DR. BOAZ DOLEV (B.S, ND., PHD)
No More Pain – The ARP Way
416.770.1757 • 206.497.1500 Tool Free Fax: 1.855.853.9659 (USA, CAN & Latin)
www.arpway.com / .ca

HEALTH - FORM 1

CONFIDENTIAL PATIENT INFORMATION Today's Date _____

Name _____ Nickname _____ Sex: M F

Date of Birth _____ Current Age _____ Social Security Number_____

Home Address: _____

Home Phone: _____ Cell Phone:_____ Personal Email: _____

Occupation: _____ Employer:_____ Work Phone: _____

Work Address:_____ Work Email: _____

Person name to be notified in case of emergency: _____ Phone : _____

1. I consider myself to be in good health. Yes __ No __

2. Have you had hospital care? Yes__ No __ Please list the hospital, address, date, and the reason that you were hospitalized:

3. Please list the medications prescribed and their dosage, including non-prescription drugs and supplements:

4. Please list any medications you have used during the last five years:

5. Please list any foods, substances, liquids, medicines, or clothing that you are allergic to:

By whom and how was the allergy identified?

6. Please check any family history of the following health disorders:

Stroke __ Heart Attack __ Parkinson's Disease __ Diabetes __ High Blood Pressure __ Migraines __ Cancer __ Bronchial __ Headaches __ Arthritis __ Liver Disorders __ Heart Trouble__ Others:

7. Your present health concern:

8. Family Physician:
Name:
Street address:
City, State, Zip Code:
Telephone Number:

9. Your Occupation:

Do you enjoy your work? Yes _ No _

10. Are you sexually active? Yes _ No_

If a woman, do you menstruate regularly? Yes _ No _

Describe your menstrual flow (copious, scant, or), and for how long:

12. If a man, do you experience erections easily or with difficulty, and are there any sexually-related problems or concerns?

13. How would you describe your eating habits and appetite?

14. Do you have acid indigestion or reflux? . Do you feel a burning sensation after eating?
Do you have a heavy or bloated feeling after eating?

Do you emit gases?

Do you experience diarrhea? .How often?

How often do you have bowel movements?
Are they: difficult , easy , loose , slimy __ , black __ , dark brown __ , yellow __ , gray __ , green __ ,
and do they contain blood ?

15. How many times a year do you have a cold?

16. Do you have any kind of sinus trouble, including polyps?

17. Are you nervous, irritable, or depressed?

18. What do you worry about?

19. Do you wear eye glasses or hearing aids?

20. Do you have difficulty going to sleep at night or wake up often during the course of the night?

21. Do you have bad breath? ___ Do you often spit up mucus?

22. Do you have canker sores or blisters in or around your mouth?

23. Do you feel tired upon arising?

Do you take naps?

When do you take naps?

24. Do you have swelling in any part of your body, and if yes, where?

25. Do you enjoy being with other people, or would you rather keep to yourself?

26. Do you read, watch television, spend time on your computer, or listen to country, swing, classical, jazz, rock, hip-hop, or any other kind of music?

27. What time do you arise in the morning and retire to bed at night?

28. Please include any information that you feel would be helpful and pertinent in assessing the condition of your health:

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I UNDERSTAND THAT DR. BOAZ DOLEV IS A DOCTOR OF NATUREORTHOPATY AND IS NOT A MEDICAL DOCTOR, AND THAT HE/SHE WILL SERVE ONLY IN THE CAPACITY OF A NATURAL HEALTH AND NUTRITIONAL EDUCATOR/PRACTITIONER AND COUNSELOR.

I ALSO UNDERSTAN,Q THAT DR. BOAZ DOLEV WILL NEITHER DIAGNOSE NOR TREAT SPECIFIC ILLNESSES OR CONDITIONS OF ANY KIND.

I ACKNOWLEDGE THAT I HAVE BEEN ADVISED BY DR. BOAZ DOLEV TO OBTAIN THE APPROVAL OF MY PERSONAL HEALTH ADVISOR OR PHYSICIAN BEFORE MAKING ANY RADICAL CHANGES IN EITHER MY DIETARY, REGIMEN OR IN MY LIFESTYLE.

I ACKNOWLEDGE THAT I HAVE BEEN ADVISED BY DR. BOAZ DOLEV TO OBTAIN THE APPROVAL OF MY PERSONAL HEALTH ADVISOR OR PHYSICIAN BEFORE USING ANY DIETARY OR INCORPORATING ANY OTHER NATURAL HEALTH AND HYGIENIC, INSTRUCTIONS INTO MY LIFESTYLE WHICH MAY BE SUGGESTED BY DR. BOAZ DOLEV.

I AM OF A SOUND MIND AND UNDERSTAND WHAT I AM SIGNING.

DATE: _____ **SIGNATURE**: _____

DATE: _____ **LEGAL GUARDIAN**: _____

(IF A MINOR, SIGNATURE OF LEGAL GUARDIAN MUST BE GIVEN WITH SUITABLE NOTATION OF THE FACT THAT IT IS THE GUARDIAN OR OTHER RESPONSIBLE PERSON WHO IS SIGNING).