❖ *NEW PATIENT PROFILE*

Please complete these pages as accurately and as completely as possible. If you need help, please ask. If possible, *please use a **blue ink pen** to make your form easier to read*.

Today's date: ____/____/____

Name:_____ Gender: Male Female
FIRST MIDDLE LAST

Date of birth:____/____/____ Current age:_____ Height:_____ Weight:_____

Home street address:_____

City: _____ State: _____ Zip code:_____

Mailing address (if preferred):_____

City, state, zip code_____

Home phone: (_____)_____ OK to leave message? Yes No

Work phone: (_____)_____ OK to leave message? Yes No

Mobile phone: (_____)_____ OK to leave message? Yes No

E-mail: _____ OK to leave message? Yes No

Occupation:_____Employer:_____

Emergency contact:_____Phone: (_____)_____

❖ *HEALTH INFORMATION—confidential*

PRESENT HEALTH CONCERNS: *Please list your most important health concerns. If possible, please list them in order of importance to you. For example, #1 is most important, and #5 is least important.*

1) _____

2) _____

3) _____

4) _____

5) _____

YOUR MAJOR GOALS FOR THE FIRST VISIT: *Please tell me what you would like to accomplish on the first visit.*

1) _____

2) _____

3) _____

4) _____

5) _____

YOUR QUESTIONS: *What questions do you have for today's visit?* _____

_____

_____

ALLERGIES: *Please list all **food, environmental,** and/or **drug** allergies*: _____

_____

_____

Name:	Today's date:

Current <u>prescription medications</u> (e.g., Prozac, atenolol, etc), **<u>non-prescription medications</u>** (e.g., aspirin, Tylenol, ibuprofen) and/or **<u>health supplements</u>** (e.g., vitamins, minerals, herbs): *Please list the medications and/or supplements that you are currently taking, with dosages:*

NAME *of medication or supplement—drugs, vitamins, herbs, minerals*	**DOSE** *in milligrams or grams (or number of capsules, tablets)*	**FREQUENCY***: Times per day/ week/ month*	**DURATION***: Been taking for how long?*

MOST RECENT VISIT TO A DOCTOR: *When was the last time you consulted a doctor, and for what reason?* _____

Date of last complete physical exam: _____

Date of most recent lab/blood tests: _____

WOMEN—date of last PAP smear: ____results:_____ Currently pregnant? YES NO UNSURE

Medical procedures, **hospitalizations, major injuries, and serious illnesses**: *Please list previous medical procedures, surgeries, hospitalizations, and serious illnesses.*

Approximate date/ year	**Surgery/ hospitalizations/ procedure/ serious illnesses/ injuries**

DIET: *Do you follow any particular diet regimens or restrictions?* _____

_____

EXERCISE: *Do you exercise regularly? If YES—what do you do? If NO—what keeps you from exercising?* _____

_____

HABITS and LIFESTYLE: *Please circle or list which of the following you use*: tobacco/cigarettes alcohol coffee black tea cola/soda aspirin/Tylenol/analgesics antacids recreational drugs prescription drugs *Other*: _____

_____

Name:	Today's date:

❖ MUTUAL UNDERSTANDINGS AND CONSENT TO TREATMENT

- The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following. Please ask any questions if you would like clarification or additional information.

- Information revealed during counseling and discussion sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.

- Each procedure and/or treatment carries with it both risks and benefits. There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and will be customized to your unique health status and your personal goals, no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s).

- Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered. Treatments, consultations (whether by phone, e-mail, or in the office), detailed correspondence on your behalf are examples of professional services. You are responsible for payment for office fees, treatments, and lab tests regardless of insurance coverage.

- When you call and schedule an appointment, time is reserved especially for you and no one else. We therefore require a $50 deposit which is applied toward your visit, labs, and treatments and which is forfeited if you cancel your appointment without giving us 24-hour notice.

- Dr. Paun is not available on a 24-hour basis at all times. You need to have another doctor with whom you can consult in the event of an emergency or urgent problem. If you have a serious health problem that requires immediate attention, you should call your other doctors(s), call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then call or email JPaun174@hotmail.com Dr. Paun and inform him of what occurred.

- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let Dr. Paun know if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). Consult your prescribing doctor before discontinuing medications. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.

- You are welcome to bring a friend or relative to your visits if such companionship is comfortable for you.

- You are encouraged to ask questions on any health-related topic and to take an active role in your health-care. Ours is a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyle that can help you attain your highest level of health.

The contact information, health history, and other information that I provided on my intake form are complete and accurate. I understand and agree to the information on this page. My questions, if any, were answered to my satisfaction.

