New Patient Packet

RESTORATION HEALTHCARE

Welcome to Restoration Healthcare!

- **First thing to know about us:** We're glad you're here, and we're currently accepting new patients from the Southern California area.
- **Second thing to know about us:** We use data and facts to help create your treatment plan, which is why we need your help in completing the attached New Patient Packet. Also, because we make it our business to stay up-to-date with the latest data and trends from the medical community at-large, we tend to update our protocols every 6 to 12 months.
- **Third thing to know about us:** We actively partner with you to discover and help you overcome chronic conditions that prevent you from living a long and healthy life. In other words, our approach to doctoring is different. We work to discover the underlying issues behind your pain or symptoms by working our way back to the point where we discover what prompted those symptoms in the first place. Then we work with you to make your life better.
- The data gathered from the forms and questionnaires that follow are important for us to help you.
  As you'll see, we want you to tell us why you are here, what you've done to help yourself in the past, and what your medical and family history looks like.
- **Fourth thing to know about us:** Our staff plays a critical role in your care. They will help our doctors map out your plan of care, work with you to solve or overcome anything 'financial' that may seemingly get in the way of your treatment, manage your scheduling, and oversee the plan of how we are going to objectively measure your progress.
- **Last thing to know about us:** In most cases, 9 months is the amount of time for us to work together to get you back on track.

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New Patient Packet

RESTORATION HEALTHCARE

General Information		
First Name:	Last Name:	
Home Phone:	Cell Phone:	
Office Phone:	Email:	
DOB:	Age:	
What is your current gender identity? (Check ALL that apply)		
☐ Male	☐ Transgender Female/Transwoman/MTF	
☐ Female	☐ Additional category (please specify):	
☐ Transgender Male/Transman/FTM	☐ Decline to answer	
What sex were you assigned at birth? (Check one)		
☐ Male	☐ Other	
☐ Female	☐ Decline to answer	
Street address:		
Zip code:	City:	State:
Emergency Contact Name:		
Emergency Contact Phone:		
Emergency Contact Relation:		

You and Your Medical Story
I am suffering from the following:
A
B
C
D
E

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Please tell us about your current health challenges and issues, including any history of treatment.

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ANTECEDENTS

In the space below, please do your best to tell us about your parents' health status and the state of their environment before you were conceived and during the pregnancy that resulted in you.

MEDIATORS/PERPETUATORS

Using the space below, please share your ideas related to the root cause of your current health issues. Everything is fair game so please don't hold back or leave anything out!

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Triggers and Triggering Events

Using the space below, please tell us about what you think kicked off the current episode of your health situation(s).

Signs, Symptoms, or Diseases Reported

Using the space below, please tell us what the first signs were of your health issue and/or how it was diagnosed by another doctor prior to you coming to see us at Restoration Healthcare.

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1. I estimate the % of the following in my daily diet:			
Gluten Free		Dairy Free	
Sugar Free		Other: (i.e. soy, corn, etc.	
2. I estimate that I consume the following number of alcoholic drinks per week:			
3. I have the following food cravings:			
4. My number of bowel movements per day is:			
5. My bowel consistency is *(loose, soft, hard):*			
6. Number *(on average)* **of hours of sleep I get per night is:**			
7. Do you snore? *(Yes or No)*			
8. Do you wake up rested? *(Yes or No):*			
9. In regard to sex:			
A. Interested *(normal / no interest):*			
B. Ability *(yes / no / some difficulty):*			
C. Any Pain or dysfunction *(Yes / No):*			
D. My sexual activity level is best described as:			
10. I do the following exercise on a *(daily / twice a week / three times a week)* **basis:**			
11. I enjoy the following things for fun:			

Medical, Family, and Social History

MEDICAL HISTORY

12. Past Medical History *(Click all that apply):*

☐ HIV	☐ Kidneys	☐ Liver Disease	☐ Bleeding Disorder
☐ Eating Disorder	☐ Arthritis	☐ Alcohol Abuse	☐ Heart Valve Disorder
☐ Heart Disease	☐ Anemia	☐ Cancer	☐ Psychiatric Illness
☐ Drug Abuse	☐ Lung Disease	☐ Thyroid Disease	☐ Gallbladder Disorder
☐ Other:			

