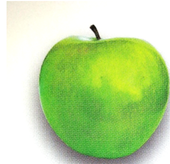

RESTORATION HEALTH
Naturopathic Health Care

Name:____
Address: ____
City, State, Zip: ____
Home Phone:______________________ Cell Phone:___________________________
Birth date: ____
Email Address: ____

Insurance name:__________________________ HMO or PPO ___________________
Primary Physician: ____

Person to notify in case of an emergency:___________________________________
Phone #: ____

Responsible party: (if patient is a minor) ____________________________________
Address: ____
Phone #: ____
Drivers license #: __________________ (only if paying by check)

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*

Cancellation Policy*: If you need to cancel your appointment, please give us 24 hour notice. Less than 24 hour notice will result in an $80 fee.*

I understand the ***RESTORATION HEALTH*** *cancellation 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	______	______	Herpes/Shingles	______	______	Eczema	______
______	Hypoglycemia	______	______	Ear infection	______	______	Asthma	______
______	Allergies	______	______	Chronic Infection	______	______	Candida	______
______	Canker sores	______	______	Thyroid problems	______	______	Anemia	______
______	Depression	______	______	High blood pressure	______	______	Pneumonia	______
______	Head Injury	______	______	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: ______________________________
Cancer: ______________________________
Diabetes: ______________________________
Mental Illness: ______________________________
Rheumatoid Arthritis:______________________________
Lupus: ______________________________
High Blood Pressure: ______________________________
Asthma: ______________________________
Hepatitis: ______________________________
Stroke: ______________________________
Celiac disease: ______________________________
Depression: ______________________________
Anxiety: ______________________________
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? ________________
Have you had a bone density test? (**Y N**) If so, when was the most recent? ______________________

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**)
Last colonoscopy? _____________

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**)