SIGNATURE of patient or guardian Date

Name:	Today's date:

REVIEW OF SYSTEMS: I have designed the following form so that it will be easy for you to complete. Simply check the appropriate box for each attribute so that we can further discuss the specific areas of concern that you have—if you have additional comments or want to provide additional information, please make a note and we can discuss your concerns during the visit. Please provide additional information where you mark the answer "Yes→." Your completing this form will enable us to work more efficiently during our time together and will allow a means by which to reassess your status on future visits.

GENERAL HEALTH	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Fatigue, lack of energy, lack of stamina	❑ 0	❑ 1	❑ 2	❑ 3
Need to decrease or alter activities of daily living due to fatigue, pain, or illness	❑ 0	❑ 1	❑ 2	❑ 3
Insomnia, lack of sleep	❑ 0	❑ 1	❑ 2	❑ 3
Excessive tiredness and increased need for sleep	❑ 0	❑ 1	❑ 2	❑ 3
Tired and/or not hungry after waking	❑ 0	❑ 1	❑ 2	❑ 3
Pain at night, night sweats	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Enlarged lymph nodes	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Frequent infections	❑ 0	❑ 1	❑ 2	❑ 3
Undesired weight loss	❑ 0	❑ 1	❑ 2	❑ 3
Undesired weight gain, difficulty losing weight	❑ 0	❑ 1	❑ 2	❑ 3
Cold hands or feet	❑ 0	❑ 1	❑ 2	❑ 3
Compulsive/binge eating, increased appetite	❑ 0	❑ 1	❑ 2	❑ 3
Decreased appetite	❑ 0	❑ 1	❑ 2	❑ 3
Hypoglycemia, low blood sugar	❑ 0	❑ 1	❑ 2	❑ 3
Allergies to food or environment	❑ 0	❑ 1	❑ 2	❑ 3
Sensitivity to fumes, chemicals, odors, exhaust	❑ 0	❑ 1	❑ 2	❑ 3
Have you been tested for iron disorders?	❑ NO	❑ YES	❑ **?**	
Past diagnosis of serious illness or chronic health condition such a systemic disease, cancer, HIV, mental condition, heart disease, infection, kidney problems, or other condition	❑ NO	❑ YES→		

MUSCLES and JOINTS	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain, swelling, or limited motion in joint(s)	❑ 0	❑ 1	❑ 2	❑ 3
Pain, swelling, or weakness in muscle(s)	❑ 0	❑ 1	❑ 2	❑ 3
Cramps in muscles, grind teeth at night?	❑ 0	❑ 1	❑ 2	❑ 3
Other problem, concerns, or questions in this area?	❑ NO	❑ YES→		

HEAD and MIND	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Headaches	❑ 0	❑ 1	❑ 2	❑ 3
Feeling of pressure inside head	❑ 0	❑ 1	❑ 2	❑ 3
Faintness, loss of consciousness	❑ 0	❑ 1	❑ 2	❑ 3
Dizziness	❑ 0	❑ 1	❑ 2	❑ 3
Seizures, epilepsy	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Difficulty thinking or processing information; confusion	❑ 0	❑ 1	❑ 2	❑ 3
Difficulty with concentrating or maintaining attention	❑ 0	❑ 1	❑ 2	❑ 3
Poor memory	❑ 0	❑ 1	❑ 2	❑ 3
Difficulty speaking or talking, slurred speech	❑ 0	❑ 1	❑ 2	❑ 3
Hyperactivity	❑ 0	❑ 1	❑ 2	❑ 3
Learning difficulties, dyslexia	❑ 0	❑ 1	❑ 2	❑ 3
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

Name:	Today's date:

EMOTIONS and SOCIAL HEALTH	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Depression, sadness	❑ 0	❑ 1	❑ 2	❑ 3
Anger, irritability, anxiety	❑ 0	❑ 1	❑ 2	❑ 3
Stressful situations	❑ 0	❑ 1	❑ 2	❑ 3
Apathy, lack of interest or concern	❑ 0	❑ 1	❑ 2	❑ 3
Use of alcohol, herbs, drugs, or medications to help manage emotions	❑ 0	❑ 1	❑ 2	❑ 3
Isolation, few friends, distant family	❑ 0	❑ 1	❑ 2	❑ 3
Problems with parents or family	❑ 0	❑ 1	❑ 2	❑ 3
Problems with employer(s) or coworker(s)	❑ 0	❑ 1	❑ 2	❑ 3
Sadness or recurrent problems from childhood or past events	❑ 0	❑ 1	❑ 2	❑ 3
Recent or current thoughts of suicide?	❑ **NO**	❑ **YES→**		
Diagnosed mental condition such as bipolar, schizophrenia, or other condition	❑ NO	❑ YES→		
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

