Restorative Health Clinic

6564 SE Lake Rd, Ste 100
Milwaukie, OR 97222
P: 503-747-2021 F: 503-747-2802
www.restorativehealthclinic.com

Patient Intake Form

Full Name _____DOB:_____ Date:_____

How did you hear about Restorative Health Clinic: _____

_____

Referred by: _____

Describe briefly (in one/two sentence) what your main problem(s) are:

_____

_____

_____

_____

List your symptoms below and indicate also the location of any pain you might have.

- Energy Level (1 very low to 10 high) _____
- Feeling of well being (1 very low 10 10 high)_____

Symptoms	Severity (Mild, Moderate, Severe)	Frequency (Daily, weekly, Monthly)
Pain		
Sleep Quality		
Insomnia		
Mood		
Fatigue		
Digestion		
Immune		

What are your top five (5) health priorities/problems you want to improve.

List them in order from Most Important to Least Important.

1_____

2_____

3_____

4_____

5_____

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1) How did your symptoms begin?_____

_____

_____

2) What was happening in your life at that time?_____

_____

_____

3) Previous or current diagnoses:_____

_____

_____

4) Marital Status (Circle one): Single Married Separated Divorced Widowed

5) Per week, how many hours do you spend at: Work____ Childcare _____ Other: _____

6) Occupation:_____Stress levels 1 lowest - 10 highest :1 2 3 4 5 6 7 8 9 10

7) How many doctors have you seen for your symptoms? _____

8) History of smoking, past or current? _____

9) Alcohol intake? _____ How often? _____

10) Other substance use_____

11) List any surgeries or hospitalization:

- Year (Approx) _____ Surgery/hospitalization_____
- Year (Approx) _____ Surgery/hospitalization _____
- Year (Approx) _____ Surgery/hospitalization _____
- Year (Approx) _____ Surgery/hospitalization _____
- Year (Approx) _____ Surgery/hospitalization _____

12) Medication List: (Use separate Sheet if Needed)

_____

_____

13) Any other allergies or sensitivities:

_____

_____

_____

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14) List all treatments you are taking or have taken that helped (Rx means by prescription only):

Rx:

_____

_____

_____

Natural or OTC:

_____

_____

_____

15) List all treatments you have taken that have caused side effects or have not helped:

Rx:

_____

_____

_____

Natural or OTC:

_____

_____

_____

Please list current treatments with dose: (Attached a separate sheet if necessary)

Prescription:
1. _____; Dose _____mg _____x a day
2. _____; Dose _____mg _____x a day
3. _____; Dose _____mg _____x a day
4. _____; Dose _____mg _____x a day
5. _____; Dose _____mg _____x a day
6. _____; Dose _____mg _____x a day
7. _____; Dose _____mg _____x a day

Non-prescription:
1. _____; Dose _____mg _____x a day
2. _____; Dose _____mg _____x a day
3. _____; Dose _____mg _____x a day
4. _____; Dose _____mg _____x a day
5. _____; Dose _____mg _____x a day
6. _____; Dose _____mg _____x a day
7. _____; Dose _____mg _____x a day

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Adrenal Checklist (Yes/No)

16) Hypoglycemia _____

17) Shakiness relieved with eating _____

18) Moodiness _____

19) Recurrent infections that take a long time to go away _____

20) Life was very stressful before symptoms began _____

21) Low blood pressure _____

22) Dizziness on first standing _____

23) Sugar cravings _____

24) Food sensitivity (if yes, please list foods above) _____

25) Have you been on Prednisone (Cortisone)? If yes: For how long? _____

26) Did you feel better when you took it? _____Which kind of steroid and which dose_____

Symptom:	
Poor tolerance to stress	No symptom 0 1 2 3 4 5 Intense/always
Anxiety with stress	No symptom 0 1 2 3 4 5 Intense/always
Fatigue or mood improved with sugar of sweets	No symptom 0 1 2 3 4 5 Intense/always
Salt cravings	No symptom 0 1 2 3 4 5 Intense/always
Eczema, psoriasis or dandruff	No symptom 0 1 2 3 4 5 Intense/always
Brown spots or increased pigmentation	No symptom 0 1 2 3 4 5 Intense/always
Sudden drop in energy "all gone feeling"	No symptom 0 1 2 3 4 5 Intense/always

