Paul Raish, N.D.
65 Commons Way, Kalispell, MT 59901

# ADULT INTAKE

(This is a confidential medical record and will not be released without your authorization)

*Please print clearly and mail back to clinic prior to first office visit.*
*Thank you for your time and effort. We look forward to providing you with the best possible care.*

NAME _____ Today's date _____
GENDER: Female / Male SS# _____ - ____ - _____ AGE _____ BIRTH DATE _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE: Home: (____) ____ - _____ Work: (____) ____ - _____ Cell: (____) ____-_____
E-mail: _____ Preferred number to contact you?

May we leave messages on your: ☐home phone ☐work phone ☐cell phone ☐email

In Case of Emergency, Contact: _____ Relationship: _____
PHONE: Home: (____) ____ - _____ Work: (____) ____ - _____ Cell: (____) ____-_____

Please tell us how you found out about our office or who you were referred by:
_____

Are you currently being seen by other health practitioners? (Please list names & phone # if avail.)
_____
_____

Current Diagnoses?_____
_____

What Type of care are you seeking from me? Primary care Adjunctive care *(Please circle)*
Specific type of treatment?_____
Please describe your desired outcome for today's visit._____
_____
…for our long-term work together/Goals _____
_____

How would you rate your overall health and well-being today?
*Worst/Dead* 0 1 2 3 4 5 6 7 8 9 10 *Best/Vibrant*

**Social History:**
Your Occupation _____Employer _____
How many hours a week do you work? _____
Education: _____
Check: ___ Current Spouse/Partner ___ Single/Widowed ___ Separated/Divorced
Children? (if yes, list sex and ages) _____
Live with: ___ Spouse ___ Partner ___Parents ___ Children ___Friends ___ Alone
Spiritual practice? ___ Yes ___No What?_____
Relaxation/Amusements/Hobbies:_____

**Physical Complaints:** Blood Type: _____
What is the reason for your visit? Please list your most important present health concerns <u>in order of significance.</u>

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

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Do you take or use any of the following? (please circle)

| | | | |
|---|---|---|---|
| Laxatives | Pain relievers | Antacids | Cortisone |
| Antibiotics | Tranquilizers | Sleeping pills | Thyroid medication |
| Birth control pills | Hormone replacement | Anti-depresants | Diurrhetics |

List prescription and over the counter medications presently taking, with dosage and reason for taking:

_____ _____
_____ _____
_____ _____

List Vitamins, Minerals, Herbs, Homeopathic remedies presently taking, with dosage:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Past Hospitalizations, Surgeries: (List reason, type and your approximate age or year it occurred)

_____ _____
_____ _____

Other past Injuries, Accidents, Serious illnesses or Childhood illnesses?

_____
_____

Last complete physical: (month & yr.) _____ Reason _____
Last Cholesterol Lab test? (month & yr.) _____ Results? _____
Women - Last PAP smear: (month & yr.) _____ Results? ____ normal ____ abnormal
Last mammogram: (month & yr.) _____ Results? ____ normal ____ abnormal
Men - Last PSA blood test: (month & yr.) _____ Results? ____ normal ____ abnormal
Last prostate exam: (month & yr.) _____ Results? ____ normal ____ abnormal

**Are you allergic to any medications or supplements? ____ YES ____ NO**
If YES, list drug/supplement and reaction: _____
_____

Are you allergic to any foods? Are there any foods that don't agree with you? (list food and reaction)

_____
_____

Any environmental allergies? _____

**Lifestyle**:
What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Rate from 0-10 with 10 being 100% committed.

*0%* 0 1 2 3 4 5 6 7 8 9 10 *100%*

What do you currently do to support your health? _____
What do you currently do that sabotages your health? _____

Who do you know who will sincerely and consistently support you with the beneficial lifestyle changes you will be making? _____

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What motivates you? _____
Average hours of sleep/night _____ Do you feel this is enough sleep? _____
Describe your sleep: ___ unbroken I wake up ___ time(s)/night Rested in AM?_____
Describe any other difficulties or patterns with your sleep _____
_____

Height: _____ Weight: _____ Weight one year ago: _____
Maximum weight: _____ when? _____

Rate your **stress** level (5 being most stressful) 1 2 3 4 5
Rate your **energy** level (5 being most energetic) 1 2 3 4 5

