

DR. NYARAI PAWENI

NATUROPATHIC DOCTOR

p: 877.961.4417

e: drnyarai@nyaraipawenind.com

www.nyaraipawenind.com

www.facebook.com/drnyaraipaweni

Welcome Letter

I am honored that you have chosen me to help you in your search for optimum health and wellness. This is your New Patient Information Packet. Please read and complete the attached forms prior to your appointment, bring them with you or email them to drnyarai@nyaraipawenind.com. The more detailed your responses, are the better able, I will be at investigating and determining some of the causes of your health concerns. This will also help us utilize our time together efficiently.

In order to best serve you, please bring or forward copies any prior lab work (within the last 12 months) and a list of the supplements and medications you are currently taking with you to your appointment.

It is our office policy to confirm appointments by phone or email one to two business days before your scheduled visit. If you have an answering machine or voice mail, a message will be left.

Many of our patients are sensitive to environmental substances, therefore we ask all patients to refrain from wearing strongly scented hair sprays, colognes, perfumes, aftershaves, etc. on the days you are here.

Please call my office at (877)961.4417 or email me at drnyarai@nyaraipawenind.com with you have any questions or concerns.

Thank you! I look forward to meeting you!

Dr. Nyarai Paweni (Dr. Nyarai)

One Delaware Place, Suite 300, Chicago, IL 60611
Housed at: DCIW, 1045 Burlington Ave, Suite 1, Lisle, IL 60531



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New Patient Checklist

- Please return completed new patient intake packet prior to new patient appointment.
- Please arrive 20 minutes early to fill out intake forms if you have not sent them in prior to your appointment.
- Allow 60 to 90 minutes for your first visit. Note this is the same for in-person/phone/Skype visit
- Please be courteous and send a call 877.961.4417 if you're running late.
- All payments are due at the time of service. We accept cash, check, or any credit card including American Express.

Please bring to your first appointment the following items:

- Recent blood work, imaging, and/or medical records if necessary (within the last 12 months).
- A list of all medications you are currently taking (including dose, frequency, and duration).
- Please bring the bottles (or photographs) of the supplements that you're currently taking.

Thank you! I look forward to meeting you!

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PATIENT INTAKE FORM

Dr. Nyarai Paweni's comprehensive consultation is only possible when we have a complete picture of the patient physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. Print all information and mark anything you don't understand with a question mark. Please be assured that we will keep this information confidential.

Thank you for taking the time to complete this form, so we may be of greater service to you.

I. PERSONAL INFORMATION

Today's Date _____

Full Name. _____ I like to be called _____
(First Middle Initial Last)

Age _____ Date of Birth _____ Gender _____

Address _____ Email _____

City _____ State. _____ Zip. _____

Phone (best to be reached) _____ (alternate) _____ May we leave messages? ___

Occupation _____ Hours per week. _____

Employer & Work Address _____

Education _____ Military Service? _____

Are you: _____ Married _____ Separated _____ Divorced

_____ Single _____ Cohabiting _____ Widowed

Live with: _____ Spouse _____ Parents _____ Alone

_____ Children _____ Partner _____ Friends

_____ Other (specify) _____

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Children's Ages _____

Emergency Contact (name and relation) _____

Contact's Phone (home) _____ (work) _____ (cell) _____

How did you hear about our Dr. Nyarai? _____

- | | |
|--|--|
| <input type="checkbox"/> Search engine inquiry | <input type="checkbox"/> Google maps |
| <input type="checkbox"/> Dr. Nyarai Paweni's website | <input type="checkbox"/> Facebook |
| <input type="checkbox"/> Twitter | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Friend/family non-patient | <input type="checkbox"/> Referred by Friend/Family current patient |

II. MEDICAL HISTORY

What are your most important health challenges? List as many as you can in order of importance.

_____	_____
_____	_____
_____	_____
_____	_____

Has any health concern recently changed or become worse? If so, which one/s?