Thyroid Checklist (Yes/No)

_____ 27). Weight gain? (_____ lbs or _____ kg - over _____ years)
_____ 28). Low body temperature (under 98 degrees)
_____ 29). High cholesterol
_____ 30). Dry skin
_____ 31). Thin hair
_____ 32). Heavy periods – **Women only**

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General Checklist:

Sensitive to cold	No symptom 0	1	2	3	4	5 Intense/always
Cold hands or feet	No symptom 0	1	2	3	4	5 Intense/always
Morning fatigue	No symptom 0	1	2	3	4	5 Intense/always
Fatigue unless exercising	No symptom 0	1	2	3	4	5 Intense/always
Sleepy during day	No symptom 0	1	2	3	4	5 Intense/always
Distracted easily	No symptom 0	1	2	3	4	5 Intense/always
Poor motivation for required tasks	No symptom 0	1	2	3	4	5 Intense/always
Headaches	No symptom 0	1	2	3	4	5 Intense/always
Water retention	No symptom 0	1	2	3	4	5 Intense/always
Constant swollen eyelids	No symptom 0	1	2	3	4	5 Intense/always
Swollen eyes in morning	No symptom 0	1	2	3	4	5 Intense/always
Swollen calves/feet	No symptom 0	1	2	3	4	5 Intense/always
Difficulty losing weight despite dieting	No symptom 0	1	2	3	4	5 Intense/always
Constipation	No symptom 0	1	2	3	4	5 Intense/always
Carpal tunnel syndrome	No symptom 0	1	2	3	4	5 Intense/always
Stiff joints in morning	No symptom 0	1	2	3	4	5 Intense/always
Joint pain worsens with cold	No symptom 0	1	2	3	4	5 Intense/always
Hoarse voice in morning	No symptom 0	1	2	3	4	5 Intense/always
Slow growing or brittle nails	No symptom 0	1	2	3	4	5 Intense/always
Diminished or increased sweating	No symptom 0	1	2	3	4	5 Intense/always
Tingling or numbness in extremities	No symptom 0	1	2	3	4	5 Intense/always
Coarse skin (rough skin)	No symptom 0	1	2	3	4	5 Intense/always

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Estrogen Checklist – Women Only

Poor memory/concentration	No symptom 0	1	2	3	4	5 Intense/always
Excessive sweating	No symptom 0	1	2	3	4	5 Intense/always
Dry vagina	No symptom 0	1	2	3	4	5 Intense/always
Pain during intercourse	No symptom 0	1	2	3	4	5 Intense/always
Wrinkles around eyes/mouth or palms	No symptom 0	1	2	3	4	5 Intense/always
New body hair	No symptom 0	1	2	3	4	5 Intense/always
Urinary incontinence	No symptom 0	1	2	3	4	5 Intense/always
First menstruation before 12 or after 15 yrs	No symptom 0	1	2	3	4	5 Intense/always
Depression/irritability before menstruation	No symptom 0	1	2	3	4	5 Intense/always
Day or night sweats or hot flashes	No symptom 0	1	2	3	4	5 Intense/always
Lost or lower libido	No symptom 0	1	2	3	4	5 Intense/always

Progesterone Checklist – Women Only

Swollen breast/belly before menstruation	No symptom 0	1	2	3	4	5 Intense/always
Fibroids of uterus	No symptom 0	1	2	3	4	5 Intense/always
Endometriosis	No symptom 0	1	2	3	4	5 Intense/always
Menstruation with strong cramping	No symptom 0	1	2	3	4	5 Intense/always
General irritability	No symptom 0	1	2	3	4	5 Intense/always
Generalized Anxiety	No symptom 0	1	2	3	4	5 Intense/always
Infertility/History of miscarriage	No symptom 0	1	2	3	4	5 Intense/always
Ovarian cysts	No symptom 0	1	2	3	4	5 Intense/always
Puffiness/Bloating/Water retention	No symptom 0	1	2	3	4	5 Intense/always

