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 <u>in order of significance.</u>

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:

_____ _____
_____ _____

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_____ _____

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_____

Diet History:

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

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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 N/A
- Night sweats N/A
- Fatigue N/A

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

HEAD
- Headache N/A
- Migraines N/A
- Head injury N/A
- Jaw or TMJ problems N/A

EARS
- Impaired hearing N/A
- Ringing N/A
- Earache/itch N/A
- Dizziness N/A

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

MOUTH & THROAT
- Frequent sore throat N/A
- Sore tongue N/A
- Sores in mouth/on lips N/A
- Gum problems N/A
- Teeth grinding N/A

MENTAL / EMOTIONAL
- Depression N/A
- Anxiety or nervousness N/A
- Mood swings N/A
- Considered suicide N/A
- Tension N/A
- Poor concentration N/A
- Memory problems N/A

ENDOCRINE
- Hypothyroid N/A
- Hypoglycemia N/A
- Heat or cold intolerance N/A
- Hyperthyroid N/A
- Hyperglycemia N/A
- Excessive thirst N/A
- Excessive hunger N/A
- Easy weight gain N/A

Seasonal depression N/A

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

RESPIRATORY
- Cough N/A
- Wheezing N/A
- Difficulty breathing N/A
- Shortness of breath N/A
- Asthma N/A
- Bronchitis N/A
- Pneumonia N/A

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

URINARY
- Pain on urination N/A
- Increased frequency N/A
- Frequent UTIs N/A
- Kidney stones N/A

MUSCULOSKELETAL
- Joint pain or stiffness N/A
- Muscle spasm or cramps N/A
- Arthritis N/A
- Weakness N/A
- Sciatica N/A

NEUROLOGIC
- Fainting N/A
- Seizures N/A
- Numbness or tingling N/A

IMMUNE
- Chronically swollen glands N/A
- Slow wound healing N/A
- Chronic fatigue syndrome N/A
- Chronic infection N/A

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

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

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?
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_____