Paul Raish, N.D.
215 S. Complex Drive, Kalipsell, 599011

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: F 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: (____) ____-_____

How did you hear about us?_____
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
Specific type of treatment?_____
Please describe your desired outcome for today's visit._____
_____
…for our long-term work together/Goals _____
_____

Social History:
Your Occupation _____
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?_____

Physical Complaints
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) _____

Do you take or use any of the following?
☐ Laxatives ☐ Pain relievers ☐ Antacids
☐ Antibiotics ☐ Sleeping pills ☐ Thyroid medication
☐ Hormone replacement ☐ Anti-depressants ☐ Cortisone

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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?

_____
_____

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? _____

Blood Type: _____

Lifestyle:
Height: _____ Weight: _____ Weight one year ago: _____Maximum weight: _____

Rate your **stress** level (5 being most stressful) 5
Rate your **energy** level (5 being most energetic) 5

Rate your activity level:
☐ sedentary ☐ slightly active ☐ moderately active ☐ significantly active
Exercise periods per week? _____ Duration of exercise periods _____
Exercise activities: _____
Freq. of bowel movements: ____ per day or ___ per week, ☐ loose ☐ normal ☐ hard
Cigarette/Cigar/Chewing tobacco use history: ☐ never ☐ former ☐ current
Alcohol intake history/qty per day or week: _____
☐ Coffee: per day _____ ☐ Soda : per day_____ ☐ Caffeine: per day_____

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Diet History:

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:	____	____	_____

Disease	Who	Past/Current
Alcoholism		NA
Auto-immune		NA
Cancer (type)		NA
Diabetes		NA
Digestive disorder		NA
Heart disease		NA
Kidney disease		NA
Liver/gall bladder		NA
Mental illness		NA
Stroke		NA
Thyroid disorder		NA

Review of Systems:
For the following, please circle: **C** = current condition **P** = a significant problem in the past

GENERAL
- Weight changes NA
- Night sweats NA
- Fatigue NA

SKIN
- Acne/Boils NA
- Eczema NA
- Hives/rashes NA
- Infection NA
- Itching NA
- Growths (such as warts Skin tags , cysts, tumors,?) NA
- Changes in hair/nails NA
- Ulcerations/erosions NA

HEAD
- Headache NA
- Migraines NA
- Head injury NA
- Jaw or TMJ problems NA

EARS
- Impaired hearing NA
- Ringing NA
- Earache/itch NA
- Dizziness NA

NOSE & SINUSES
- Frequent colds NA
- Nose bleeds NA
- Sinus problems NA
- Loss of smell/taste NA

MOUTH & THROAT

- Frequent sore throat NA
- Sore tongue NA
- Sores in mouth/on lips NA
- Gum problems NA
- Teeth grinding NA

MENTAL / EMOTIONAL

- Depression NA
- Anxiety or nervousness NA
- Mood swings NA
- Considered suicide NA
- Tension NA
- Poor concentration NA
- Memory problems NA

ENDOCRINE

- Hypothyroid NA
- Hypoglycemia NA
- Heat or cold intolerance NA
- Hyperthyroid NA
- Hyperglycemia NA
- Excessive thirst NA
- Excessive hunger NA
- Easy weight gain NA
- Seasonal depression NA

CARDIOVASCULAR

- Cold hands/feet NA
- Deep leg pain NA
- Swelling in ankles NA
- Anemia NA
- Easy bleeding/bruising NA
- Heart disease NA
- High/Low blood pressure NA
- Blood clots NA
- Palpitations NA
- Chest pain NA

RESPIRATORY

- Cough NA
- Wheezing NA
- Difficulty breathing NA
- Shortness of breath NA
- Asthma NA
- Bronchitis NA
- Pneumonia NA

GASTROINTESTINAL

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

URINARY

- Pain on urination NA
- Increased frequency NA
- Frequent UTIs NA
- Kidney stones NA

MUSCULOSKELETAL

- Joint pain or stiffness NA
- Muscle spasm or cramps NA
- Arthritis NA
- Weakness NA
- Sciatica NA

NEUROLOGIC

- Fainting NA
- Seizures NA
- Numbness or tingling NA

IMMUNE

- Chronically swollen glands NA
- Slow wound healing NA
- Chronic fatigue syndrome NA
- Chronic infection NA

MALE

- Hernia NA
- Testicular masses NA
- Testicular pain NA
- Discharge or sores NA
- Sexually transmitted illness NA
- Difficulty stopping or starting urination NA
- Prostate disease NA
- Impotence NA

FEMALE

- Age menses began _____
- Age of last menses (if menopausal) _____
- No. of days menstrual flow _____
- Length of complete cycle _____
- Are cycles regular? ☐ C ☐ N
- Anything unusual regarding menstruation? ☐
- Endometriosis NA
- Ovarian cysts NA
- Abnormal vaginal discharge NA
- Pain during intercourse NA
- STD NA
- Which one(s)?_____
- Difficulty conceiving ☐
- EVER had an abnormal PAP? ☐ Yes ☐ No
- Ever used birth control pills? ☐ Yes ☐ No
- If so how long?

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No. of pregnancies _____
No. of live births _____
No. of miscarriages _____
No. of Abortions _____

Do you still have a uterus?	NA
Do you still have ovaries?	NA
Menopausal symptoms?	NA
Self breast exams?	NA
Breast Pain/Tenderness	NA
Breast lumps	NA
Nipple Discharge	NA

GENERAL

Do you tend to hold onto emotions/things in the past? No
Is it difficult to let things go? No
Do you consider yourself an Introvert or an Extrovert? Extrovert
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?_____
_____
Do you have an aversion to any foods?_____

Financial Policy

Thank you for choosing The Natural Path where we are committed to providing the best medical care possible. The following statement explains our financial policy which we ask you to read, sign and return to us prior to your treatment. Naturopathic Medicine mayor may not be covered by some PPO plans. Check with your insurance company to determine if this is a covered benefit. I am liable for bill either way.

- Payment is due in full at time of service for all procedures. We gladly accept cash, check, or card.
- All phone consultations will be paid via credit card before consultation begins.
- All supplements used by Dr. Raish's office are of the highest quality. Dr. Raish has and continues to spend a 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.

Consent to Treat

I authorize The Natural Path to perform general diagnostic procedures, psychological counseling, lifestyle counseling, exercise prescriptions herbs/natural medicines, dietary advice and therapeutic nutrition, pharmaceutical prescriptions, if necessary, soft tissue and osseous manipulation, electromagnetic and thermal therapies, injections (Prolozone, IV therapy, vitamin injections, ozone treatment), and accept all potential risks and benefits from the treatment given to me therein. I voluntarily consent to treatment, 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.

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.

I consent to the use and/or disclosure of my protected health information by The Natural Path for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I understand and agree that diagnosis or treatment of me by The Natural Path and my physician may be conditioned upon my consent as evidence by my signature on this document. I have read and agree to this financial policy.

Print Name of Patient _____

Signature of Patient _____

Date_____

Please email to thenaturalpath@protonmail.com