EYES	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Watery, red, or itchy eyes	❑ 0	❑ 1	❑ 2	❑ 3
Dark circles under eyes	❑ 0	❑ 1	❑ 2	❑ 3
Decrease or loss of vision; cataracts, or glaucoma	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Poor night vision, night blindness	❑ 0	❑ 1	❑ 2	❑ 3
Pain in eye(s)	❑ 0	❑ 1	❑ 2	❑ 3
Pain near or behind eye(s)	❑ 0	❑ 1	❑ 2	❑ 3
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

EARS	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Earaches, pain in ear(s)	❑ 0	❑ 1	❑ 2	❑ 3
Ringing in ear(s)	❑ 0	❑ 1	❑ 2	❑ 3
Ear infections	❑ 0	❑ 1	❑ 2	❑ 3
Decrease or loss of hearing	❑ 0	❑ 1	❑ 2	❑ 3
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

MOUTH, NOSE, and THROAT	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Swollen or tender tongue or gums	❑ 0	❑ 1	❑ 2	❑ 3
Decreased sense of taste or smell	❑ 0	❑ 1	❑ 2	❑ 3
Stuffy nose, nasal congestion	❑ 0	❑ 1	❑ 2	❑ 3
Sinus infections, sinus pain	❑ 0	❑ 1	❑ 2	❑ 3
Nasal polyps	❑ 0	❑ 1	❑ 2	❑ 3
Ulcers or sores in mouth or lips, oral herpes	❑ 0	❑ 1	❑ 2	❑ 3
Allergies/ sneezing/ runny nose	❑ 0	❑ 1	❑ 2	❑ 3
Excessive mucus formation	❑ 0	❑ 1	❑ 2	❑ 3
Drainage to back of throat	❑ 0	❑ 1	❑ 2	❑ 3
Sore throat	❑ 0	❑ 1	❑ 2	❑ 3
Cough or wheeze	❑ 0	❑ 1	❑ 2	❑ 3
Change in voice	❑ 0	❑ 1	❑ 2	❑ 3
Hoarseness, loss of voice	❑ 0	❑ 1	❑ 2	❑ 3
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

Name:	Today's date:

LUNGS and HEART	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain in left arm and/or left side of neck or face	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Shortness of breath, difficulty breathing	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Irregular heartbeat	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Rapid or pounding heartbeat	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Chest congestion, bronchitis	❑ 0	❑ 1	❑ 2	❑ 3
Asthma	❑ 0	❑ 1	❑ 2	❑ 3
Medications for lungs or heart	❑ 0	❑ 1	❑ 2	❑ 3
Current or past cigarette smoking or tobacco use	❑ 0	❑ 1	❑ 2	❑ 3
Pain in chest	❑ **NO**	❑ **YES→**		
High blood pressure, high cholesterol, or high triglycerides?	❑ **NO**	❑ **YES→**		
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

SKIN, HAIR, and NAILS	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Acne	❑ 0	❑ 1	❑ 2	❑ 3
Eczema	❑ 0	❑ 1	❑ 2	❑ 3
Psoriasis	❑ 0	❑ 1	❑ 2	❑ 3
Dry skin	❑ 0	❑ 1	❑ 2	❑ 3
Oily skin	❑ 0	❑ 1	❑ 2	❑ 3
Flushing, hot flashes	❑ 0	❑ 1	❑ 2	❑ 3
Itchy skin (with or without redness) or hives	❑ 0	❑ 1	❑ 2	❑ 3
Decrease in body or facial hair	❑ 0	❑ 1	❑ 2	❑ 3
Decrease in head hair (not male pattern baldness)	❑ 0	❑ 1	❑ 2	❑ 3
Increase in body or facial hair	❑ 0	❑ 1	❑ 2	❑ 3
Excessive sweating	❑ 0	❑ 1	❑ 2	❑ 3
Insufficient sweating when hot or active	❑ 0	❑ 1	❑ 2	❑ 3
Area(s) of numbness	❑ 0	❑ 1	❑ 2	❑ 3
Area(s) of tingling	❑ 0	❑ 1	❑ 2	❑ 3
Area(s) of pain	❑ 0	❑ 1	❑ 2	❑ 3
Weak or ridged fingernails	❑ NO	❑ YES		
Change in skin color or pigmentation, vitiligo	❑ NO	❑ YES		
Small rough bumps on back of upper arms	❑ NO	❑ YES		
Other problem, concerns, or questions in this area?	❑ NO	❑ YES→		

