# Registration Form

| PLEASE PRINT | | | | | Appointment Date: | | | |
|---|---|---|---|---|---|---|---|---|
| **PATIENT INFORMATION** | | | | | | | | |
| Patient's last name: | First: | Middle: | Mr. Mrs. | Miss Ms. | Marital status: Please circle | | | |
| | | | | | Single Mar Div Sep Wid Other | | | |
| Is this your legal name? | If not, what is your legal name? | (Former name): | | | Birth date: | Age: | Sex: | |
| Yes No | | | | | | | M F | |
| Street address: | | Social Security no.: | | | Home phone no.: | Cell phone no. | | |
| | | | | | | | | |
| P.O. box: | City: | | | | State: | ZIP Code: | | |
| | | | | | | | | |
| Occupation: | Employer: | | | | Employer phone no.: | | | |
| | | | | | | | | |
| Chose clinic because/referred to clinic by (Please circle) | | Insurance plan | Yellow Pages | Friend/Family | Close to home/work | | | |
| Dr. (please give name): | | | | | | | | |
| Other family members seen here: | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | |
| (Please give your insurance card and driver's license to the receptionist.) | | | | | | | | |
| Person responsible for bill: | Birth date: | Address (if different): | | | Home phone no.: | | | |
| | | | | | | | | |
| Is this person a patient here? | Yes | No | | | | | | |
| Occupation: | Employer: | Employer address: | | | Employer phone no.: | | | |
| | | | | | | | | |
| Is this patient covered by insurance? | Yes | No | | | | | | |
| Name of primary insurance | | | | | | | | |
| Subscriber's name: | SSN: | Birth date: | Co-payment: | | | | | |
| | | | $ | | | | | |
| Patient's relationship to subscriber: | Self | Spouse | Child | Other | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | |
| Subscriber's name: | SSN: | Birth date: | Co-payment: | | | | | |
| | | | $ | | | | | |
| Patient's relationship to subscriber: | Self | Spouse | Child | Other | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work/Cell phone no.: | | | | | |
| | | | | | | | | |

*I consent to treatment necessary for the care of the above named patient. I authorize Dr. Kennedy to release or obtain all medical records to referring and family physicians, pharmacies and to my insurance company, if applicable. I allow fax/electronic transmittal of my medical records, if necessary. We will bill your insurance company as a courtesy to you. It is your responsibility to see that they pay on time. I understand that Dr. Kennedy is not accepting Motor Vehicle Accidents or Labor & Industry claims without prior authorization from this office. We reserve the right to either cancel or reschedule your appointment if prior authorization is not obtained. I understand that any balance considered patient responsibility is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Sheila Z. Kennedy, D.O. I hereby authorize the subscriber of the insurance, if not the patient, to speak with a representative of Sheila Z. Kennedy, D.O., regarding any balances owed by myself or to coordinate payment with my insurance company. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. I have read the privacy policy* and understand my rights. *The Privacy Policy can be printed from the main menu.*

| *Patient/Guardian signature* | | *Date* | |
|---|---|---|---|

Sheila Z. Kennedy, D.O. Family Practice & Manipulation
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# HISTORY

**Patient Name:** **Age:** **Appointment Date:**

**What do you do all day?** *(i.e., sit at a desk, clear the back forty, etc)*

**Marital Status:** ☐**Single** ☐**Married** ☐**Widow** ☐**Divorced** ☐**Separated** ☐**Life Partner**

**How did you find our office?**

**Reason for your visit today, and what you wish to accomplish.**

**Childhood Illness'** *(Check all that apply)* ☐**Measles** ☐**Mumps** ☐**Chickenpox** ☐**Rubella** ☐ **Rheumatic Fever** ☐**Polio** ☐**Other**

**Last Tetanus Shot** **Last Flu Shot** **HEP B Vaccine? Yes / No** **Pneumonia Vaccine Yes / No**

| **MEDICAL HISTORY/ROS:** ***Check all that apply*** | **Y** | **N** |
|---|---|---|
| Arthritis/Autoimmune | | |
| Fibromyalgia/Chronic Fatigue | | |
| Joint / Muscle Pain | | |
| Osteoporosis | | |
| If yes, date of last bone scan: | | |
| Depression/Anxiety/Eating Disorders | | |
| Learning Problems | | |
| Migraines/Stroke/Seizures | | |
| Abuse, Sexual/Physical/Emotional | | |
| Chronic Constipation/Diarrhea | | |
| Have you had a colonoscopy? | | |
| If yes, date Result | | |
| Liver Disease / Hepatitis | | |
| Ulcers / Heartburn | | |
| Diabetes | | |
| Thyroid | | |
| Kidney Stones / Chronic Bladder Infections | | |
| Sexually Transmitted Diseases | | |
| Heart Disease | | |
| High Blood Pressure | | |
| High Cholesterol | | |
| Asthma | | |
| Emphysema | | |
| Frequent Upper Respiratory Infections | | |
| Last Chest X-Ray? Date: | | |
| Allergies | | |
| Anemia | | |
| Blood Clots | | |
| Breast Disease | | |
| Cancer- Type | | |

