Jennifer V. Rabinovich, N.D.
Doctor of Naturopathic Medicine

1657 E. Layton Rd.
Freeland, WA 98249
Tel: 360.331.2464
Fax: 866.277.7173

... bringing you the gold standard of natural medical care. **www.whidbeydoctor.com**

PATIENT PROFILE

I. Patient Information

Name of patient (*Last, First, Middle Initial*): ____

Parent or legal guardian (*if a minor*): ____

Mailing address: ____

Birth date: ______________________________ Sex: Male Female (*circle*)

Marital status: Single__ Married __ Widowed __ Separated __ Divorced __

Home phone: (   )____________________ May we call & leave messages at this number? Yes/No (*circle*)

Work phone: (   )____________________ May we call & leave messages at this number? Yes/No (*circle*)

Mobile phone: (   )____________________ May we call & leave messages at this number? Yes/No (*circle*)

When is the best time to reach you? ____

Occupation: __________________________ Employer/School: ______________________________

Employer/School address: ____

Email address: ______________________________ May we email you important health updates? Yes/No (*circle*)

How did you hear about Dr. Rabinovich? ____

Who are your health care providers?

Primary care physician: ________________________ Surgeon: ________________________

Chiropractor: ________________________ Other (*specify*): ________________________

Would you like Dr. Rabinovich to act as your primary care physician? (*circle*): Yes No

II. Spousal Information

Spouse's name: ________________________ Spouse's birth date: ______________________________

Spouse's occupation: ____________________ Spouse's employer: ______________________________

III. Who to Contact in Case of Emergency

Name: ____________________________________ Relationship: ___________________________

Home phone: __________________ Work phone: __________________ Mobile: ________________

IV. Responsible Party

Who is responsible for this account (if other than patient)? ____

Relationship to Patient: ____

Responsible Party Home Phone: __________________ Work Phone: ______________ Mobile: ____________

I understand that I am financially responsible for all charges.

____

Responsible Party Signature *Date*

V. Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers/Sisters				

Check if your *blood relatives* had any of the following:

Check	Disease	Relationship	Check	Disease	Relationship
	Alcoholism			Gout	
	Alzheimer's Disease			Hay Fever	
	Arthritis			Heart Disease	
	Asthma, Allergies, Hives			High Blood Pressure	
	Autoimmune Disease			HIV/AIDS	
	Cancer			Kidney Disease	
	Chemical Dependency			Mental Illness	
	Depression			Strokes	
	Diabetes			Obesity	
	Epilepsy			Parkinson's Disease	
	Gastrointestinal Disease			Suicide	
	Glaucoma			Tuberculosis	

VI. Medical History

What is the reason for your visit today?

____

____

____

Physicians most recently consulted regarding chief complaint(s):

____

Please list symptoms in order of importance: Severity (1=least, 10= most severe)

1. ____ ________________________

2. ____ ________________________

3. ____ ________________________

4. ____ ________________________

5. ____ ________________________

Health History: please check/grade/circle symptoms as applicable. **<u>1= least severe, 5= most severe.</u>**

Illness	Now, 1-5	Past	Never	Illness	Now, 1-5	Past	Never
EXAMPLE	3	√		Heart Disease			
AIDS				Heart Murmur			
Allergies				Hemorrhoids			
ADD/ADHD				Hepatitis			
Alcoholism				Herpes			
Altered Sense: (e.g. taste, smell)				High Cholesterol			
Anemia				High Blood Pressure			
Anxiety/Panic Attacks				HIV			
Appendicitis				Hyperthyroid			
Arthritis				Hypothyroid			
Asthma				Injury (Serious)			

