Paul Raish, N.D.
215 S. Complex Drive, Kalipsell, 59901

NAME _____ Today's date _____
GENDER: F AGE _____ BIRTH DATE _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE: Home: (____) ____ - _____ Work: (____) ____ - _____ Cell: (____) ____-_____
E-mail: _____

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

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:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current Medical Conditions

_____
_____
_____
_____

List all Allergies

_____
_____

Hieght_____ Weight_____

Circle all symptoms that you are experiencing and how long you have been experiencing:

Fatigue _____
Headache _____
Loss of taste _____
Loss of smell _____
Fever _____
Digestive issues _____
Muscle aches/pains _____
Dizziness _____
Sinus issues _____
Sore Throat _____

Difficulty breathing _____
Chest pain _____
Shortness of breath _____
Cough _____

Other _____
_____
_____
_____
_____

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CONSENT FOR TREATMENT

I understand that I may ask questions regarding my treatment 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, realizing that no guarantees have been given to me by my physician.

Financial Policy

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

I have read and understand all of the Consent for Treatment and Financial Policy.

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

Please email to thenaturalpath@protonmail.com