Dr April St. John-Keenoy DO

Gilead HEALING CENTER

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Patient Information and Registration

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Alternate Phone: _____

Sex: Male or Female Date of Birth: _____ Martial Status: S M D W

Email Address: _____

Name of Spouse/Parent: _____ Date of Birth: _____

Relative Not Living with You: _____ Phone: _____

Address: _____ Relationship: _____

Primary Doctor: _____ Phone: _____

Address: _____

Primary Insurance

Name of Insured_____
Relationship to patient_____
Insured's birth date_____
Employer_____

Insurance Company_____
Group #_____
Employee/Cert. #_____

Deductible_____
Max. Annual benefit_____

Secondary Insurance

Name of Insured_____
Relationship to patient_____
Insured's birth date_____

Insurance Company_____
Group #_____
Employee/Cert.. _____

Deductible_____
Amount already used_____
Max. Annual benefit_____

Name _____ Date of Birth _____

- What is your chief complaint? _____

_____

- Other Complaints? _____

_____

_____

_____

- Have you experienced these or similar conditions in the past? _____
- List previous treatments you have had: _____

_____

_____

- List activities that aggravate your symptoms: _____

_____

Is this condition interfering with your: Daily routine? _____ Work? _____ Sleep? _____ Other? _____

- List all surgeries you have had and the dates (prosthesis or medical devices; pacemakers, etc): _____

_____

_____

- List all surgical/anesthesia complications: _____

_____

- List all infections, viruses, and inflammations: _____

_____

- List all chronic illness you have (such as Diabetes, Glaucoma, Hypertension or High B/P)

_____

_____

- List any allergies to food or medication: _____

_____

_____

_____

- Other Allergies (Hay fever/seasonal, Dust, Pollens, Pet, Etc)

_____

_____

_____

- List all Prescription drugs you are on or have recently taken:

Name ***Strength*** ***How Taken***

_____

_____

_____

_____

_____

_____

_____

List all non– prescription drugs, vitamins, herbs or nutritional supplements you are taking:_____

_____

_____

_____

_____

_____

_____

_____

A PICTURE OF YOU AND YOUR LIFE AND HABITS

Please answer YES or NO and Explain where needed

1. Do you live alone? Yes No

2. Do you live with others? Yes No Who? _____

3. Do you have children that do not live with you? Yes No Why?_____

4. Do you have a job or career with pay? Yes No Outside the home? Yes No

5. Do you do volunteer work? Yes No

6. Are you a "stay-at-home" parent or spouse? Yes No

7. Are you in school or training? Yes No

8. Are you retired or have a previous career? Yes No

9. Are you responsible for taking care of sick or special needs family? Yes No

10. Do you exercise? Yes No What kind and how often?_____

11. What do you do to "relax" and have some "time off"_____

12. Do you go to church? Yes No

13. Do you make time for quiet time?(prayer,meditation,spiritual study) Yes No

14. Do you smoke cigarettes, pipe, cigars or chew tobacco? Yes No Amount_____

15. Are you an ex-smoker or user of above? Yes No Date quit:_____

16. How many times a week do you eat fruit? _____

17. Do you drink alcohol? Yes No If yes, type and amount_____

18. Do you drink water daily? Yes No What kind? Bottled Tap other_____

19. Do you drink coke or soda pop? Yes No What kind?_____How often?_____

20. Do you eat meat, eggs, and dairy? (milk and cheese) Yes No

21. Do you eat: white bread "airy" whole wheat bread or "heavy-weight" whole grain bread?

22. Do you drink coffee? Yes No Amount_____ Anything in it? Yes No

23. What is your usual weight and height _____

24. Do you use marijuana? (medical marijuana) Yes No

25. Do you use other street drugs? Yes No Type and Amount:_____

26. Have you ever been overly dependent on prescription drugs? Yes No When?_____

27. Do you eat green vegetables and or salads regularly? Yes No

28. Do you over-do: a) sweets & candy? Yes No b) fast-food or eating out? Yes No

29. Do you over-do: c) TV watching? Yes No d) tend to eat dinner w/ TV? Yes No

30. Do you do nice things for yourself? Yes No (Examples-massage, pedicures)

31. Do you see a chiropractor or other special alternative medicine? Yes No

32. How would you describe your stress level? Minimal Moderate Severe Intolerable

33. Is there anything else you want us to know about you?

_____

_____

_____

When was your last physical exam?_____

Name of Doctor: _____phone or location:_____

Have you ever had any:

