symptoms: _____

_____

_____

(PLEASE TURN PAGE)

Past Medical History:
Diseases: Heart Disease ❑ Hypertension ❑ Diabetes ❑ Stroke ❑ Asthma ❑
Seizure ❑ Cancer ❑ Hepatitis ❑ Thyroid Disease ❑ HIV/AIDS ❑
Other: _____
_____

Known Allergies: _____
_____

Surgeries: _____
_____

Current Medications: _____
_____

Other Medications in the Past Year: _____
_____

Family Medical History (Father, Mother, Siblings):
Heart Disease ❑ Hypertension ❑ Diabetes ❑ Stroke ❑
Seizure ❑ Cancer ❑ Hepatitis ❑ Thyroid Disease ❑ HIV/AIDS ❑

Other family conditions that may be relevant to your present medical condition:
_____
_____
_____

Personal Habits:
Smoking ❑ Alcohol ❑ Coffee ❑ Recreational Drugs ❑
Sugar ❑ Chocolate ❑

Amount of exercise per week: _____

THANK YOU! THIS INFORMATION WILL HELP TO MAKE YOUR INITIAL INTAKE AND TREATMENT MORE COMPREHENSIVE.