| **GYN / OB** |
|---|
| **1.** Age at first menstrual cycle: |
| **2.** Have you had a hysterectomy? *If no, skip to question 3.* |
| a. If yes, why?( i.e. fibroids, cancer) |
| b. Date: *Skip to question 5* |
| **3.** Menstrual Flow Amount? |
| a. ( ) Light ( ) Moderate ( ) Heavy |
| **4.** Any pain with menstruation? |
| a. ( ) Cramps ( )Back Pain ( ) Headaches |
| **5.** Sexually Active? ( )Yes ( )No |
| a. If yes, with ( )Male ( )Female ( )Both |
| b. How long with your current partner? |
| c. Pain with intercourse? ( )Yes ( )No |
| d. Number of Sexual Partners in Lifetime? |
| **6.** Date of Last Pap Smear? |
| **7.** Date of Last Mammogram? |
| **8.** Any bladder or kidney infections in the last year? |
| **9.** Any problems with control of urination? ( )Yes ( )No |
| **10**. Hot flashes or night sweats? ( )Yes ( )No |
| **11**. Breast tenderness, lumps, or nipple discharge? ( )Y ( )N |
| |
| **PREGNANCY** |
| How many times have you been pregnant? |
| Age at first pregnancy? |
| # of miscarriages / Terminated Pregnancies? |
| Did you go full term with all pregnancies? |
| C-Sections? |
| What are you currently using for contraception? |

| **ALLERGIES/SENSITIVITES TO MEDICATIONS / REACTION** (*i.e., hives, rash, shortness of breath, throat closing*) | **CURRENT MEDICATIONS** *(List all Prescriptions, Herbals, Vitamins and Over-The-Counter Medications you take* | |
|---|---|---|
| | Name of Medication | Strength |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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Name:

| **SURGICAL / HOSPITAL STAYS –** *Please list all dates of surgeries or hospital stays, and the reason* | | |
|---|---|---|
| Date | Surgery / Illness / Trauma | Why |
| | | |
| | | |
| | | |
| | | |
| | | |

| **SOCIAL HISTORY** | **Y** | **N** |
|---|---|---|
| **1.** Do you currently, or have you in the past, used tobacco products? *If no, skip to question 2.* | | |
| a. If yes, at what age did you start? | | |
| b. What type of tobacco product do/did you use? ( )Cigarettes ( )Chew ( )Pipe ( )Cigars | | |
| c. How much do/did you use on a daily basis? | | |
| d. If you have quit, please give date: | | |
| **2.** Do you drink alcohol? *If no, skip to question 3* | | |
| a. Have you, or someone close to you, ever felt you should cut down on your drinking? . | | |
| b. Have people annoyed you by criticizing your drinking? | | |
| c. Have you ever felt bad or guilty about your drinking? | | |
| d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? | | |
| **3.** Do you now, or have you in the past, used street drugs? *If no, skip to question 4.* | | |
| a. If yes, at what age did you start? | | |
| b. What type? c. How often? | | |
| d. Did you, ever, even once, use a needle? | | |
| **4.** Are you currently in recovery for alcohol / drug abuse? If yes, date: | | |
| **5.** Do you drink caffeine? *Include coffee, tea, soda, etc.* | | |
| a. Number of beverages a day? | | |
| **6.** Do you exercise regularly? | | |
| a. ( )at least 1-2x weekly for 30 min/day ( )3x weekly for 30 min/day ( )4x weekly for 30 min/day | | |
| **7.** Are you currently dieting? | | |
| a. Number of average meals you eat in a day? | | |
| b. Do you snack? *If yes, what is your typical snack?* | | |
| **8.** Do you live alone? | | |
| **9.** Do you fall frequently, or accident prone? | | |
| **10.** Do you wear contacts or glasses, or have vision problems? *i.e., color blindness* | | |
| **11.** Do you have problems with your hearing, or wear a hearing aid? | | |
| **12.** Do you have any tattoos? *If yes, what age or year did you get them*? | | |
| **13.** Have you ever had a blood transfusion? *If yes, year:* | | |
| **14.** Do you have an Advance Directive or Living Will? | | |
| a. Would you like more information? | | |

*For more information on Advance Directives or Living Wills, please visit our web site @ http://www.do-online/sheilazkennedy. Click on Links, then Washington State Department of Health, Living Wills.*

**FAMILY HISTORY**

Is your Father still alive? ( )Yes ( )No If no, what did he die from? Age at Death?

Is your Mother still alive? ( )Yes ( )No If no, what did she die from? Age at Death?

| | Who | | Who |
|---|---|---|---|
| Cancer -Type | | Stroke | |
| Breast | | High Blood Pressure | |
| Ovarian | | High Cholesterol | |
| Uterine | | Arthritis | |
| Lung | | Osteoporosis | |
| Liver | | | |
| Other | | | |
| Diabetes | | | |
| Thyroid Disease | | Depression | |

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