File No. ________________

The Prana Group
Narrowband UVB Phototherapy Intake Form

Last Name: ____ First: ______________________ Middle. _______

Age: __________ Birth date (m/d/y): ________________ Gender: (circle one) Female Male Other

Address: ____ Postal Code: ________________________

Home Phone: ___________________ Work Phone: ___________________Cell Phone: ______________________

Email Address: ____

Occupation: _______________________________ Employer's Name: ____________________________________

Emergency Contact Name: _________________________________ Phone : ______________________________

How did you discover Prana? ___________________ If referred, name of the person who referred you: __________________
Name of your Medical Doctor or Dermatologist: ____
What other health care providers are you seeing, and their specialty? ____
____
____
What health conditions and/or diagnoses have you been given: ____
____
____

Please rank current & ongoing problems by priority and complete:

Describe Problem	Date	Mild/Mod/Severe	Treatment Approach	Success
Example: Psoriasis	Jan'06	Moderate	Topical steroids	Moderate
1.				
2.				
3.				
4.				
5.				

Please list the date of your most recent procedures and circle any tests that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
Chest x-ray		TB test		Pap Smear		Others:	
Kidney x-ray		EKG		Mammogram			
G.I. Series		MRI		Sigmoidoscopy			
Colon x-ray		CAT scan		Rectal Exam			
Spine x-ray		Cardiac stress test		Complete Physical Exam			
Blood tests		Cholesterol		PSA			

Please list any medications you are currently taking, include both prescription & non-prescription drugs.

Medication Name	Date Started	Dosage	Purpose

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Health History

Have you ever (circle all that apply):			If yes, explain when and why.
Been hospitalized	Yes	No	______________________
Had a broken bone	Yes	No	______________________
Had surgery	Yes	No	______________________
Been diagnosed and/or treated for cancer?	Yes	No	______________________
Been bedridden for more than a week?	Yes	No	______________________
Had x-rays, CAT scan or MRI?	Yes	No	______________________
Had a work/vehicular accident related injury?	Yes	No	______________________

Please circle any condition you have now or have had in the past: (circle all that apply)

Back pain	Chest pain	Colon/Stomach trouble	Auditory difficulties/deafness
Neck pain	Respiratory difficulty	Eye problems	Gall bladder problems
Shoulder/arm pain	Asthma	Liver trouble/Hepatitis	Mononucleosis
Hip/leg pain	High blood pressure	Seizures/convulsions	Thyroid disease
Sciatica	Poor circulation	Kidney problems	Skin problems
Arthritis	Heart attack/angina	Easy bruising	Difficulty urinating
Frequent infections	Stroke	Cancer	Orthotics (past or current)
Allergies/Sinusitis	Environmental Sensitivities	Prostate problems (Men)	Menstrual problems (Women)

Other:____

____

Your Skin Type

Would you classify your skin type? (check only one)

- ☐ **Type I** - Always burns easily, never tans, extremely sensitive skin. Tends to have freckles, red or fair hair, blue or green eyes.
- ☐ **Type II** - Always burns easily, tans minimally, very sensitive skin. Tends to have light hair, blue or brown eyes.
- ☐ **Type III** - Sometimes burns, tans gradually to light brown, sun-sensitive skin. Tends to have brown hair and eyes.
- ☐ **Type IV** - Burns minimally, always tans to moderate brown, minimally sun-sensitive. Tends to have dark brown eyes & hair.
- ☐ **Type V** - Rarely burns, tans well, sun-insensitive skin. Often has dark brown eyes and hair.
- ☐ **Type VI** - Never burns, deeply pigmented, sun-insensitive skin. Usually has black-brown eyes and hair.

Please describe the skin condition you are currently experiencing? Include details of symptoms, frequency & duration.

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Phototherapy with The Prana Group

UVB treatment involves exposing the skin to an artificial UVB light source for a set length of time on a regular schedule. This may result in a burn to your skin and prolonged exposure to ultraviolet radiation can cause side effects including an increased risk of developing skin cancer. We strongly recommend that you have a referral from your medical doctor or dermatologist prior to proceeding with this type of treatment.

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

New Patient Signature: ________________________________ Date: ________________

If New Patient is a minor (under 18 years of age):

Signature of parent or legal guardian: ____________________________ Date: ________________

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