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

____
____
____
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____

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