Illness	Now, 1-5	Past	Never	Illness	Now, 1-5	Past	Never
Bleeding Difficulties (ex. hemophilia or hypercoagulation)				Kidney Disease			
Blood in Stools				Liver Disease/Jaundice			
Blurred Vision				Low blood sugar (hypoglycemia)			
Breast Lump				Measles			
Cancer				Migraine Headaches			
Candida (yeast) infection				Multiple Sclerosis			
Cataracts				Numbness/Tingling			
Chemical Dependency				Obesity			
Chemical Sensitivities				Ovarian Cysts			
Chicken Pox				Pacemaker			
Chronic Fatigue				Pneumonia			
Colitis				Post Traumatic Stress Disorder			
Depression				Prostate Problem			
Diabetes				Recreational Drug use			
Dizziness/Vertigo				Rheumatic Fever			
Eczema				Rheumatoid Arthritis			
Emphysema				Scarlet Fever			
Epilepsy				Schizophrenia			
Fainting				Seizure/Epilepsy			
Fibromyalgia				Stroke			
Genital Herpes				Syphilis			
Gastrointestinal Ulcers				Tuberculosis			
Glaucoma				Ulcers			
Gout				Venereal Disease			
Headaches				Other:			

Review of Systems: please check/grade/circle symptoms as applicable. **1= least severe, 5= most severe.**

	Now, 1-5	Past	Never
General:			
Do you usually feel tired or worn out?			
Have you recently been more thirsty than normal?			
Has there been any unusual weight gain or loss recently?			
Do you perspire a lot?			
Do you prefer warm or cold (*specify*)?			
Skin/Hair/Nails:			
Have you noticed any changes in the color of your skin?			
Have you noticed any skin rashes or itching?			
Have you noticed any unusually dry skin?			
Have you noticed any growth on your skin that bothers you?			
Have you noticed any sores or wounds that do not heal?			
Have you noticed any change in color or size of moles?			
Do you have brittle nails?			
Eyes:			
Have you had any pain in your eyes?			
Have you had any blurry vision?			
Have you noticed any change in your vision in the past year?			
Do you often have itchy eyes?			
Are you nearsighted or farsighted (*circle one*)?			

	Now, 1-5	Past	Never
Have you noticed any redness or burning in your eyes?			
Do you see halos around lights?			
Ears, Nose, Throat:			
Do you have any difficulty hearing?			
Do you have any ringing or buzzing in your ears?			
Do you have earaches or discharge from your ears?			
Do you have a lot of nasal stuffiness or sinusitis?			
Do you have drainage down the back of your throat?			
Do you experience frequent or severe nosebleeds?			
Do you have any lumps in your throat?			
Do you experience sore tongue or mouth?			
Do you have bleeding or easily infected gums?			
Do have excessive saliva?			
Respiratory System:			
Do you have frequent chest colds?			
Do you have a constant or bothersome cough?			
Do you cough up blood?			
Do you have sputum or phlegm between colds?			
Do you have any difficulty breathing?			
Have you noticed any wheezing or whistling?			
Cardiovascular System:			
Do you have pain/tightness/pressure in front or back of your chest? (SPECIFY)			
If yes, is it when walking fast, working hard or when excited?			
Have you ever had an abnormal EKG?			
Do you have swelling of your feet or ankles?			
Do you have cramps in the calf muscles when you walk?			
Do you ever awaken at night with difficulty breathing?			
Do you need to sleep on more than one pillow?			
Does your heart ever beat fast or irregularly?			
Do your fingers or toes ever get cold/numb/blue? (SPECIFY)			
Gastrointestinal System:			
Note foods that give you upset or pain:			
Have you recently experienced nausea/vomiting? (SPECIFY)			
Do you have excessive burping/gas? (SPECIFY)			
Have you vomited blood?			
Do you have a lot of indigestion, heartburn or reflux?			
Do you experience any trouble swallowing?			
Do you experience constipation?			
Do you experience diarrhea?			
Do you have a poor appetite or are easily satiated?			
Have you ever had blood in your stools?			
Do you have hemorrhoids?			
Do you take laxatives regularly?			
Do you feel bloated after meals?			
Do you experience abdominal pain or cramping?			
Genitourinary System:			
Do you have any burning or pain on urination?			
Do you have any change in frequency of urination?			
Have you experienced urinary incontinence?			
Do you get up at night to urinate?			
Do you have a problem dribbling urine?			
Have you ever passed blood in your urine?			
Do you have frequent bladder or kidney infections?			
Men, do you have prostate trouble?			