Have you consulted any other physician or health practitioner? When and for what? _____

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What is your blood type (A/B/O) _____ Unsure _____

Do you have any body parts that are not your own? (Implants, transplants)? _____

Weight _____ Weight 1 year ago _____

Maximum Weight _____ When (Year/Age) _____ Ideal Weight: _____

Did you have standard childhood immunizations? _____

Immunizations for international travel? Which ones and when? _____

Any negative reactions? Explain _____

What childhood illnesses have you had? Please list approximate year or age:

Approximately how many times in your life have you had antibiotics? _____

What hospitalizations or surgeries have you had? Please list date. _____

Do you have any dietary restrictions (religious, vegetarian, vegan, paleo, raw etc.?) _____

How long have you had these dietary restrictions: _____

Any foods you avoid: _____

III. FAMILY HISTORY

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Do your close relatives (parents, grandparents, siblings & children) have any of the following medical conditions?

Please circle and indicate the relative with the disease:

Disease	Relative/s	Disease	Relative/s
High Blood Pressure	_____	Birth Defects	_____
Heart Attack, Stroke	_____	Suicide	_____
Obesity	_____	Depression	_____
Diabetes	_____	Mental Illness	_____
Glaucoma	_____	Alcoholism	_____
Asthma	_____	Epilepsy	_____
Hay Fever	_____	Ulcers	_____
Eczema	_____	Arthritis	_____
Skin Disease	_____	Gout	_____
Food Allergies	_____	Thyroid Disease	_____
Emphysema	_____	Easy Bleeding	_____
Tuberculosis	_____	Sickle Cell Anemia	_____
Lung Cancer	_____	Osteoporosis	_____
Breast Cancer	_____	Other	_____

IV. THERAPIES AND LIFESTYLE

Current Medications: Please list any prescription medications, nutritional supplements, herbs or homeopathic remedies you are currently taking. Please list doses if known. Bringing bottles with you to your visit is helpful.

None _____

Please list any medications, natural or prescription that you have tried in the past.

Other therapies _____

Are you allergic to any drugs? _____

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Are you allergic to anything else? _____

Do you use:

	YES	AMOUNT		YES	AMOUNT
Alcohol	_____	_____	Pain Relievers	_____	_____
Hormones	_____	_____	Birth Control Pill	_____	_____
Laxatives	_____	_____	Soda/ Pop	_____	_____
Coffee/Caffeine	_____	_____	Cortisone	_____	_____
Fast Food	_____	_____	Electric Blanket	_____	_____
Tobacco	_____	_____	Thyroid Medication	_____	_____
Sleeping Aids	_____	_____	Antacids	_____	_____
Appetite Suppressants	_____	_____	Recreational Drugs	_____	_____
Sugar	_____	_____			
Other: _____	_____	_____			

How much sleep do you get a night? _____ Is it enough? _____ Do you wake during the night?#? _____

Do you wake refreshed in the morning? _____

Do you currently exercise? _____ How often? _____ What type? _____

Past exercise? _____ When? _____

V. FINAL NOTES

What do you think causes or has contributed to your health problems? _____

What do you feel needs to happen for you to get better? _____

What do you enjoy most in your life? _____

What potential obstacles/challenges do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Is there anything else you wish to share? _____

Thank you for taking the time to complete this form. We look forward to providing you the best possible care.

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Financial Policies

The following is to assist you in understanding the financial policies associated with your care with Dr. Nyarai Paweni. Please discuss any financial concerns you have with Dr. Nyarai prior to your visit.

Payment Requirements: Appointments must be paid for at time of service. We accept Visa, MasterCard, American Express, Discover, check, cash, Travelers Checks or PayPal. You will be charged a \$25 fee for returned checks.

All clients are asked to pay in full at the time of the visit. Labs, supplements, herbs, homeopathic medicines and hydrotherapy treatments are an additional fee added to the cost of the visit

Appointments: 24 hour notice is needed to change or cancel your appointment. You will be charged a fee of 50% of the total cost of any missed appointment if the 24 hour advance cancellation policy was not met.

Records: Dr. Nyarai will keep a record of your health care. A small fee is charged for copies of your medical records. Your medical record will not be disclosed to others unless you direct Dr. Nyarai to do so or unless the law authorizes her to disclose the information.

Insurance and Medicare: Dr. Nyarai Paweni does not bill insurance companies and is not a preferred provider for any insurance company. You may submit your paid invoice to your insurance for reimbursement. Please request this upon checkout if you wish to do this. Dr. Nyarai is not a Medicare provider. Medicare will not reimburse you for services rendered at the clinic and you should not seek reimbursement from Medicare.

Thank you for taking the time to complete this form. We look forward to providing you the best possible care.

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