
RESTORATION HEALTH

Your Team for Integrative Health Care

Welcome to Restoration Health

Naturopathic medicine is a holistic practice of medicine. Therefore we look at every aspect of your health, including physical, mental, emotional and spiritual. We will examine your primary symptoms, as well as contributing factors such as sleep, digestion, energy, stress, and hormones.

Naturopathic doctors are trained as primary care doctors and we use many tools to bring you back to health. We typically use a combination of herbal medicine, nutrition, lifestyle changes and natural hormones. We **also will use** traditional blood work along with non-traditional labs to diagnose the problem.

You can expect about an hour of speaking about your health concerns, a physical exam if it is indicated, and a treatment plan. Depending on your needs, this treatment plan may include dietary recommendations, nutritional supplements, and a recommendation for blood work or other testing. We encourage you to bring past lab work with you if it is relevant.


We ask that you fill out the intake form then fax or email it back to us **before** your visit, this way we can get a clearer picture of who you are and spend more time talking about the best way to bring you back to optimal health. You can fax it to (323) 372-3836 or email it to info@restoration-health.com.

Unfortunately, many insurance companies don't cover Naturopathic medicine so we don't bill insurance. However, we do give you a superbill that you can submit to request reimbursement. The first visit is \$250 and follow-up visits are **\$95**. We take cash, check, or credit card. However, there is a \$10 discount if you pay by **cash or check**.

We have a **24-hour cancellation policy**. If **you are unable** to make your appointment, please call at least **24 hours** prior to **reschedule**, **otherwise you will be charged** the full price of the visit.

We look forward to building a relationship with you.

Sincerely,



Lisa Fillis, ND

3199 E. Pacific Coast Highway #201 Signal Hill, CA 90755
(562) 533-1909 www.restoration-health.com

RESTORATION HEALTH

Your Team for Integrative Health Care

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

SSN: _____ Birth date: _____

Email Address: _____

Person to notify in case of an emergency: _____

Phone #: _____

Responsible party: _____

Address: _____

Phone #: _____

Drivers license #: _____

Referred by: _____

Financial Policy: Currently, **RESTORATION HEALTH** does not accept insurance. Payment is expected at the time the services are rendered. Please speak with Dr. Lisa Fillis if special arrangements need to be made.

I understand the **RESTORATION HEALTH** financial policy.

X _____
Signature of client, or parent if minor Date

Your Current Health Problems

What is the **primary** reason for coming in today? If you have a specific health condition please describe it in detail. When was the first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and continuation.

List in order of importance other health problems that are troubling you:

- 1. _____ length of time _____
- 2. _____ length of time _____
- 3. _____ length of time _____
- 4. _____ length of time _____

What kind of treatment have you received and from whom? _____

Your Health History

The general state of your health is: [**excellent** **good** **average** **fair** **poor**]
On average, rate your energy level from 1-10 (10 is highest and 1 is lowest) _____
When during the day is your energy the best? _____ worst? _____

What is your current approximate height? _____ weight? _____ one year ago? _____
What is your blood type? _____

What childhood illnesses have you had?

Measles	___	mumps	___	chickenpox	___	whooping cough	___
polio	___	diphtheria	___	rheumatic fever	___	scarlet fever	___
smallpox	___	typhoid fever	___	tuberculosis	___	mono	___

Did you have all the standard childhood vaccinations? _____ Any recent vaccinations, including flu shots? _____

Please list any surgeries and hospitalizations (include dates): _____

What does your usual diet consist of:

Breakfast- _____

Lunch- _____

Dinner- _____

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) _____

What time do you go to bed? _____ What time do you get up? _____

How long does it take to fall asleep? _____ How many times do you wake at night? _____

Are you currently sexually active? (Y N) Is your sexual desire above or below normal? _____

Any problems with sex? (pain, decreased lubrication) _____

Female

Age of first menses _____ If periods have stopped at what age did they stop? _____

Are your cycles regular (Y N) Period begins every _____ days. For how long? _____

Are your periods (**Heavy Medium Light**)? What color is the blood? (**Light red dark red medium**)

Any clots? _____ Do you use birth control? (Y N) What type? _____

Do you have vaginal discharge? (Y N) Any color, odor, texture? _____

Do you have any spotting or bleeding between periods? (Y N) Any cramps with period? _____

Do you have any PMS symptoms? (**water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings**) other? _____

Number of pregnancies _____ Number of abortions _____ Number of miscarriages _____

Any problems getting pregnant? _____

Do you get yearly PAP smears? (Y N) When was your last? _____ Any abnormal PAP's (Y N)

Any breast lumps? (Y N) Nipple discharge? (Y N) Last mammogram? _____

Male

How often do you get up at night to urinate? _____ Is this an increase in the past few years (Y N)

Any problems with getting or maintaining an erection? (Y N) Any sores on penis? (Y N)

Painful testes? (Y N) Abnormal discharge from your penis? (Y N)

Any prostate problems (Y N) Have you every had your prostate examined? (Y N) When? _____

Digestion

Do you have any problems with gas, bloating or fullness after eating? (Y N)

How often? _____

How long have you had this problem? _____

How often do you have bowel movements? _____

Do you have **blood, mucus, undigested food** in your stool?

Any rectal itching? (Y N) Do your stools tend to be (**formed loose**)?

Do you have alternating constipation and diarrhea? (Y N)

Do you ever have yellow or light colored stools? (**often sometimes never**)

Have you traveled outside the U.S. in the last 5 years? (Y N) Have you gone camping in the last 5 years? (Y N)