Please complete this registration form and either mail it in or bring it along at your first Progressive Health Center appointment.

REGISTRATION FORM

(PLEASE PRINT)

Today's Date:							
PATIENT INFORMATION							
Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F		
Street address:		Social Security no.:	Home phone no.: ( )	Cell phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:				
E-mail Address:							
Occupation:	Employer:	Employer phone no.: ( )					
Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.		☐ Hospital				
☐ Family	☐ Friend	☐ Internet/website	☐ Advertisement	☐ Other			
Other family members seen here:							
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )				
The above information is true to the best of my knowledge. I understand that I am financially responsible for any fees.							
Patient/Guardian signature		*Date*					

Original Date:
Dates Revised:

Mailing address: 701 E. Hampden Ave. Suite 225
Englewood, CO 80113

Phone: 303-788-9399

Fax: 303-788-1352

Website: www.progressivehealthcenter.org

QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

BODY		
How many hours of sleep do you get each night?	☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ other ___________	
If you wake up at night, what are the hours?	☐ 11pm ☐ 12am ☐ 1am ☐ 2am ☐ 3am ☐ 4am ☐ 5am	
Do you wake up feeling tired?	☐ Yes	☐ No
Do you eat a nutritious breakfast regularly?	☐ Yes	☐ No
Do you eat on the run or at the table?	☐ Run	☐ Table
Do you drink water regularly during the day?	☐ Yes	☐ No
Do you engage in physical activity 3x a week?	☐ Yes	☐ No
Do you engage in weight bearing and/or flexibility activities daily?	☐ Yes	☐ No
Do you take regular breaks, including lunch?	☐ Yes	☐ No
EMOTIONS		
Do you feel irritable, anxious, or impatient at home or work?	☐ Yes	☐ No
Do you attach yourself to other people's issues?	☐ Yes	☐ No
Do you take time for activities for which you have a passion?	☐ Yes	☐ No
Do you take time to nurture yourself?	☐ Yes	☐ No
Are you grateful for your achievements and blessings?	☐ Yes	☐ No
Do you feel anger, grief, guilt or fear? (circle all that apply)	anger grief	guilt fear
Do you feel joyful in your life?	☐ Yes	☐ No
Do you use sugar to feed your emotions?	☐ Yes	☐ No
MIND		
Are you able to focus on one thing at a time?	☐ Yes	☐ No
Do you find yourself living in the …	☐ past ☐ present ☐ future	
Do you react to situations, rather than processing them first?	☐ Yes	☐ No
Do you take time for creative activities?	☐ Yes	☐ No
Do you take your work home with you?	☐ Yes	☐ No
Do you hold onto mindful chattering thoughts?	☐ Yes	☐ No
SPIRIT		
Do you love what you do?	☐ Yes	☐ No
Do you spend time with what is most important to you?	☐ Yes	☐ No
Do you spend time in reflection/meditation?	☐ Yes	☐ No
Do you spend time in nature?	☐ Yes	☐ No
Do you listen and honor your gut and intuition/inner spirit?	☐ Yes	☐ No
Additional Comments or Questions:		

MEDICAL PROBLEMS/HEALTH HISTORY

Check all that applies:

☐ Alcohol/Drug Addictions	☐ Eating Disorder	☐ Seizures
☐ Allergies	☐ Gall Bladder	☐ Serious Accident/Trauma
☐ Asthma	☐ Headaches/Migraines	☐ Sexual Assault/Verbal Abuse
☐ Back	☐ Hearing	☐ Sleep Disorders
☐ Bronchitis	☐ Heart/Heart Attack	☐ Stomach
☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Chronic Fatigue	☐ Kidney	☐ Thyroid/Hormonal
☐ Circulation	☐ Liver	☐ Urinary Tract
☐ Clot	☐ Lungs	☐ Vision
☐ Colon	☐ Pancreas	☐ Weight Problems
☐ Depression /Psychological Issues	☐ Post Traumatic Stress	☐ Other, briefly explain below
☐ Diabetes	☐ Pregnancy Miscarriage	☐
☐ Digestive	☐ Reproductive Organs	☐

Have you had any surgeries? ☐ Yes ☐ No

What kind? When?

Surgeries

Year	Reason	Hospital

MEDICATIONS/SUPPLEMENTS

Check what applies: ☐ OTC Medicine ☐ Prescription Medication ☐ Homeopathic Vitamins/Supplements /Herbs/Remedies

List your over-the-counter drugs, prescribed drugs, supplements:

TREATMENTS MODALITIES

Treatments modalities that you have used or are currently using:

☐ Acupuncture ☐ Chiropractic ☐ Herbal therapy ☐ Homeopathy ☐ Massage therapy ☐ Nutrition ☐ Psychotherapy ☐ Hypnosis

☐ Other