pearl NATURAL HEALTH

B12 Happy Hour
Kelly Raylinsky ND

PATENT INTAKE FORM

Name_____Date_____
Address_____
City_____State_____Zip Code_____
Phone (hm)_____(wk)_____E-mail_____
Age_____Date of Birth_____Gender female O male O
Place of Birth_____
Employer_____Social Security #_____
O Married O Partnership O Single O Separated O Divorced O Widowed
Live with: O Spouse or Partner O Parents O Children O Friends O Alone

Emergency Contact
Name_____Relationship_____
Phone_____Address_____

Insurance Information

Health Insurance_____Phone #_____
Address_____
City_____State_____Zip Code_____
Subscriber's Name_____Date of Birth:_____
ID #_____Group/Policy #_____

Are you currently receiving healthcare? Y N
If yes, from whom?_____
If no, when and where did you last receive medical or healthcare?_____
What was the reason?_____
Have you ever been to a Naturopathic Doctor? Y N
Are you interested in Naturopathic Care Y N
What are your most important health concerns? List in order of importance:
(1) _____(2)_____(3)_____
Name 3 Health goals you have.
(1)_____(2)_____(3)_____
Name 3 expectations you have from receiving b12 injections.
(1)_____(2)_____(3)_____
Name 3 things you love to do.
(1)_____(2)_____(3)_____
Allergies: Are you hypersensitive or allergic to any foods, drugs, environmentals, or chemicals? _____
Medications
Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking:
(1) _____ (3) _____
(2) _____ (4) _____

Current Energy Level: 1—2—3—4—5—6—7—8—9—10
Low----------High

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Review of Systems

Social
Do you use recreational drugs? Y N P

Have you been treated for drug dependence? Y N P
Do you use alcoholic beverages? Y N P
If yes, how many drinks per week? _____

Mental/Emotional
Have you been treated for emotional problems? Y N P
Mood Swings? Y N P
Considered/Attempted Suicide? Y N P
Poor concentration? Y N P
Fears, phobia? Please specify:_____
Depression? Y N P
Anxiety or Nervousness? Y N P
Tension? Y N P
Increased Irritability? Y N P
Difficulty Concentrating? Y N P

General
Fever? Y N P
Fatigue? Y N P
Night Sweats? Y N P
Malaise? Y N P
Difficulty Falling Asleep? Y N P
Interrupted Sleep? Y N P
Wake feeling rested? Y N P
Weight Loss? Y N P

Neurological
Memory Problems? Y N P
Memory Loss? Y N P
Seizures? Y N P
Numbness or Tingling? Y N P
Confusion, Change in Mental Status? Y N P
Loss of Balance? Y N P
Depression? Y N P
Light-headedness? Y N P
Disorientation? Y N P
Dementia? Y N P
Vertigo? Y N P
Dizziness? Y N P

Musculoskeletal
Muscle Pain? Y N P
Muscle Tension? Y N P
Pain? Y N P
Numbness? Y N P
Tightness? Y N P
Stiffness? Y N P
Fibromyalgia? Y N P

Nutritional Status
Vegetarian Diet or Vegan Diet? Y N P
Pernicious Anemia? Y N P
MTHFR genetic mutation? Y N P
Take Anti-acid frequently? Y N P
Acid Reflux Medication? Y N P

Gastrointestinal
Diarrhea? Y N P
Constipation? Y N P
Loss of Appetite? Y N P
Crohn's Disease? Y N P
Celiac Disease? Y N P
Stomach upset? Y N P

Infections/Immune
Parasitic Infection? Y N P
EBV/Mononucleosis? Y N P
Lyme Disease? Y N P
Past Chronic Fatigue Syndrome? Y N P
Other Autoimmune Disease? Y N P

Cardiac/Respiratory
High/Low Blood Pressure? Y N P
Shortness of Breath? (mostly during exercise) Y N P
Rapid heart rate and breathing? Y N P

Oral/Dental
Bleeding gums? Y N P
Swollen/red tongue? Y N P

Hematologic
Easy bruising or bleeding? Y N P
Pale skin? Y N P