ray clinic

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: _____

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. _____

#106-1196 Pinetree Way, Coquitlam, BC V3B 0L8 TEL: 604-461-7900 FAX: 604-461-7901 www.rayclinic.ca

ray clinic

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	C/P
__ alcohol/drug misuse	__ HIV/AIDS
__ allergies	__ hypoglycemia (low blood sugar)
__ anemia	__ jaundice
__ arthritis	__ joint problems
__ asthma	__ kidney problems
__ bladder concerns	__ low back pain
__ cancer, type: _____	__ lung problems
__ colds/flus, frequent	__ mononucleosis
__ diabetes I / II	__ neck pain
__ digestive problems	__ numbness, pins/needles
__ dizziness	__ occupational exposure to toxic substances
__ ear problems	__ parasites
__ eating disorders	__ phobias
__ epilepsy	__ psychological – anxiety / depression
__ eye problems	__ recreational drugs (past or present)
__ fatigue, chronic	__ sexually transmitted infections
__ fever	__ skin problems
__ food restrictions: _____	__ smoking (past or present)
__ gallbladder/liver problems	__ stress
__ gum/teeth problems	__ suicidal ideation, history, or attempt
__ gynecological (female health) concerns	__ thyroid concerns
__ hay fever/sinus problems	__ trigeminal neuralgia
__ headaches	__ ulcer
__ heart/circulatory problems	__ vertigo
__ heart surgery/pacemaker	__ water retention (edema)
__ hepatitis	__ yeast infections
__ high/low blood pressure	__ 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

#106-1196 Pinetree Way, Coquitlam, BC V3B 0L8 TEL: 604-461-7900 FAX: 604-461-7901 www.rayclinic.ca

ray clinic

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:

#106-1196 Pinetree Way, Coquitlam, BC V3B 0L8 TEL: 604-461-7900 FAX: 604-461-7901 www.rayclinic.ca

ray clinic

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?

<u>PRIVACY NOTICE</u>

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.

<u>FEE SCHEDULE</u>

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

<u>CONSENT & AGREEMENT</u>

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)

<u>*Scent-Free Environment</u>: 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.

#106-1196 Pinetree Way, Coquitlam, BC V3B 0L8 TEL: 604-461-7900 FAX: 604-461-7901 www.rayclinic.ca