



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. _____



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



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
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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:



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, vitamins, and supplements 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): \$180	IV Therapy (Push): \$90	Lab Tests: Varies
Follow-up Visit (30 min): \$90	IV Therapy (Drip): \$145	Supplements: Varies
Extended Follow-up (45min): \$135	IM Injection (B12): \$30	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)

***Scent-Free Environment: Patients in our clinic may have sensitivity and/or allergic reactions to various fragrant products. We ask that you avoid personal products that are perceptible to others when visiting the clinic. Your understanding and support is greatly appreciated. Thank you.**