Rate your activity level:
___ sedentary ___ slightly active ___ moderately active ___ significantly active
Exercise periods per week? _____ Duration of exercise periods _____
Exercise activities: _____
What types of physical activities do you enjoy? _____
Freq. of bowel movements: ____ per day or ___ per week, ___loose ___normal ___hard
Cigarette/Cigar/Chewing tobacco use history: _____ never
___ former: (between ages ___ - ___, packs/day ___ ) ___ current: (since age ___, packs/day ___ )
Alcohol intake history/qty per day or week: _____
Coffee/Soda/Caffeine intake history/qty per day: _____
Recreational drug use history: _____

**Diet History:**
Dietary preference: ___ Std. American ___ Reduced red meat ___ Chicken/Turkey/Fish
___ Fish & Vegetarian ___ Vegetarian only (How many years? ____)
I eat on average ____ meals per day ____ snacks per day ___ I graze all day

**Typical Food Intake:**
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Treats: _____
To Drink: _____

**Family History: (blood relatives)**

| | *still alive at age:* | **OR** *age at death:* | *Cause of death:* |
|---|---|---|---|
| MOTHER: | ____ | ____ | _____ |
| Maternal GM: | ____ | ____ | _____ |
| Maternal GF: | ____ | ____ | _____ |
| FATHER: | ____ | ____ | _____ |
| Paternal GM: | ____ | ____ | _____ |
| Paternal GF: | ____ | ____ | _____ |

Birthplace _____
Other locations lived & for how long? _____
_____

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| Disease | Who | Past/Current |
|---|---|---|
| Alcoholism | | |
| Arthritis | | |
| Asthma | | |
| Auto-immune | | |
| Blood disorder | | |
| Cancer (type) | | |
| Diabetes | | |
| Digestive disorder | | |
| Heart disease | | |
| High Blood Pressure | | |
| Kidney disease | | |
| Liver/gall bladder | | |
| Mental illness | | |
| Migraine | | |
| Stroke | | |
| Thyroid disorder | | |
| Tuberculosis | | |

**Review of Systems:**
For the following, please circle: **Y** = a condition you have now **P** = a significant problem in the past

GENERAL

| | | |
|---|---|---|
| Weight changes | Y | P |
| Night sweats | Y | P |
| Fatigue | Y | P |
| Fever | Y | P |
| Eat out often | Y | P |

SKIN

| | | |
|---|---|---|
| Acne/Boils | Y | P |
| Eczema | Y | P |
| Hives | Y | P |
| Rashes | Y | P |
| Infection | Y | P |
| Itching | Y | P |
| Growths (such as warts skin tags , cysts, tumors,?) | Y | P |
| Changes in hair/nails | Y | P |
| Ulcerations/erosions | Y | P |

HEAD

| | | |
|---|---|---|
| Headache | Y | P |
| Migraines | Y | P |
| Head injury | Y | P |
| Jaw or TMJ problems | Y | P |

EYES

| | | |
|---|---|---|
| Impaired vision | Y | P |
| Glasses or contacts | Y | P |
| Eye pain or strain | Y | P |
| Tearing or dryness | Y | P |
| Double vision | Y | P |
| Cataracts | Y | P |
| Glaucoma | Y | P |
| Color blindness | Y | P |

EARS

| | | |
|---|---|---|
| Impaired hearing | Y | P |
| Ringing | Y | P |
| Ear ache/itch | Y | P |
| Dizziness | Y | P |

NOSE & SINUSES

| | | |
|---|---|---|
| Frequent colds | Y | P |
| Nose bleeds | Y | P |
| Stuffiness | Y | P |
| Sinus problems | Y | P |
| Post nasal drip | Y | P |
| Loss of smell | Y | After |

MOUTH & THROAT

| | | |
|---|---|---|
| Frequent sore throat | Y | P |
| Sore tongue | Y | P |
| Sores in mouth/on lips | Y | P |
| Gum problems | Y | P |
| Dental cavities | Y | P |
| Hoarseness | Y | P |
| Teeth grinding | Y | P |

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| MENTAL / EMOTIONAL | | |
|---|---|---|
| Depression | Y | P |
| Anxiety or nervousness | Y | P |
| Mood swings | Y | P |
| Considered suicide | Y | P |
| Attempted suicide | Y | P |
| Tension | Y | P |
| Poor concentration | Y | P |
| Memory problems | Y | P |

| ENDOCRINE | | |
|---|---|---|
| Hypothyroid | Y | P |
| Hypoglycemia | Y | P |
| Heat or cold intolerance | Y | P |
| Hyperthyroid | Y | P |
| Hyperglycemia | Y | P |
| Excessive thirst | Y | P |
| Excessive hunger | Y | P |
| Easy weight gain | Y | P |
| Seasonal depression | Y | P |

| CARDIOVASCULAR | | |
|---|---|---|
| Cold hands/feet | Y | P |
| Deep leg pain | Y | P |
| Varicose veins | Y | P |
| Swelling in ankles | Y | P |
| Anemia | Y | P |
| Easy bleeding/bruising | Y | P |
| Heart disease | Y | P |
| Angina | Y | P |
| High/Low blood pressure | Y | P |
| Heart murmur | Y | P |

| CARDIOVASCULAR (cont.) | | |
|---|---|---|
| Blood clots | Y | P |
| Fainting | Y | P |
| Palpitations | Y | P |
| Chest pain | Y | P |
| Rheumatic fever | Y | P |

| RESPIRATORY | | |
|---|---|---|
| Cough | Y | P |
| Wheezing | Y | P |
| Coughing up blood | Y | P |
| Difficulty breathing | Y | P |
| Shortness of breath | Y | P |
| Asthma | Y | P |
| Bronchitis | Y | P |
| Pneumonia | Y | P |
| Emphysema | Y | P |
| Tuberculosis | Y | P |
| Pain on breathing | Y | P |

| GASTROINTESTINAL | | |
|---|---|---|
| Difficulty swallowing | Y | P |
| Change in appetite | Y | P |
| Change in thirst | Y | P |
| Nausea/vomiting | Y | P |
| Heartburn | Y | P |
| Ulcer | Y | P |
| Bloated after eating | Y | P |
| Belching or gas | Y | P |
| Loose stools | Y | P |
| Diarrhea | Y | P |
| Constipation | Y | P |
| Blood in stool | Y | P |
| Black stool | Y | P |
| Jaundice | Y | P |
| Liver/gall bladder disease | Y | P |
| Hemorrhoids | Y | P |
| Abdominal pain/cramps | Y | P |

| URINARY | | |
|---|---|---|
| Pain on urination | Y | P |
| Increased frequency | Y | P |
| Frequency at night | Y | P |
| Inability to hold urine | Y | P |
| Frequent UTIs | Y | P |
| Kidney stones | Y | P |

| MUSCULOSKELETAL | | |
|---|---|---|
| Joint pain or stiffness | Y | P |
| Muscle spasm or cramps | Y | P |
| Arthritis | Y | P |
| Broken bones | Y | P |
| Weakness | Y | P |
| Sciatica | Y | P |

| NEUROLOGIC | | |
|---|---|---|
| Fainting | Y | P |
| Seizures | Y | P |
| Paralysis | Y | P |
| Numbness or tingling | Y | P |
| Loss of memory | Y | P |
| Vertigo or dizziness | Y | P |

| IMMUNE | | |
|---|---|---|
| Chronically swollen glands | Y | P |
| Slow wound healing | Y | P |
| Chronic fatigue syndrome | Y | P |
| Chronic infection | Y | P |

| MALE | | |
|---|---|---|
| Hernia | Y | P |
| Testicular masses | Y | P |

| | | |
|---|---|---|
| Testicular pain | Y | P |
| Discharge or sores | Y | P |
| Sexually transmitted illness | Y | P |
| Difficulty stopping or starting urination | Y | P |
| Prostate disease | Y | P |
| Impotence | Y | P |

FEMALE

| | | |
|---|---|---|
| Age menses began _____ | | |
| Age of last menses (if menopausal) _____ | | |
| No. of days menstrual flow _____ | | |
| Length of complete cycle _____ | | |
| Are cycles regular? | Y | N |
| Painful menses | Y | P |
| Bleeding between menses | Y | P |
| Excessive flow | Y | P |
| PMS symptoms _____ | Y | P |
| Endometriosis | Y | P |
| Ovarian cysts | Y | P |
| Abnormal vaginal discharge | Y | P |
| Pain during intercourse | Y | P |
| Gonorrhea | Y | P |
| Herpes | Y | P |
| Chlamydia | Y | P |
| Genital warts | Y | P |
| Syphilis | Y | P |
| Difficulty conceiving | Y | P |
| EVER had an abnormal PAP? | Y | N |
| Ever used birth control pills? | Y | N |
| If so, how long? _____ | | |
| No. of pregnancies _____ | | |
| No. of live births _____ | | |
| No. of miscarriages _____ | | |
| No. of abortions _____ | | |
| Still have your own uterus? | Y | N |
| Still have your own ovaries? | Y | N |
| Menopausal symptoms | Y | P |
| Self breast exams? | Y | N |
| Breast pain/tenderness | Y | P |
| Breast lumps | Y | N |
| Nipple discharge | Y | P |

GENERAL (Please circle)

Does your body temperature run Hot or Cold
When sick, do you run a temperature?
99 100 101 102 103 104 105 degrees F
Do you tend to hold onto emotions/things in the past? Y N
Is it difficult to let things go? Y N
Do you consider yourself an Introvert or an Extrovert?
Does humidity bother you? Y N Explain_____
_____

Does Hot weather bother you? Y N Explain_____
_____
Does Cold weather bother you? Y N Explain_____
_____
Do you have any Fears or Phobias?
If so of what?_____
Do you have any recurrent dreams?_____ If so, do you remember what they are about? ____ Describe_____
_____
How would you describe yourself?_____
_____
How would others describe you?_____
_____
What is your reaction to every day stresses?_____
_____
What types of things cause you stress?_____
_____
What do you do to relax?_____
_____
What do you do for fun?_____
_____
What do you do to treat yourself?_____
_____
What are your favorite foods?_____
_____
Do you have an aversion to any foods?_____
Does your body run Hot or Cold?
How is your immune system?_____
How often do you get sick? Times per year?
Colds? Flu?

At what age/period of your life did most of your problems begin?_____
When did they become the worst?_____

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## CONSENT FOR TREATMENT

I hereby authorize Dr. Paul Raish to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**General Diagnostic Procedures** (including but not limited to general physical exams, neurological and musculoskeletal assessments, venipuncture, pap smears, radiography, and blood and urine lab work)

**Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions Herbs/Natural Medicines** (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

**Dietary Advice and Therapeutic Nutrition** (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

**Pharmaceutical** preparations may also be prescribed when needed, but are not the 1st line of treatment.

**Soft Tissue and Osseous Manipulation** (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

**Electromagnetic and Thermal Therapies** (includes the use of ultrasound, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and hydrotherapies.)

**Injections:** Prolozone, IV therapy, vitamin injections, ozone treatment

**Potential Risks:** Discomfort, blistering, discolorations, infection, fainting or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydro-therapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

**Potential benefits:** Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

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**Notice to Pregnant Women:** All female clients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

**I understand** that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by my physician. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee if such request involves expense to send.

| | |
|---|---|
| _____ | _____ |
| Client's Name (PRINT) | Guardian/Personal Representative's Name |
| _____ | _____ |
| Client's Signature | Guardian/Personal Representative's Signature |
| _____ | _____ |
| Date | Relationship/Representatives Authority |

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**Financial Policy**

Payment is due in full at time of service for all procedures. We gladly accept cash, check, Visa, Mastercard, and American Express.

It is the patient's responsibility to verify their insurance coverage and whether they accept Naturopathic Doctors on the insurance plan. As a courtesy to you, we will gladly process and submit your insurance claim for you, however, if insurance does not cover the entire balance, it is the patient's responsibility to ensure full payment. Co-pays will be collected at time of service.

All phone consultations will be paid via credit card before the consultation begins.

All supplements used by Dr. Raish's office are of the highest quality. Dr. Raish has and continues to spend significant time researching products and companies ensuring that the products he prescribes are of the greatest integrity and provide the best care. All supplements are paid for at time of service.

If you need to cancel an appointment, please do so at least 24 hours ahead of time. There will be a $50 fee assessed for no shows. Special circumstances for absence can be discussed.

I have read and understand my financial responsibility.

_____ _____ _____
Print Name Signature Date

**Acknowledgement of Receipt of Notice of Privacy Practices**
***You May Refuse to Sign this Acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Relation to Patient: _____

Signature: _____ Date: _____

For Office Use Only:

□ Individual refused to sign □ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify) -

_____

_____