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SURGICAL HISTORY

13. Surgical History and dates of surgery; List any complications:

14. Using the table below, please tell us about any prior ultrasound or scans you have had, such as mammograms, colonoscopy, MRIs, Pap Smear, bone density, CTs etc.:

Type of Imaging / Diagnostic	Date	Result *(normal / abnormal)*

15. Have you had any medical or lab testing done?

16. For women: when was your last menstrual cycle and describe *(light, normal or heavy)*

17. Are you on birth control? What Kind?

18. When was your last Pap, Mammo?

Continued on next page.

19. List your past medical providers with their specialty, phone and FAX number:

Name of provider	Specialty	Phone	FAX

20. Genetic Background

☐ African American ☐ Hispanic ☐ Mediterrean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

Family History

21. Father: Current age? Please list any health issues. If deceased, at what age and and what was the cause of death?

22. Mother: Current age? Please list any health issues. If deceased, at what age and what was the cause of death?

23. Maternal and paternal grandparents: Please list any health issues. If deceased, at what age and what was the cause of death?

24. If you have any children, how many, what are their age(s) and gender? Please list any health issues. If deceased, at what age and what was the cause of death?

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25. Family Medical History *(Check all that apply)*

☐ High Blood Pressure	☐ Nervous Breakdown	☐ Heart Trouble	☐ Cancer
☐ Stroke	☐ Anemia	☐ Obesity	☐ Kidney Disease
☐ Suicide	☐ Migraines	☐ Allergies	☐ Bleeding (abnormal)
☐ Arthritis	☐ Epilepsy	☐ Syphilis	

Social History

26. My relationship status is:

☐ Single, never married	☐ Domestic partnership / living with a partner
☐ Divorced	☐ Partnered, not living together
☐ Married	☐ Polyamorous / non-monogamous
☐ Civil union	☐ Widowed / grieving the loss of a partner
☐ Decline to answer	

27. Living arrangements *(house, apartment, who do you live with?):*

28. Occupation *(please tell us about your current occupation):*

29. Education (*what is your highest level of education*):

30. Rate your stress level on the scale of 1-10 during the average week? *(1 being the lowest and 10 being the highest)*	
31. How many times do you eat out per week?	
32. How many times do you eat fish per week?	
33. How many times do you eat raw nuts or seeds per week?	

34a. List the three worst foods you eat during the average week:

1.

2.

3.

34b. List the three healthiest foods you eat during the average week:

1.

2.

3.

Continued on next page.

35. Are you exposed to any potential environmental pathogens?
36. Have you had known exposures *(mold, heavy metals, ticks, tick bites, etc.):*
37. I estimate that I consume the following number of alcoholic drinks per week:
38. How many caffeinated beverages do you consume per week?
39. Do you smoke? ☐ **Yes** ☐ **No** *(If yes, for how many years and how much?):*

Medications & Supplements & Allergies

40. Using the table below, please tell us about any medications you currently take.

Medication	Dosage	Brand Name	Frequency	Taken for

Continued on next page.

41. Using the table below, please tell us about any supplements you currently take.

Supplement	Dosage	Brand Name	Frequency	Taken for

42. Using the table below, please tell us about any of your known allergies:

Type	**Reaction** *(nausea, rash, hives, etc.)*	**Severity** *(mild, moderate, severe, fatal, unknown)*

43. Allergy Testing Done? ☐ **Yes** ☐ **No**

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Additional Information			
44. When, where and from whom did you last receive medical or health care?			
45. Insurance and Pharmacy:			
46. Insurance Carrier		**47. Member ID:**	
48.Preferred Pharmacy Name:		**49.Pharmacy Phone:**	
50. Pharmacy Address			
51. Do we have your permission to link your Restoration Healthcare patient account with your Superscripts account at your pharmacy? *(Superscripts handles the electronic transmission of prescriptions between healthcare organizations and pharmacies)* ☐ **Yes** ☐ **No**			

Signature: _____

Name: _____

Date: _____

Parent or Guardian signature (if patient is under the age of 18).

Signature: _____

Name: _____

Date: _____

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