	Now, 1-5	Past	Never
Men, have you ever experienced erectile dysfunction?			
Musculoskeletal System:			
Do you have pain in your legs or feet?			
Have you ever been diagnosed with scoliosis?			
Do you have joint pain or stiffness?			
Do you have trouble walking or using your hip or knee joints?			
Do you experience regular pain in your body? (SPECIFY LOCATION)			
Central Nervous System:			
Do you have frequent or severe headaches?			
Do you have dizzy spells, faintness or lightheadedness?			
Do you sometimes lose track of what happens around you for a short time?			
Do you sometimes lose the ability to speak for a few seconds?			
Have you fainted, blacked out or lost consciousness?			
Do you consider yourself a nervous person?			
Do you have trouble remembering recent events?			
Have you ever had convulsions or fits?			
Do you experience insomnia?			
Have you been highly emotional lately?			
Psychological/mental status:			
Do you experience depression?			
Do you experience anxiety or panic attacks?			
Have you ever been diagnosed with a psychological condition?			
Have you ever been hospitalized for a psychological condition?			
Have you ever had any suicidal attempts?			
Do you have suicidal thoughts?			
Do you experience excessive restlessness?			
Do you experience mental confusion?			
Are you critical of yourself or others?			
Do you experience mood swings?			
Do you experience loneliness?			
Environmental Exposure:			
Have you ever worked around known toxic chemicals?			
Have you ever been exposed to chemical solvents?			
Do you use oil paints?			
Do you have mercury amalgam fillings?			
Have you ever been excessively exposed to toxic fumes (i.e. gasoline, exhaust fumes, burning of toxic materials)?			
Do you have any known exposure to heavy metals?			
Are you a gardener?			
Miscellaneous:			
Treated for parasitic/bacterial/viral infections (*circle*)			
Please list past surgeries here:			
Have you lived in a foreign country for more than 6 months? Yes/No. If Yes, please list countries:			
How often have you taken antibiotics? (*Note # times per age category)* Infancy/Childhood _____ Teen _____ Adulthood_____			
Dental Interventions? Yes/No. If Yes, please list:			
Typical Childhood Vaccinations? Yes/No Received regular booster shots to date? Yes/No			

Women Only: Gynecology and Pregnancy

Please specify the number of: Births: _______ Miscarriages: _______ Terminations: _______

Age at first period: _______ Onset of most recent period: _____________ (MM/DD/YYYY)

If applicable: Age at Menopause: _______ Current menopausal symptoms: ______________________________

Duration of flow: _______days. Time between cycles: ______days. Regular / Irregular cycles (SPECIFY)

Flow (check one):
__Excessive
__Moderate
__Scanty

PMS?
__Yes: Symptoms ____
__No *(ex. severe cramps, moderate insomnia, mild depression)*

Method(s) of birth control ____

I will alert Dr. Rabinovich if I know or suspect that I am pregnant while under her care: __________(*initial*)

Check if you currently have:

__Breast lumps
__Breast tenderness
__History of genital warts
__Mother or sister with breast cancer
__Nipple discharge
__Pain during intercourse
__Pain during orgasm
__Abnormal vaginal discharge
__Vaginal dryness
__Vaginal itching
__Vulvar itching
__Water retention
__Pass clots with periods
__Past or current use of IUD
__Perform self-breast exams
__Spotting between periods
__History of abnormal pap
__Infertility problems

VII. Medications and Allergies

Medications and **supplements** you are currently taking, including **dosage**, **frequency**, and **how long taken**:

____

____

____

Pharmacy Name ____ Pharmacy Phone Number _________________

ALLERGIES to medications or substances: ____

VIII. Health Habits

Health Habits: Check which substances you use and describe *how much* you use:

__ Caffeine _________________
__ Drugs ___________________
__ Tobacco _________________
__ Alcohol __________________
__ Soda ____________________
__ Other ___________________