1. Serious accidents, severe injuries_____
2. Head injuries_____
3. Fractures or broken bones_____

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain):

Measles_____	no	yes	Migraine headaches__	no	yes	Hives or eczema_____	no	yes
Mumps _____	no	yes	Tuberculosis_____	no	yes	AIDS or HIV_____	no	yes
Chickenpox_____	no	yes	Diabetes_____	no	yes	Infectious Mono_____	no	yes
Whooping cough__	no	yes	Cancer_____	no	yes	Bronchitis_____	no	yes
Scarlet fever _____	no	yes	Polio_____	no	yes	Mitral Valve Prolapse___	no	yes
Diphtheria_____	no	yes	Glaucoma_____	no	yes	Stroke_____	no	yes
Smallpox_____	no	yes	Hernia_____	no	yes	Hepatitis_____	no	yes
Pneumonia _____	no	yes	Blood or Plasma____	no	yes	Ulcer_____	no	yes
Rheumatic fever __	no	yes	transfusions			Kidney Disease_____	no	yes
Heart disease_____	no	yes	Back trouble_____	no	yes	Thyroid Disease_____	no	yes
Arthritis_____	no	yes	High or low blood__	no	yes	Bleeding tendency_____	no	yes
Venereal Disease__	no	yes	pressure			Any other disease_____	no	yes
Anemia _____	no	yes	Hemorrhoids_____	no	yes	(please list)		
Bladder infections_	no	yes	Date of last chest x-ray	_____				
Epilepsy _____	no	yes	Asthma_____	no	yes			

CHILDHOOD HISTORY

Childhood diseases: (any special or particular problems you had in childhood)

_____

_____

Complications: _____

_____

Surgeries: _____

_____

_____

FAMILY MEDICAL HISTORY

Mother living? Yes No
If living, health is: good fair poor
If deceased, cause of death: _____
Present age____ or age of death _____

Father living? Yes No
If living, health is: good fair poor
If deceased, cause of death: _____
Present age ____or age of death _____

CONTINUE WITH OTHER FAMILY MEMBERS:

Present age or age at death
If living, health is: good fair poor
If deceased, cause of death

Siblings_____
_____
_____
_____
_____
_____
_____

Spouse _____
Children_____
_____
_____
_____
_____
_____

Family History

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain):

Cancer_____	no	yes
Tuberculosis_____	no	yes
Diabetes_____	no	yes
Heart Disease_____	no	yes
High blood pressure____	no	yes
Asthma_____	no	yes
Chronic lung disease____	no	yes
Drug or alcohol problem_	no	yes
Mental illness _____	no	yes
Leukemia_____	no	yes
Migraine headaches____	no	yes
Obesity_____	no	yes
Thyroid Disease_____	no	yes
Ulcer_____	no	yes

Depression_____	no	yes
High Cholesterol_____	no	yes
Kidney Disease_____	no	yes
Glaucoma_____	no	yes
Gout_____	no	yes
Stroke_____	no	yes
Epilepsy_____	no	yes
Allergies_____	no	yes
Anemia_____	no	yes
Bleeding tendency_	no	yes

HEAD TO TOE
TOTAL HEALTH QUESTIONNAIRE

NAME_____

(Specific Health Area)

Key: ✓ **= No problem**
N= Now problem
P= Past problem

EXPLAIN

All is well with my eyes & eyelids N & P

All is well with my ears/hearing. _____ *N=Lense for far vision, reading glasses.* *P=Sty's, chalazions, & eye infections*

All is well w/my throat & mouth. __?__ *occ bad breath*

A. **EYES,EARS, NOSE AND THROAT**
All is well with my….
1. EYES and EYELIDS
no vision problems, eye inflammation or eye strain _____
2. EARS and HEARING
(no ear pain, ear noise, ear drainage, hearing loss _____
3. NOSE
no nose pain, drainage, bleeding, hard to nose breathe _____
4. THROAT / MOUTH
hoarseness, sore mouth, mouth or lip sores _____
5. TEETH / GUMS
dental problems, sore or bleeding gums _____

B. **HEAD**
No problems with headaches, head injury problems, dizziness, fainting, convulsions/seizures, confusion, forgetfulness/memory _____

C. **SLEEP, RELAXATION**
No problem _____

D. **CONCENTRATION, CALM CONF**IDENCE
No problems with ADD or ADHD, learning disabilities, anxiety/nerves, stress, extreme worry _____

E. **OTHER NERVE PROBLEMS**
No problems with muscle jerking or twitching, paralysis or weak areas, numbness or tingling, face droop or foot drag, or difficult speech, stroke _____

F. EMOTIONAL HEALTH
No problems with depression or blues, crying, sadness, grief/loss, thoughts of suicide, or...excessive happiness, talkativeness, impulsiveness _____

G. SELF-CONTROL
No problems with anger or addiction _____

H. SPIRITUAL HEALTH / FAITH LIFE
No problems feeling a sense of purpose and meaning in your life, no problem in feeling a connection with/to God, and no problem making time for your spiritual life such as prayer and meditation, fellowship and so on. _____

I. HEART HEALTH
No heart problems, rapid or irregular heartbeat, no chest pain, high cholesterol, blood pressure problems _____

J. **CIRCULATION HEALT**H
No varicose veins, poor circulation, leg fluid, blood clots, aneurysms, carotid artery blockage, or bleeding problem _____

K. RESPIRATION
No difficulty breathing, lung problems, persistent cough, coughing up phlegm, or coughing up blood, smoking now or in the past _____

L. URINARY ELIMINATION
No bladder or kidney trouble, excessive urination, painful urination, scanty urination, discolored urine, stones _____

M. MALES ONLY
No discharge from penis, no pain or lump in testicle, no impotence or erection problem, no infertility _____

N. BOWEL ELIMINATION
No constipation, no diarrhea, or irritable bowel, no black stool or bloody stool, no hemorrhoids _____

✓= No problem
N= Now problem
P= Past problem
?= Not sure/occ= occasionally

O. STOMACH AND EATING

No difficulty chewing, swallowing poor appetite, excessive hunger, nausea vomiting food, vomiting blood, abdominal pain, weight problem _____

P. **LIVER AND GALLBLADDE**R

No liver trouble, gallbladder problem, alcohol or drug problem at any time, including DUI, prescription drugs, or injected drug use, no jaundice or yellow _____

Q. **HISTORY OF PHYSICAL OR SEXUAL ABUSE**

No experience of physical violence or other type of abuse whether currently or in the past by either family members or others _____

R. **FEMALES ONLY**-periods

No menstrual problems such as pain/severe cramps, heavy bleeding, abnormal bleeding such as too light or fewer days or bleeding or spotting between periods _____

S. **FEMALES ONLY** –vagina

No vaginal itching, discharge, odor and no pain with intercourse or other sexual problem _____

T. **FEMALES ONLY**-Answer Questions

Age period began_____
# of days periods last_____
Date of last period_____
Date of last pelvic exam_____
Date of last mammogram_____
Type of Birth Control_____
# of pregnancies_____
# of living children_____
# of children born premature_____.

U. SKIN / FEET / HANDS

No skin problems, no acne, eczema, psoriasis, shingles, cold sores on lips, boils, abscesses, cellulitis which is bacterial skin infection, MRSA, ringworm or athlete's feet or jock itch or other fungal infection or infection near a fingernail or toenail or ingrown toenail, etc. _____

✓= No problem
N= Now problem
P= Past problem
?= Not sure/occ= occasionally

V. MUSCLES, BONES ,JOINTS

No neck problems, low back pain
pain between shoulders, arm or leg
problem, swollen or stiff or painful joints,
gout, sore or weak muscles, walking problems,
ruptures, broken bones, osteoporosis _____

W. INFLAMMATORY CONDITIONS

No fibromyalgia, lupus, scleroderma,
chronic fatigue syndrome, migraines,
rheumatoid arthritis, osteoarthritis,
psoriasis or other inflammatory condition _____

Please mail or return this paper work back to Gilead
<u>BEFORE</u> your appointment date. Thank you!

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