PATIENT INFORMATION

Date:_____________________________

Name: ____

First: Middle Last

Date of Birth: ___________________________ **Gender:** ____ **Male** _____ **Female**

Cell Phone: ________________________________ **Work Phone:**_________________________________

Home Phone: _________________________________ **Fax:**____

Email: ____

Primary Address: ____

House Number and Street Apt. No.

____

City State Zip

Alternate Address: ____

____

EMERGENCY CONTACT

Name:____ **Number(s):**_______________________________________

Address:____

CURRENT PRIMARY CARE PHYSICIAN

Name:_____________________________________ **Number:**____

Fax:____ **Address:**____

How did you hear about our Medical Practice?

- **Internet Search/Website**
- **Facebook/Social Media**
- **Magazine**______________________________
- **Newspaper**_____________________________
- **Seminar**________________________________
- **Doctor** _________________________________
- **Friend/Family** ___________________________
- **Other**__________________________________

RestoraLife™

PATIENT HEALTH QUESTIONNARE

Please list all operations you have had:

____
____
____
____

Medications/Supplements	Dosage	Reason For Use

Please list all allergies (medications, foods, seasonal):

____
____
____
____

Do you smoke? **YES** **NO** **If yes, how much per day?** ____________

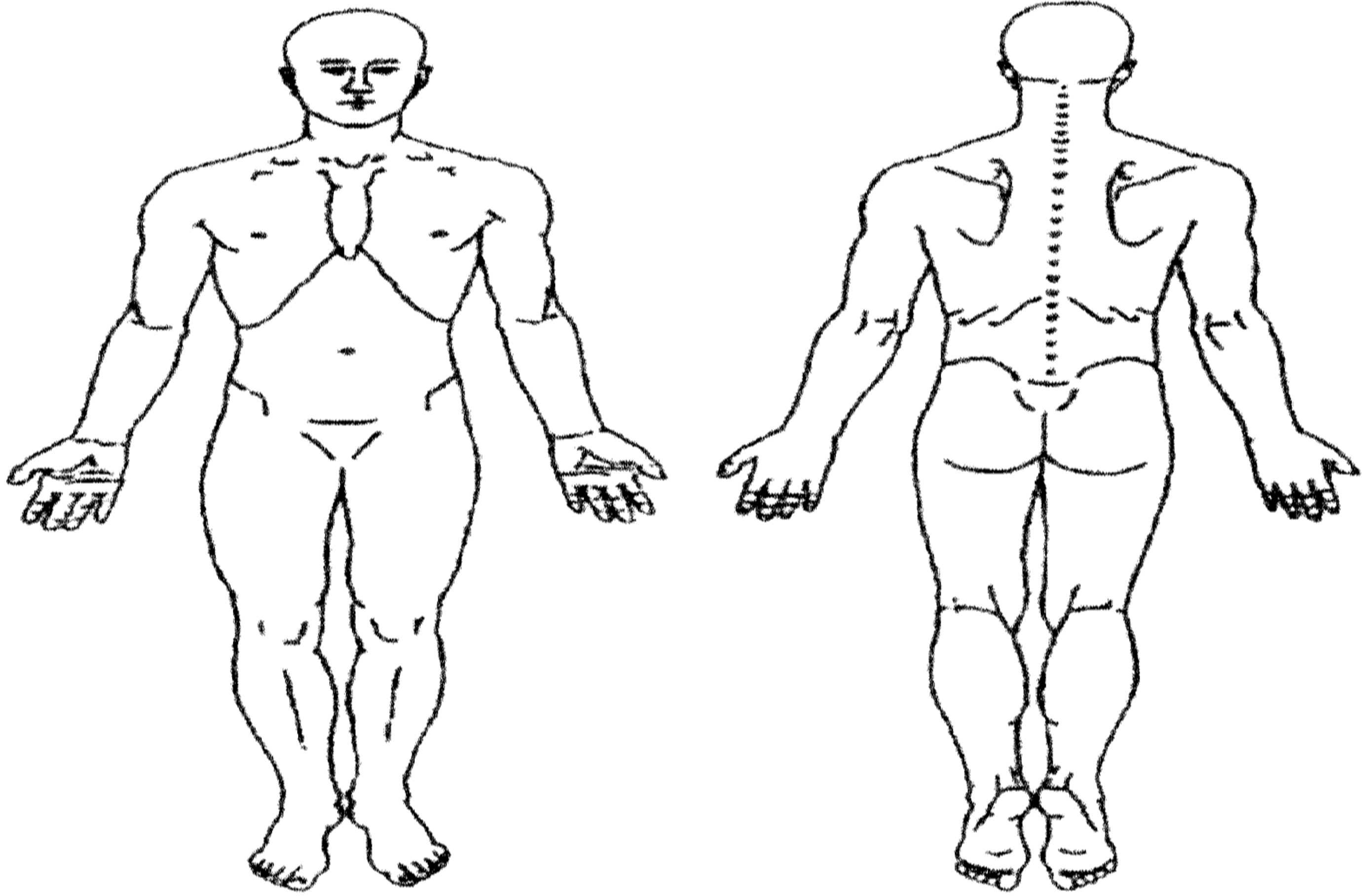
Do you drink alcohol? **YES** **NO** **If yes, how many drinks per day?** ____________