Occupational: Check if your work exposes you to the following:

__ Stress
__ Heavy Lifting
__ Hazardous Substances: If YES, list:
____
__ Other _________________________________

Are you familiar with “safe sex” practices? Yes/No **EXERCISE**: ____

Do you follow any dietary modifications? Yes/No If Yes, please describe: __________________________________

IX. Signature

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Rabinovich or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____ Date ______________________

Consent for Treatment

I hereby authorize **DR. JENNIFER RABINOVICH** to perform and/or order procedures that include but may not be limited to the following in order to facilitate my diagnosis and treatment:

General Diagnostic Procedures- including but not limited to pap smears, X-rays, blood and urine laboratory evaluation, allergy testing, infrared thermography studies, and general physical exams.
Psychological Counseling, Lifestyle Counseling, and Exercise Prescriptions
Herbs, Natural, and Allopathic Medicines- prescribing of various therapeutic substances including plant remedies, vitamins and minerals, amino acids, glandulars, and pharmaceutical drugs. Substances may be given in the form of teas, pills, powders, and tinctures that may contain alcohol; topical creams, essential oils, homeopathic remedies, flower essences, and suppositories; other medicines may also be used.
Dietary Advice and Therapeutic Nutrition- use of foods, dietary suggestions or nutritional supplements for treatment.
Soft Tissue and Osseous Manipulation- including but not limited to the use of massage, muscle energy stretching, Cranial Therapy, visceral manipulation, as well as manipulation of the spine and extremities by hand or with an activator-type device.
Thermal and Hydrotherapies- including but not limited to ultrasound, hydrocollator packs, microcurrent therapy, colonic hydrotherapy, hot and cold immersions or topical applications.
Vitamin and other Injections

Potential benefits of treatment: Restoration of health and the restoration of optimal function, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential risks of any medical treatment: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Notice to pregnant and breastfeeding patients: All patients who know or suspect that they are pregnant and/or breastfeeding must alert Dr. Rabinovich, since some of the therapies used could present a risk to the pregnancy and/or breastfeeding infant. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. Some therapies are also contraindicated for breastfeeding women.

Agreement

Dr. Rabinovich does her utmost to ensure that you receive the most effective care. Because of the quality of the care she tries to give her patients, she can only schedule a limited number of patients each day. In consideration of this, she requests that you show up for your appointments on time. If you need to cancel an appointment, please give her 24 hours' notice. Without the 24 hours' notice, there will be a $50 charge for missed appointments. This will be strictly enforced.

Dr. Rabinovich specializes in specific therapeutic modalities and patterns of illness, presented in more detail in the above section. Her treatment suggestions **should be considered recommendations along with conventional treatments**.

Patient Acknowledgement

I have read and understand the above statement regarding possible treatments and was given the opportunity to have any questions concerning my care answered by Dr. Rabinovich.
I am aware that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Rabinovich.
I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or by my representative or otherwise permitted or required by law; however, by signing this form I authorize the release of my confidential health information to other participating providers directly involved in my healthcare.
I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.
I certify to the best of my knowledge that the above information is correct.
I have read, understood, and agree to the terms outlined in this document.
I hereby consent to Naturopathic treatment for myself or my child/dependent.
I understand that I will pay for the services provided by Dr. Rabinovich and her staff at the time of my appointment, either in full, or according to a payment plan discussed with Dr. Rabinovich prior to the appointment.
I understand that Dr. Rabinovich requires 24 hours' notice (not including weekends and holidays) if I need to cancel or reschedule an appointment. There will be a $50 charge for appointments cancelled or rescheduled with less than 24 hours' notice.
I am not here in my function as a government agent.
I understand that Dr. Rabinovich does not offer services during times other than regular business hours.
I have read the **Patient Orientation and Office Policies** handout for Dr. Rabinovich's services. By signing below I am in agreement with these policies.

Signed: ____ Date: _____________________________

Print name: ____

Relationship: Self / Parent / Guardian (*circle*)