



Female PATIENT INFORMATION

All information contained in this questionnaire is strictly confidential. It will be protected to the highest HIPAA standards. It 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?:

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

Please describe or explain any of the above: _____

Other Medical Issues: _____

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

Pregnancies and Births

Female Health

Age of 1 st menstruation		Total # of pregnancies	_____	Menopause	Y	N
Last menstrual period	/ /	Total # of live births	_____	Age	_____	
# of days per cycle	_____	Total # of miscarriages	_____	Artificial Menopause	Y	N
# of days of flow	_____ <input type="checkbox"/> Heavy <input type="checkbox"/> Light	Total # of abortions	_____	Age	_____	
Cycle	<input type="checkbox"/> Reg <input type="checkbox"/> Irreg	# of tubal pregnancies	_____	Perimenopause	Y	N
Disabling menstruations	Y N	Total # of C-sections	_____	Age	_____	

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

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 Dizziness 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:

Medical Intake Information and History

First Name	Last Name	Sex	Date of Birth

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

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

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:

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:

Dessert(s):

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? _____

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Rectal:

Lymph nodes:

Musculoskeletal:

Extremities:

Neurologic:

Patient Name: _____ Date of Birth: _____

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

Current Status – 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

	0	1	2	3	4	5	6	7	8	9	10	Comments, if any
Irritability (feeling nervous, inner tension, feeling aggressive)	0	1	2	3	4	5	6	7	8	9	10	_____
Heart Discomfort (usual awareness of heart beat, heart skipping, racing, tightness)	0	1	2	3	4	5	6	7	8	9	10	_____
Sleep Problems (difficulty falling asleep, sleeping through the night, waking up early)	0	1	2	3	4	5	6	7	8	9	10	_____
Anxiety (inner restlessness, feeling panicky)	0	1	2	3	4	5	6	7	8	9	10	_____
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	_____
Depressive Mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	0	1	2	3	4	5	6	7	8	9	10	_____
Hot Flashes, Night Sweats	0	1	2	3	4	5	6	7	8	9	10	_____
Bladder Problems (difficulty in urinating, increased need to urinate, bladder incontinence)	0	1	2	3	4	5	6	7	8	9	10	_____
Vaginal Dryness (sensation of dryness or burning, difficulty with sexual intercourse)	0	1	2	3	4	5	6	7	8	9	10	_____
Chronic Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	_____
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	_____
Hair Issues (hair loss, thinning of the hair)	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	_____
Physical & Mental Exhaustion (general decrease in performance)	0	1	2	3	4	5	6	7	8	9	10	_____
Joint & Muscular Discomfort (pain in the joints, rheumatoid complaints)	0	1	2	3	4	5	6	7	8	9	10	_____
Sexual problems (change in sexual desire, in sexual activity and satisfaction)	0	1	2	3	4	5	6	7	8	9	10	_____
↓ Exercise Tolerance	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	_____
Weight Control	0	1	2	3	4	5	6	7	8	9	10	_____
Memory Lapses (impaired memory, decrease in concentration, forgetfulness)	0	1	2	3	4	5	6	7	8	9	10	_____

Are you currently taking your progesterone? Yes No

Current Dose and Type: _____ Troche RDT (rapid dissolve tablet) Capsule

First day of your last menstrual cycle? _____

Patient Signature: _____ Date: _____