STOMACH and DIGESTIVE TRACT	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Heartburn	❑ 0	❑ 1	❑ 2	❑ 3
Poor digestion	❑ 0	❑ 1	❑ 2	❑ 3
Nausea	❑ 0	❑ 1	❑ 2	❑ 3
Vomiting	❑ 0	❑ 1	❑ 2	❑ 3
Diarrhea	❑ 0	❑ 1	❑ 2	❑ 3
Constipation	❑ 0	❑ 1	❑ 2	❑ 3
Belching, intestinal bloating, gas or flatulence	❑ 0	❑ 1	❑ 2	❑ 3
Pain in stomach, intestines, colon	❑ 0	❑ 1	❑ 2	❑ 3
Rectal itching, pain, or bleeding	❑ 0	❑ 1	❑ 2	❑ 3
Hemorrhoids	❑ 0	❑ 1	❑ 2	❑ 3
Loss of bowel control, incontinence	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

Name:	Today's date:

KIDNEYS and GENITALS	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Kidney stones	❑ 0	❑ 1	❑ 2	❑ 3
Other kidney problems	❑ 0	❑ 1	❑ 2	❑ 3
Difficulty controlling urination, incontinence	❑ **0**	❑ **1**	❑ **2**	❑ **3**
Bladder problems (other than infections)	❑ 0	❑ 1	❑ 2	❑ 3
Frequent urination	❑ 0	❑ 1	❑ 2	❑ 3
Pain or burning with urination	❑ 0	❑ 1	❑ 2	❑ 3
Discharge or blood in urine	❑ 0	❑ 1	❑ 2	❑ 3
Urinary tract (kidney, bladder, urethra) infection(s)	❑ 0	❑ 1	❑ 2	❑ 3
Sexually transmitted disease(s)	❑ 0	❑ 1	❑ 2	❑ 3
Genital herpes	❑ 0	❑ 1	❑ 2	❑ 3
Low sex drive, low libido	❑ 0	❑ 1	❑ 2	❑ 3
Have you been tested for HIV?	❑ Negative	❑ Positive	❑ Not tested	
Other problem, concern, or question in this area?	❑ NO	❑ YES→		

For WOMEN only—*HORMONAL STATUS and SEXUAL FUNCTION*	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Irregular menses	❑ 0	❑ 1	❑ 2	❑ 3
Painful menses	❑ 0	❑ 1	❑ 2	❑ 3
Pain between menses	❑ 0	❑ 1	❑ 2	❑ 3
Painful, swollen, or fibrocystic breasts	❑ 0	❑ 1	❑ 2	❑ 3
Water retention	❑ 0	❑ 1	❑ 2	❑ 3
Premenstrual syndrome	❑ 0	❑ 1	❑ 2	❑ 3
Excessive bleeding	❑ 0	❑ 1	❑ 2	❑ 3
Abnormal uterine bleeding	❑ NO	❑ YES→		
Missed menses	❑ 0	❑ 1	❑ 2	❑ 3
Vaginal dryness, irritation, painful intercourse	❑ 0	❑ 1	❑ 2	❑ 3
Yeast infections	❑ 0	❑ 1	❑ 2	❑ 3
Uterine fibroids	❑ NO	❑ YES		
Menopausal symptoms or concerns	❑ NO	❑ YES→		
Infertility	❑ NO	❑ YES		
Annual Pap smear, breast examination, and health checkup?	❑ NO	❑ YES		
Family history of breast, uterine, or ovarian cancer	❑ NO	❑ YES→		
Other problem, injury, concern in this area?	❑ NO	❑ YES→		

For MEN only—*HORMONAL STATUS and SEXUAL FUNCTION*	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain or difficulty obtaining or maintaining erection	❑ 0	❑ 1	❑ 2	❑ 3
Pain or difficulty with ejaculation	❑ 0	❑ 1	❑ 2	❑ 3
Pain or mass in testicles	❑ 0	❑ 1	❑ 2	❑ 3
Slow stream of urine or frequent urination	❑ 0	❑ 1	❑ 2	❑ 3
Undescended testis, testis in abdomen or pelvis	❑ NO	❑ YES		
Men over 50: annual PSA test and prostate exam?	❑ NO	❑ YES		
Family history of prostate cancer	❑ NO	❑ YES→		
Other problem, injury, concern in this area?	❑ NO	❑ YES→		

Additional notes or comments: