TRINITY *Integrative* MEDICINE, P.A.

DR. BERNARDA ZENKER, M.D.

2434 EAST 117TH STREET, SUITE 200 • BURNSVILLE, MN 55337 • TEL 952.465.3883 • FAX 952.465.3885

NEW CLIENT REGISTRATION

Accepted forms of payment: Cash, Check, Visa, MC, Insurance

Patient # ________________

PATIENT INFORMATION

Name Last	Middle	First	Preferred/Nickname

Maiden Name	Social Security Number	Prefix (Circle One) Miss Mrs. Ms	Age	Date of Birth

Marital Status (Circle One) S M W Sep. D	Gender M F	Primary Language	Interpreter Required Yes No	Preferred Interpreter

Address	City	State	Zip

Home Phone	Work Phone	Cell Phone	Preferred # (Circle One) Home Work Cell

Pharmacy: Name	Location	Phone Number

E-Mail	Referred by
Employer	Person Responsible for this Account
Spouse/Partner's Name	Primary Care Physician and Phone Number

Emergency Contact Name	Relationship to Patient	Emergency Contact Phone #

☐ I give Trinity Integrative Medicine permission to leave messages at the following phone number(s): Cell phone____________________,

home___________________, other________________

Name____________________________________ Date____________________________ Signature_________________________________

Parent/Guardian Signature____________________________________

☐ I give Trinity Integrative Medicine permission to send information via encrypted email to this email: ______________________________________. Email methods of communication are only encrypted when Dr. Zenker/Trinity Integrative Medicine are sending emails to you. Emails sent to info@trinityintegrativemedicine.com are not fully secure since they do not meet the security requirements set forth by the Health Insurance Portability and Accountability Act (HIPPA). Phone and fax are considered more secure and can be used to communicate Dr. Zenker securely.

Name___________________________________ Date_________________________ Signature_________________________

I hereby authorize **Trinity Integrative Medicine, P.A.** to furnish information to all insurance carriers and referring physicians concerning my illness and treatment. I acknowledge that I should share all information provided by Dr. Zenker with my primary care physician.

____ ____ _________________________________

Signature Parent/Guardian Signature Date

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NEW CLIENT MEDICAL HISTORY

Name: ______________________________ Today's Date: ____________________

What brings you here today?______________________________ Date of Birth: ____________________

HISTORY OF PRESENT ILLNESS

Current Health Concerns: How long have you been ill? Describe your discomfort and level of severity. What makes you feel better or worse? Treatments you have tried. (Use back of page if necessary)

____

____

____

PAST MEDICAL HISTORY

Current Prescription Medications:

____

____

____

____

____

Have you ever had an adverse reaction to a medication?
Yes ___, No ___ If Yes, please describe: ________________

____

____

Drug Allergies: (Name of drug and type of reaction)

____

____

Current Supplements: (Name of supplement and dosage)

____

____

____

____

____

Past Surgeries and dates:

____

____

Past Illnesses: (Include date of onset)

____

____

____

HEALTH HABITS

Do you currently use Tobacco? Yes _____ No _____
How many packs per day? _____ Total years smoked? _____

What is your Alcohol Consumption? per day ________,
per week ________, per month ________, per year ________

Immunizations:
___ Tetanus (Date:_________) ___ MMR (Date:______)
___ Pneumonia (Date:_________) ___ Varicella (Date:______)
___ Shingles (Date:_________) ___ Flu (Date:________)
___ Pertussis (Date:_________)

Food Allergies:

____

____

SOCIAL HISTORY

Highest level of Education completed? ______________ List Special Training or Advanced Degrees? ______________________

Where do you find Emotional Support? Spouse ____, Friends ____, Family ____, Children ____, Neighbors ___, Other ____________

What do you do for Fun? ______________________________

What are your Hobbies / Special Interests: ______________________________

Health Goals: ______________________________

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(NEW CLIENT MEDICAL HISTORY, page 2**)** Patient Name ______________________________ Date ___________

Family History:
Father:Age_____ Illnesses ______________________________ Died at age ____ of ____________________

Mother:Age_____ Illnesses ______________________________ Died at age ____ of ____________________

Please Check Any Symptoms Present In The Last Month:

General:
___ weight change
___ generally healthy
___ change in strength or exercise tolerance.

Head:
___ headaches
___ vertigo
___ injury

Eyes:
___ vision
___ diplopia (double vision)
___ tearing
___ scotomata (partial loss of vision)
___ pain

Ears:
___ change in hearing
___ tinnitus (ears ringing)
___ bleeding
___ vertigo

Nose:
___ epistaxis (nosebleeds)
___ coryza (mucous membrane inflammation)
___ obstruction
___ discharge

Mouth:
___ dental difficulties
___ gingival bleeding
___ use of dentures

Neck:
___ stiffness
___ pain
___ tenderness
___ noted masses

Breast:
___ noted lumps
___ tenderness
___ swelling
___ nipple discharge

Chest:
___ dyspnea (shortness of breath)
___ wheezing
___ hemoptysis (coughing up blood)
___ cough

Heart:
___ chest pains
___ palpitations
___ syncope (fainting)
___ orthopnea (breathlessness)
___ swelling ankles

Abdomen:
___ change in appetite
___ dysphagia (difficulty swallowing)
___ abdominal pains
___ bowel habit changes
___ emesis (vomiting)
___ melena (bloody stools)
___ constipation
___ diarrhea
___ gas/bloating

Genital/Urinary:
___ urinary urgency
___ dysuria (painful urination)
___ change in nature of urine
___ urinate at night/ _____ times

Gynocological:
___ change in menses
___ dysmenorrhea (painful menstruation)
___ vaginal discharge
___ pelvic pain

Musculoskeletal:
___ pain in muscles or joints
___ limitation of range of motion
___ paresthesias or numbness

Neurologic:
___ weakness
___ tremor
___ seizures
___ changes in mentation
___ ataxia (lack of muscle control)
___ problems w/attention
___ problems with concentration
___ problems with memory
___ tingling in fingers/toes

Psychiatric:
___ depressive symptoms
___ changes in sleep habits
___ difficulty falling asleep
___ difficulty staying asleep
___ tired all day
___ changes in thought content

Mental/Emotional:
___ anxiety
___ depression

Skin:
___ changing mole, dryness or rashes.

Additional Information
____
____
____
____
____
____
____