RESTORE FAMILY HEALTH

11230 West Ave #3203
210-408-6446 phone 210-888-8520 fax
www.restorefamilyhealth.com email support@restorefamilyhealth.com

New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Restore Family Health to release my personal medical information to me.

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Date of Birth: _____ **Spouse's name:** _____ **Phone:** _____

Your Occupation/Employer: _____

In order of importance, list the health concerns you are most interested in correcting:	**How long have you noticed these concerns?**
1. _____	**1.** _____
2. _____	**2.** _____
3. _____	**3.** _____
4. _____	**4.** _____

1. **Name all of the doctors you have seen for these concerns and what treatment you received:**

_____
_____
_____
_____
_____

2. **Have your symptoms** (please circle one)**: Improved Worsened Stayed the same**

Is there anything that improves symptoms? _____
Is there anything that makes symptoms worse?_____

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3. **Is this condition interfering with any of the following** (please circle all that apply):

Work Sleep Daily Activities Relationships Quality of Life

Mood Recreation Activities Mental Health

4. In the past, have you used birth control pills or taken antibiotics? _____

a. For how long?_____

5. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Cold hands/feet
Breathing issues	High blood pressure	Unexplained weight change
Pain –area?	High cholesterol	Digestive issues
Chronic cold/flu symptoms	Numbness/tingling	Hot flashes
Chronic fatigue	Irritability	Reduced sex drive
Depression/mood swings	Tension	Hair loss
Diabetes	Osteoporosis	Sleep issues

6. How much sleep do you get each night on average?
_____

7. Do you have any food restrictions?
_____
_____

8. Do you smoke, drink, or use recreational drugs?
_____
_____

a. How much, how often? _____
b. How often do you drink caffeinated beverages?_____

9. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):_____

10. Are there foods that you eat on a daily or almost daily basis?_____
_____

a. Do you "miss" these foods if you do not eat them?_____

11. Write briefly about any weight gain/loss history:_____
_____
_____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom
b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

12. Please list close relatives that have diabetes, heart disease or obesity:_____
_____

13. What methods have you tried to lose/gain weight_____
_____

14. How is your energy level?_____
a. Are there times in the day that you feel best?_____**worst?**_____

15. Are you happy in your life right now?
_____

16. What are your main sources of stress_(work, family, financial)_____
_____

17. How do you deal with your stress?_____

18. Next to each question assign a number between 0 and 10. You should assign values as follows:

0 = Not true, 1-2-3-4-5-6-7-8-9-10 = Very true

_____ <----------> _____

___ I have difficulty falling asleep.
___ I wake up throughout the night.
___ I frequently feel "wired" in the evenings.
___ I have energy highs and lows throughout the day.
___ I feel tired all the time.
___ I need caffeine to get going in the morning.
___ I usually go to bed after 10 pm.
___ I frequently get less than 8 hours of sleep per night.
___ I get fatigued easily.
___ Things I used to enjoy seem like a chore lately.
___ My sex drive is lower than it used to be.
___ I have been experiencing feelings of depression such as sadness or loss of motivation.

___ If I skip meals I feel low energy or foggy and disoriented.

___ My ability to handle stress has decreased.

___ I find that I am easily irritated or upset

___ I have had one or more stressful major life events (*i.e.*: divorce, death of a loved one, job loss, new baby, new job).

___ I tend to overwork with little time for play or relaxation for extended periods of time.

___ I crave sweets.

___ I frequently skip meals or eat sporadically.

___ I am experiencing increased physical complaints such as muscle aches, headaches, or more frequent illnesses.

_____

19. Check (√) off any of the following that have applied to you <u>within the last 30 days:</u>

_____Do you feel nauseous?	_____Do you have abdominal/intestinal pain?
_____Do you have bloating?	_____Do you get bloated after meals?
_____Do you get heartburn?	_____Do you have diarrhea?
_____Do you have constipation?	_____Do you travel outside of the U.S.?
_____Do you have gas?	_____Are your stools compact/hard to pass?
_____Do you belch following meals?	_____Do you have gurgles in your stomach?
_____Do your bowel movements alternate between constipation and diarrhea?	

20. In your estimation, how physically fit are you right now?

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

21. How often do you exercise?

_____

a. What is your workout regimen?_____

22. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

_____

23. Please list past surgeries, starting with most recent:

_____
_____
_____

24. Hospitalizations/Accidents (falls, motor vehicle)

_____
_____

25. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	**Do you often:**
Now Past **Satisfactory**	Now Past **Feel depressed**
Now Past **Boring**	Now Past **Have anxiety**
Now Past **Demanding**	**Do you often:**
Now Past **Unsatisfactory**	Now Past **Have irrational fears**
Do you worry over:	Now Past **Feel upset**
Now Past **Home life**	Now Past **Feel things go wrong**
Now Past **Marriage**	Now Past **Feel shy**
Now Past **Children**	Now Past **Cry**
Now Past **Job**	Now Past **Feel inferior**
Now Past **Income**	**Have you:**
Now Past **Money problems**	Now Past **Seriously considered suicide**
	Now Past **Attempted suicide**

26. Who is your primary care physician: _____

List ALL allergies/sensitivities to medication, food, and other items here:

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Item you react to:	Reaction:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Times Daily
1. _____	1. _____	1._____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

1. _____	1. _____	1._____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

I consent to a professional and complete Chiropractic examination. I understand I will be financially responsible for any fees related to the care received in this office.

Name: _____Signature: _____

Date: _____