Restorative HEALTH

PATIENT INFORMATION

All information contained in this questionnaire is strictly confidential, will be protected to the highest of HIPPA standards, and will become part of your Restorative Health Record

Patient Information:

Name:_____ Date:_____

Last First Middle

Date of Birth:_____ Age in Yrs:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-Mail Address:_____ May we contact you via E-Mail Yes No

How do you prefer to be contacted? Phone Email Text Other_____ May we leave a voice mail? Yes No

Marital Status (check one): Married Separated Divorced Widow(er) Living with Sig Other Single

Spouse or Sig Other Name:_____ Phone:_____

In Case of an Emergency Contact:_____ Relationship:_____

Driver's License Number:_____

Primary Care Physician Name:_____Speciality: _____

Preferred Pharmacy:_____ Phone:_____

How did you hear about us? TV Radio Web Radio Web Pandora Social Media Referral

If you were referred, who referred you? _____

SMS Text Communication Okay? Yes No

What are your top 4 goals you would like to accomplish in or program (please put in order of importance)?
1.
2.
3.
4.

Have you ever had or do you have any of the following?:

- ☐ Anemia
- ☐ Abnormal Wght Loss/Gain
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar
- ☐ Bleeding Disorder
- ☐ Blood Pressure (high or low)
- ☐ Cancer
- ☐ Celiac
- ☐ Connective Tissue Disorder
- ☐ Crohn's / IBS
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Epilepsy/Seizures
- ☐ Excessive Fatigue
- ☐ Excessive Stress
- ☐ GERD / Ulcers
- ☐ Genital Herpes
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ HIV or AIDS
- ☐ Implants (Breast/Other)
- ☐ Keloid Scarring
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis (A,B, C)
- ☐ Lyme Disease
- ☐ Memory Loss
- ☐ Oral Herpes or Cold Sores
- ☐ Osteoporosis / Osteopenia
- ☐ PCOS
- ☐ Pacemaker or Palpitations
- ☐ Psoriasis
- ☐ Respiratory Condition
- ☐ STD's
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ TIA's
- ☐ Transplant
- ☐ Urinary Incontinence

Please describe or explain any of the above:_____

_____

_____

_____

Other Medical Issues: _____

_____

_____

_____

Current Prescription Medication, Over the Counter Medication and Supplements			
Name of Medication / Supplement	Reason for Taking	Strength	Dosing Instruction
Example: Tylenol	Headaches	500mg	1 tab 3 times per day

Allergies to medicine, supplements, vaccines, foods, environmental or other substances	
Substance	Reaction
Example: Penicillin	Hives, Swelling, Shortness of Breath

Past Surgical and Hospitalization History	
Surgery and / or Hospitalization	Date

Family History

Illness	Mother	Father	Brothers	Sisters	Grand Mother	Grand Father
	Alive Y N	Alive Y N	How Many?_____	How Many?_____	Alive Y N	Alive Y N
			How Many Alive?_____	How Many Alive?_____		
Anxiety						
Bi-Polar						
Bleeding Disorder						
Breast Cancer						
Colon Cancer						
Depression						
Dementia / Alzheimer's						
Diabetes						
Heart Disease						
High Blood Pressure						
Lung Cancer						
Headaches (Migraine)						
Osteoporosis						
Ovarian Cancer						
Prostate Cancer						
Stroke						
Thyroid (hyper/hypo)						
Other:						
Other:						

Staff Notes:

Social History

Do you smoke? Y N If yes – how many packs per day?
If no – have you ever smoked? Y N If yes, when did you quit?
Type of tobacco used: Cigarettes Cigar Chew Pipe Other:

Do you drink alcoholic beverages? Y N
If yes – how many drinks per week?

Do you use any street drugs (i.e. marijuana, cocaine etc) Y N
If yes – which drugs do you use?

Do you drink coffee? Y N
If yes – how many cups per day?

Do you drink caffeinated beverages? Y N
If yes – how many beverages per week?

Recent significant changes in your life? Y N
If yes – please explain:

Dissatisfied with current employment? Y N
If yes – please explain:

Special stressors in your life? Y N
If yes – please explain:

In an abusive relationship (physical, verbal, sexual)? Y N
If yes – please explain:

Children? Y N
If yes – how many sons? daughters?
Name and ages of your children:

Questions for Women and Men

	Y	N		Y	N		Y	N		Y	N
Blood in urine			Urinating > 2x/night			Sexually Active			Pain with intercourse		
Difficulty urination			Painful urination			Difficulty with sex life			Genital sores		

Questions for Women

Hx of infertility			Fibrocystic breasts			PCOS			Pelvic Pain		
Self breast exam			Breast lumps/nipple DC			Endometriosis			Vaginal DC / itching		

Last Pap Smear / / ☐ Normal ☐ Abnormal ☐ Unknown
Last Mammogram / / ☐ Normal ☐ Abnormal ☐ Unknown

Menstrual History

Age of 1st menstruation _____
Last menstrual period / / /
# of days per cycle _____
# of days of flow _____ □ Heavy □ Light
Cycle □ Reg □ Irreg
Disabling menstruations Y N

Pregnancies and Births

Total # of pregnancies _____
Total # of live births _____
Total # of miscarriages _____
Total # of abortions _____
# of tubal pregnancies _____
Total # of C-sections _____

Female Health

Menopause Y N
Age _____
Artificial Menopause Y N
Age _____
Perimenopause Y N
Age _____

Have you ever been treated with bio-identical or non bio-identical hormones before? Y N If yes, please explain:

Questions for Men

	Y	N		Y	N		Y	N		Y	N
Penile discharge			Lump in testicals			Testicular pain			Prostate problems		
Erectile dysfunction			Lump in scrotum			Vasectomy			Hx of hernia		

Last prostate/rectal exam: / / Last Prostate Specific Antigen lab: / / Last testicular exam: / /

Have you ever been treated with bio-identical or non bio-identical hormones before? Y N If yes, please explain

Health

Rate your energy from 1-10: Morning _____ Noon _____ Night _____ Before Meals _____ After Meals _____

Rate your current overall stress level between 1-10 (1 very relaxed, 10 very stressed): _____

What factors most contribute to your stress: ☐ Health ☐ Work ☐ Money ☐ Spouse or Significant Other ☐ Children ☐ Other

What best helps you with stress?

