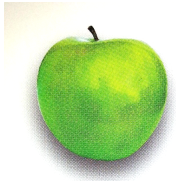

RESTORATION HEALTH
Naturopathic Health Care

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?

Chickenpox	___	Mononucleosis	___	Tuberculosis	___	Measles	___
Polio	___	Whooping cough	___	Smallpox	___	Rheumatic fever	___
Mumps	___	Diphtheria	___	Typhoid fever	___	Scarlet fever	___

Were you born by vaginal birth or C-section? _____ Breastfed? _____

Did you have all the standard childhood vaccinations? _____ Any recent vaccinations, including flu shots? _____
Please list any surgeries and hospitalizations (include dates): _____
_____

Which of the following have you had, and indicate "now" or "past":

now or past	year	now or past	year	now or past	year
_____ Diabetes	_____	_____Head injury	_____	_____ Eczema	_____
_____ Hypoglycemia	_____	_____Ear infection	_____	_____ Asthma	_____
_____ Allergies	_____	_____Chronic Infection	_____	_____ Candida	_____
_____ Canker sores	_____	_____Thyroid problems	_____	_____ Anemia	_____
_____ Depression	_____	_____High blood pressure	_____	_____ Pneumonia	_____
_____ Herpes	_____	_____Heart Disease	_____	_____ Hepatitis	_____

Do you have allergies to any drugs, herbs, food, animals or other? (**Y N**) Which? _____
_____

Are you sensitive to medications? (**Y N**) to herbal products? (**Y N**) to caffeine? (**Y N**) Do you need to take a smaller dose of medication than what's typically prescribed? (**Y N**)

Which of the following do you currently use? How often?

Alcohol _____ Tobacco _____
Hormones _____ Cortisone Steroids _____
Sedatives _____ Laxatives _____
Recreational drugs _____ Antacids _____
Other medications _____
_____

Vitamins/Supplements: _____
_____
_____

Family History

Please list family members having had these ailments:

Heart Disease: _____ Asthma: _____
Cancer: _____ Hepatitis: _____
Diabetes: _____ Stroke: _____
Mental Illness: _____ Celiac disease: _____
Rheumatoid Arthritis:_____ Depression: _____
Lupus: _____ Anxiety: _____
High Blood Pressure: _____ Thyroid problems: _____

Dental History

Childhood dental work? _____ Cavities? _____ Braces? _____
How often do you get your teeth cleaned? _____
Root canals? (**Y N**) Fillings? _____ Fillings removed? _____

Lifestyle

Do you exercise? (**Y N**) If yes, what kind, how much, and how often? _____
_____

How would you rate your stress? None 0 1 2 3 4 5 6 7 8 9 10 I'm going out of my mind
Do you have good stress-relieving habits (**Y N**) What kind? _____

What does your usual diet consist of:
Breakfast: _____
Lunch: _____
Dinner: _____
How much water do you drink? _____ Other fluids? _____

In general after eating, do you feel **tired**, **energized**, or just **no longer hungry**?

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? _____
Do you feel refreshed when you wake up? (**Y N**)

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. How many days of bleeding? _____
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 regular PAP smears (**Y N**) When was your last? _____ Any abnormal PAP's (**Y N**)
If **Y** for abnormal PAP, what treatment was performed? _____
Any breast lumps? (**Y N**) Nipple discharge? (**Y N**) Last mammogram? _____
How often do you get bladder infections? _____ Yeast infections? _____

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 your penis? (**Y N**)
Painful testes? (**Y N**) Abnormal discharge from your penis? (**Y N**)
Any prostate problems? (**Y N**) Have you ever had your prostate examined? (**Y N**) When? _____

Digestion
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**)

Do you have any problems with gas, bloating, or fullness after eating? (**Y N**)
How often? _____
How long have you had this problem? _____

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**)