

Paul Raish, N.D.
215 S. Complex Drive. Ste. 1, 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 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 in order of significance.
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

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

| | | |
|---------------------|------------------|--------------------|
| Laxatives | Pain relievers | Antacids |
| Antibiotics | Sleeping pills | Thyroid medication |
| Hormone replacement | Anti-depressants | Cortisone |

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)

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

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 _____

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 | | |
| Auto-immune | | |
| Cancer (type) | | |
| Diabetes | | |
| Digestive disorder | | |
| Heart disease | | |
| Kidney disease | | |
| Liver/gall bladder | | |
| Mental illness | | |
| Stroke | | |
| Thyroid disorder | | |

Review of Systems:

For the following, please select: **C** = current condition **P** = a significant problem in the past

GENERAL

- Weight changes
- Night sweats
- Fatigue

SKIN

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

HEAD

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

EARS

- Impaired hearing
- Ringing
- Earache/itch
- Dizziness

NOSE & SINUSES

- Frequent colds

- Nose bleeds
- Sinus problems
- Loss of smell/taste

MOUTH & THROAT

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

MENTAL / EMOTIONAL

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

ENDOCRINE

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

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

RESPIRATORY
Cough
Wheezing
Difficulty breathing
Shortness of breath
Asthma
Bronchitis
Pneumonia

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

URINARY
Pain on urination
Increased frequency
Frequent UTIs
Kidney stones

MUSCULOSKELETAL
Joint pain or stiffness
Muscle spasm or cramps
Arthritis
Weakness
Sciatica

NEUROLOGIC
Fainting
Seizures
Numbness or tingling

IMMUNE
Chronically swollen glands
Slow wound healing
Chronic fatigue syndrome
Chronic infection

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

FEMALE
Age menses began _____
Age of last menses (if menopausal) _____ No. of
days menstrual flow _____ Length of
complete cycle _____ Are cycles
regular?
Anything unusual regarding menstruation?

Endometriosis
Ovarian cysts
Abnormal vaginal discharge
Pain during intercourse
STD
Which one(s)? _____
Difficulty conceiving
EVER had an abnormal PAP?
Ever used birth control pills?
If so, how long? _____
No. of pregnancies _____
No. of live births _____
No. of miscarriages _____
No. of Abortions _____
Do you still have a uterus?
Do you still have ovaries?
Menopausal symptoms?
Self breast exams?
Breast Pain/Tenderness
Breast lumps
Nipple Discharge

GENERAL
Do you tend to hold onto emotions/things in the past?
Is it difficult to let things go?
Do you consider yourself an Introvert or an Extrovert?
What types of things cause you stress?
What do you do to relax?

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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 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 evidenced by my signature on this document. I have read and agree to this financial policy.

Print Name of Patient _____

Signature of Patient _____

Date _____