Do you use recreational drugs? **YES** **NO**

HAVE YOU USED ANY OF THESE REGULARLY OR FOR A LONG TIME?:

NSAIDS (advil, ibuprofen, motrin, celebrex, aspirin)**?** **YES** **NO**
Tylenol (acetaminophen)**?** **YES** **NO**
Acid blocking drugs (zantac, prilosec, nexium)**?** **YES** **NO**

RestoraLife™



Please mark on the diagram above the areas you are experiencing pain.

PRIMARY* concern or area of pain?

____

____

SECONDARY* concern or area of pain?

____

____

RestoraLife™

Medical Symptom/Toxicity Questionnaire

Please check all that apply:

Endocrine
__Diabetes
__Over or Underactive Thyroid

Mouth/Throat
__Chronic Coughing
__Gagging; frequent need to clear throat
__Sore Throat, Hoarseness, Loss of Voice
__Swollen/Discolored Tongue, Gums, Lips

Digestive Track
__Nausea or Vomiting
__Diarrhea
__Constipation
__Bloated
__Belching or Passing Gas
__Heartburn
__Ulcers
__Liver Disease/Hepatitis

Heart/Vascular
__Irregular or Skipped Heartbeat
__Rapid or Pounding Heartbeat
__Chest Pain
__Blood Clots
__High Blood Pressure
__Heart Murmur
__Heart Surgery or Angioplasty

Head
__Headaches
__Seizures
__Strokes
__Dizziness
__Insomnia
__Facial Pain

Emotions
__Mood Swings
__Anxiety
__Depression
__Irritability/ Aggressiveness

Lungs
__Chest Congestion
__Asthma, Bronchitis
__Wheezing
__Shortness of Breath
__Difficulty Breathing

Nose
__Nasal Obstruction
__Stuffiness or Congestion
__Nasal Discharge
__Nose Bleeds

Energy/Activity
__Fatigue, Sluggish
__Apathy, Lack of Interest
__Hyperactivity
__Restlessness

Skin
__Skin Cancer
__Hives, Rashes, Dry Skin
__Hair Loss
__Flushing, Hot Flashes
__Excessive Sweating

Ears
__Itchy
__Earaches, Infections
__Drainage
__Ringing
__Hearing Loss

Joint/Muscles
__Pain or Aches in Joints
__Arthritis
__Stiffness/Limitation of Movement
__Pain/Ache in Muscles
__Feeling of Weakness

Weight
__Binge Eating or Drinking
__Cravings, Compulsive Eating
__Water Retention
__Excessive Weight
__Under Weight

Eyes
__Watery
__Itchy
__Puffy/Swollen
__Red/Irritated
__Blurred or Tunnel Visions
__Floaters
__Glaucoma

Mind
__Poor Memory
__Confusion
__Difficulty Concentrating
__Poor Physical Coordination
__Stuttering or Stammering
__Slurred Speech

Other
__Frequent Illness
__Frequent Urination
__Prostate Problems
__Kidney Disease

Do you have a pacemaker or any implanted devices?	**YES**	**NO**
Are you pregnant?	**YES**	**NO**
Have you had a steroid injection in the last 7 days?	**YES**	**NO**
Do you have any known allergies or sensitivities to DMSO (Dimethyl Sulfoxide)?	**YES**	**NO**
Do you have any known allergies to products from birds such as feathers, eggs and/or poultry?	**YES**	**NO**
Do you currently have cancer or been previously diagnosed with cancer?	**YES**	**NO**

Patient Signature:____ **Date:**________________