Have you ever had an adrenal gland / cortisol test? Y N

Health Continued

Do you experience any insomnia at night? □ Yes □ No How many hours do you sleep each night? _____

If insomnic, what have you taken to help you sleep? _____

Do you wake up at night? □ Yes □ No How many times do you wake up each night? _____

Current Weight:_____ Desired Weight:_____ Weight 1 year ago:_____

Are you on a special diet? Y N
If yes – please describe:

Do you exercise regularly? Y N
If yes – please describe:

Describe a Typical Day's Diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Desert (how often):

Fluids (including type and amount):

Do you crave sugar, carbs, salt or protein? Explain:

Have you ever had food allergy testing? ☐ Yes ☐ No
Genetic health testing? ☐ Yes ☐ No
Nutrition testing? ☐ Yes ☐ No
Gut testing? ☐ Yes ☐ No

Do you experience: □ Constipation □ Diarrhea □ Gas □ Episodic skin rashes

How many times do you eat out at restaurants per week? _____

Restorative HEALTH

MALE SYMPTOMS QUESTIONNAIRE

Patient Name:_____ Date of Birth:_____

Please circle a number for each of the following categories to let us know how you have been feeling:

What are your CURRENT Symptoms Over the Past 1-4 Weeks?

0 means you have no symptoms / 1 means you have very mild symptoms

5 would be moderate symptoms / 10 would mean you have severe symptoms

												Comments, if any
Sleep Disturbances/Changes	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Fatigue	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Depression	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Sad and/or Grumpy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Low Energy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Decreased Enjoyment in Life	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Irritability	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Anxiety	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Low Sex Drive	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Erection Strength & Endurance	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Hot Flashes	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Night Sweats	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Poor Focus	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Memory Lapse	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Loss of Muscle Tone	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
↓ Exercise Tolerance	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Body Joint Pains	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Dry Skin	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Answer the questions below that pertain to you

- Have you lost weight? YES NO
- Are you experiencing difficulty losing weight? YES NO
- Have you gained weight gradually without an obvious cause? YES NO
- Are you retaining fat in your abdomen (increased belly fat)? YES NO
- Have you been diagnosed with insulin resistance, diabetes, or metabolic syndrome? YES NO
- Do you produce less semen so your ejaculation quantity is reduced? YES NO
- Are you losing body hair, especially on the legs? YES NO
- Are you balding? YES NO
- Do you have less ability to cope with stress? YES NO
- Are you more emotional? YES NO
- Have you noticed a recent deterioration in your ability to play sports? YES NO
- Are you falling asleep after dinner? YES NO
- Has there been a recent deterioration in your work performance? YES NO

Review of Systems

Constitutional Symptoms: □ Fever □ Night sweats □ Fatigue □ Weight Gain □ Weight Loss

Eyes: □ Blurred vision □ Double vision □ Eye discharge

HEENT: □ Hearing loss □ Ringing in ears □ Dizzyness □ Vertigo □ Nose bleeds □ Bleeding gums □ Lack of taste or smell □ Sinusitis

Respiratory: □ Chronic cough □ Coughing up blood □ Wheezing □ Shortness of breath

Cardiovascular: □ Chest pain □ Irregular heart beat □ Palpitations □ Swelling (feet, ankles, hands)

Gastrointestinal: □ Loss of appetite □ Blood in stools □ Nausea □ Vomiting □ Reflux □ Rectal bleeding □ Abdominal pain

Genitourinary: □ Urinary urgency □ Urinary frequency □ Blood in urine □ Painful urination □ Gas □ Episodic skin rashes

Integumentary: □ Skin rash □ Itching □ Change in skin color □ Change in hair or nails

Musculoskeletal: □ Joint pain □ Joint stiffness □ Joint swelling □ Back pain □ Neck pain □ Cold extremities

Endocrine: □ Heat or cold intolerance □ Excessive thirst or urination □ Change in hat or glove size

Hematologic / Lymphatic: □ Enlarged nodes or glands □ Bleeding tendency □ Anemia

Psychiatric: □ Anxiety □ Low mood □ Fear □ Panic attacks □ Visual Hallucinations □ Auditory Hallucinations

Neurological: □ Headache □ Weakness □ Stiffness □ Numbness □ Seizures □ Tingling □ Difficulty chewing □ Choking □ Tremors □ Difficulty walking □ Falls □ Tremors □ Confusion □ Trouble concentrating □ Snoring

Physical Exam (Staff Only)

General Appearance:

Vital Signs: Height: Weight: Blood Pressure: / Pulse: Temp:

Skin:

HEENT:

Neck:

Chest:

Lungs:

Cardiovascular:

Abdomen:

Rectal:

Lymph nodes:

Musculoskeletal:

Extremities:

Neurologic: