REGISTRATION

Name ____ Date of First Visit _________________

Address____________________________________ City_____________ Postal Code________

Home Phone __________________________ Work/Cell Phone __________________________

Email ____ Relationship Status _______________

May we contact you via email: Yes ____ No ___; email updates/newsletters: Yes ____ No ___

Age _______ Date of Birth (M/D/Y) ____________________ Gender: female ____ male ____

Occupation _____________________________ Employer _____________________________

Extended Health Plan Carrier ____

Has any other family member already been a patient at the clinic? _______________________

If patient is a minor (<18yrs), Parent or Guardian name(s) ______________________________

Emergency Contact Person ___________________ Relationship to Patient _______________

Home Phone ______________________ Work/Cell Phone ____________________________

How did you hear about Ray Clinic? ____

HEALTH OVERVIEW

Name of your current GP (Medical Doctor) _______________________________________

MD's contact information ___________________Your last MD visit __________________

What was the reason? ____

Are you seeing medical specialist(s)? Y N If yes, for what reason? _________________

Name(s) of medical specialist(s) ____

Name(s) of other health care professional(s) _____________________________________

What is the main reason for your visit today? _____________________________________

____

What are your most important health concerns? Please list in order of importance to you.

1. ____

2. ____

3. ____

4. ____

5. ____

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REVIEW OF SYSTEMS

Please mark any of the following – 'C' (*currently* experience) or 'P' (*past*), or *check* √ if you have any concerns about:

C/P

__ alcohol/drug misuse
__ allergies
__ anemia
__ arthritis
__ asthma
__ bladder concerns
__ cancer, type: ___________________
__ colds/flus, frequent
__ diabetes I / II
__ digestive problems
__ dizziness
__ ear problems
__ eating disorders
__ epilepsy
__ eye problems
__ fatigue, chronic
__ fever
__ food restrictions: ____________________
__ gallbladder/liver problems
__ gum/teeth problems
__ gynecological (female health) concerns
__ hay fever/sinus problems
__ headaches
__ heart/circulatory problems
__ heart surgery/pacemaker
__ hepatitis
__ high/low blood pressure

C/P

__ HIV/AIDS
__ hypoglycemia (low blood sugar)
__ jaundice
__ joint problems
__ kidney problems
__ low back pain
__ lung problems
__ mononucleosis
__ neck pain
__ numbness, pins/needles
__ occupational exposure to toxic substances
__ parasites
__ phobias
__ psychological – anxiety / depression
__ recreational drugs (past or present)
__ sexually transmitted infections
__ skin problems
__ smoking (past or present)
__ stress
__ suicidal ideation, history, or attempt
__ thyroid concerns
__ trigeminal neuralgia
__ ulcer
__ vertigo
__ water retention (edema)
__ yeast infections
__ other: _______________________________

Family History: Please circle any of the following that applies in your family history.

Cancer: type	Diabetes	Heart Disease
High Blood Pressure	High Cholesterol	Stroke
Epilepsy	Mental Illness	Asthma
Hay Fever/Hives/Allergies	Anemia	Kidney Disease
Glaucoma	Tuberculosis/TB	Arthritis

Other:

Anthropometric Data:

Height _____________ Weight _____________ Recent Weight Changes? Y N

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Female Reproductive/Breast Health:

Age of first menses ______ Length of cycle _____ days Date of last PAP exam ___________

Length of menses _______ Age of last menses (if menopausal) _______

Please mark any of the following 'C' for current, 'P' for past:

	Irregular Cycles		Sexually Active
	PMS (premenstrual syndrome)		Menopausal
	Menstrual Cramps		Cervical Dysplasia / Abnormal PAP
	Clotting		Endometriosis
	Heavy or excessive menstrual flow		Fibroids
	Bleeding between cycles		Ovarian cysts
	Breast lumps and/or pain		Nipple discharge
	Sexual difficulties/painful intercourse		Difficulty conceiving

Are you currently pregnant? Y N If yes, how long? ________ weeks

Are you currently on Birth Control Pill? Y N How long? ________ Type ________________

Number of pregnancies ______ Number of live births ______ (vaginal ___ c-section ___)

Number of miscarriages ______ Number of abortions _______

Hysterectomy? Y N If yes, when?___________ Do you do breast self-exam? Y N

Male Reproductive Health:

	Hernias		Sexually Active
	Testicular masses		Birth control: type
	Testicular or scrotal pain		Poor sperm morphology
	Low sperm count		Low sperm motility
	Erectile dysfunction		Premature ejaculation
	Prostate problem		Discharge or sores

Childhood Illnesses: Please circle any of the following you experienced as a child.

Scarlet Fever	Mumps	Diphtheria	Measles	Rheumatic Fever	German Measles

Immunizations: Please check any of the following immunizations you have received.

	Polio		Pertussis
	Tetanus		Diphtheria
	Measles/Mumps/Rubella (MMR)		Pneumococcal
	Hepatitis B		Meningococcal
	Hemophilus influenza B		Influenza ('flu shots')
	Travel Related:		Other:

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What injuries, hospitalizations, surgeries, and other procedures have you had?

__________________________ year:_____ __________________________ year:_____

__________________________ year:_____ __________________________ year:_____

Please list any hypersensitivity or allergy to medications, chemicals, foods, or environment:

____

Please list all medications, <u>vitamins</u>, and <u>supplements</u> you are currently taking:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

What specific expectations do you have from today's visit?

What long-term expectations do you have from working with Ray Clinic?

What expectations do you have of me personally as your physician?

PRIVACY NOTICE

Privacy of personal information is of utmost importance while providing quality naturopathic medical care. The clinicians and staff at Ray Clinic understand the importance of protecting personal information and are committed to collecting, using, and disclosing personal information responsibly.

FEE SCHEDULE

Initial Consultation (1 hour): $175+hst	IV Therapy (Push): $90+hst	Lab Tests: Varies
Follow-up Visit (30 min): $85+hst	IV Therapy (Drip): $140+hst	Supplements: Varies
Extended Follow-up (45min):$130+hst	IM Injection (B12): $25+hst	Missed Appt Fee: $55

CONSENT & AGREEMENT

I hereby request and consent to receive treatment from the physicians at Ray Clinic. I understand that this consent is voluntary and may be withdrawn at any time in written or verbal format. I understand the fee schedule, including the cancellation policy – I am responsible for paying the missed appointment fee if I do not give 24 hrs notice of change or cancellation. I accept responsibility for prompt payment at the time of each visit or treatment. I give permission for the clinic to leave messages regarding appointments at the contact information I have provided above.

Patient Name (Please Print) ____

Patient Signature ____ Date ________________

(Guardian signature required for patients <18yrs)

Thank you for your time in providing this information.

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