Fatigue Clinic, LLC
364 New Byhalia #1
Collierville, TN 38017

PATIENT REGISTRATION FORM

Patient Name:_____ Date of Birth: _____
Address: _____ Age: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Social Sec. # _____
Female: _____ Male: _____ email: _____
Marital Status: Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐
Employer _____ Phone_____
Employer Address: _____
Employer City: _____ State: _____ Zip _____

SPOUSE INFORMATION or RESPONSIBLE PARTY FOR BILLS (if different from patient)

Name:_____ Date of Birth: _____
Address: _____ Relationship: _____ Age: _____
City: _____ State: _____ Zip: _____ Female: _____ Male: _____
Home Phone: _____ Work Phone: _____
Social Security Number: _____
Employer: _____
Employer Address: _____

IN CASE OF EMERGENCY NOTIFY

Name:_____ Phone Number: _____
Relationship: _____

ADDITIONAL INFORMATION

Referred to us by: _____
Primary Care Physician: _____ Phone: _____
Address: _____

Primary Insurance Co. (Co-Pay Amt.$ _____)	Secondary Insurance Co. (Co-Pay Amt.$ _____)
Insurance Name: _____	Insurance Name: _____
Address: _____	Address: _____
Policy or ID Number: _____	Policy or ID Number: _____
Group Number: _____	Group Number: _____
Main Policy Holder: _____	Main Policy Holder: _____
Relationship to Patient: _____	Relationship to Patient: _____

Fatigue Clinic Collierville Holistic Health

HISTORY AND PHYSICAL EXAM

CHIEF COMPLAINT:

HISTORY OF PRESENT

Past Medical History

Previous Hospitalizations/Surgery

MEDICATIONS:

Medication Allergies/Adverse Reactions

FAMILY HISTORY :

Father:

Mother:

SOCIAL HISTORY

Occupation
Environmental Exposures
Travel History
Tobacco, Alcohol and Other Drug Use
Diet and Exercise
Education

REVIEW OF SYSTEMS-

Constitutional *(fever, chills, night sweats, weight change ,fatigue, malaise nutrition, deformities, grooming)*

Eyes *(vision, pain, discharge, photophobia)*

Ears/Nose/Throat *(hearing, tinnitus, dizziness pain, discharge, smell, , hoarseness, nose bleeds smell, hearing, discharges, lesions, hoarseness)*

Mouth / Dental *(tooth decay, gum disease, last visit to dentist, speech problems, sinus drainage, taste, snoring)*

Breast *(lumps, nipple discharge, family history of breast cancer, self breast exam)*

Cardiovascular *(Palpitation, angina, heart attack, chest pain, shortness of breath, PND, orthopnea, claudication, syncope, hypertension, cyanosis, varicosities, edema)*

Respiratory *(asthma, dyspnea, cough/sputum, hemoptysis, TB skin test status)*

Gastrointestinal *(dysphagia, anorexia, nausea, vomiting, hematemesis, diarrhea, constipation, melena, rectal bleeding, change in bowel habits, hemorrhoids, jaundice, abdominal pain, food intolerance)*

Genito-Urinary *(dysuria, hematuria, frequency, polyuria, urgency, hesitancy, incontinence, renal stones, nocturia, infection, frequency, dysuria, retention, incontinence)*

Male Reproductive *–(penile discharge, STD history, testicular pain or mass, infertility, impotence, libido)*

Female Reproductive *– menarche, last period, age of menopause, postmenopausal symptoms, postmenopausal bleeding, abnormal periods, , STD history, last Pap test, OB-Hx, discharge, odor, infertility, libido, method of contraception*

Musculoskeletal *(joint pain(mono or poly articular), edema, heat, redness, stiffness, deformity, muscle pain, tenderness, fatigue(e.g. with arthritis), atrophy?)*

Neurological *(headache, syncope, vertigo, seizures, loss of vision, diplopia, parasthesias paralysis, weakness in any limbs, tremor, ataxia, memory loss)*

Skin *(itching, rash, lump and bumps, hair and/or nail change, de/pigmentation)*

Endocrine: *(excessive thirst, sweating, dizziness, palpitations, weight change)*

Hematologic/Lymphatic: *(bruising, cyanosis, rashes, lesions, enlargement of lymph nodes, petechiae, purpura)*

Psychiatric: *(stress, insomnia, previous psychiatric illness, depression, anxiety, hallucinations, memory loss)*