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Female Testosterone Checklist – Women Only

Decreased strength/endurance	No symptom 0	1	2	3	4	5 Intense/always
Weaker bones/muscles	No symptom 0	1	2	3	4	5 Intense/always
Increased fat deposition/less muscle	No symptom 0	1	2	3	4	5 Intense/always
Depression/Mood changes/less courage	No symptom 0	1	2	3	4	5 Intense/always
Loss of sexual desire	No symptom 0	1	2	3	4	5 Intense/always
Difficult/weaker orgasm	No symptom 0	1	2	3	4	5 Intense/always

Other female hormonal symptoms:

33). Number of pregnancies?_____ Live births? _____
34). Irregular periods?_____ How many days in between starting period?_____ How long does the bleeding last?_____
35). Menopausal or peri-menopausal? Y / N Date of last menstrual period _____
36). Any nipple discharge? Y / N Right Breast/Left Breast/Both breasts?_____
37). History of hysterectomy? Y / N Ovaries removed? Y / N Other gyn surgery?_____
38). Other or total symptom load worse the week before your period? Y / N
39). Cold sores/herpes or other outbreaks worse before period? Y / N

Testosterone symptoms --- Males Only

Lack of sense of well-being/life enjoyment	No symptom 0	1	2	3	4	5 Intense/always
Increased fatigue	No symptom 0	1	2	3	4	5 Intense/always
Low sex drive/libido	No symptom 0	1	2	3	4	5 Intense/always
Difficulty achieving/maintaining erection	No symptom 0	1	2	3	4	5 Intense/always
Decreased firmness/frequency of erections	No symptom 0	1	2	3	4	5 Intense/always
Reduced muscle mass/strength/tone	No symptom 0	1	2	3	4	5 Intense/always
Decreased concentration	No symptom 0	1	2	3	4	5 Intense/always
Lower bone mass/osteoporosis	No symptom 0	1	2	3	4	5 Intense/always
Lower work performance	No symptom 0	1	2	3	4	5 Intense/always
Lower motivation	No symptom 0	1	2	3	4	5 Intense/always

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Lack of attention to detail	No symptom 0	1	2	3	4	5 Intense/always
Too emotional/easy anger/weeping	No symptom 0	1	2	3	4	5 Intense/always
Increased sweating	No symptom 0	1	2	3	4	5 Intense/always
Irritability/depression	No symptom 0	1	2	3	4	5 Intense/always
Hair loss	No symptom 0	1	2	3	4	5 Intense/always
Poor wound healing	No symptom 0	1	2	3	4	5 Intense/always
Swollen prostate/urinary incontinence	No symptom 0	1	2	3	4	5 Intense/always

Tick Borne Infections

____ 40). History of frequent tick bites?_____ Lived in an area with many ticks?_____If so, how many? _____
____ 41). Rash after tick bite?
____ 42). Rash that looked like a "bull's eye"?
____ 43). Have you been treated for Lyme disease?
____ 44). Numbness or tingling in your fingers or feet?
____ 45). History of a positive Lyme Test?

Prostate -- Males Only

____ 46). Burning on urination
____ 47). Groin aching/Aware of prostate
____ 48). Discharge from your penis?
____ 49). Urine urgency with a small volume

Sinus/Upper respiratory tract

____ 50). Chronic nasal congestion or post nasal drip
____ 51). Chronic yellow, green, or bloody nasal discharge
____ 52). Chronic bad taste in your mouth or bad breath
____ 53). Headaches under or over eyes
____ 54). Scratchy/watery eyes
____ 55). Do you have chronic or intermittent low-grade fevers (over 99°F/_____ °C).
If yes, how high does the fever go? _____

1. Did your illness begin with a fever? _____
2. Do you have lung congestion? _____
3. How often do you have the fever? _____

____ 56). Has any antibiotic you've been on in the past even temporarily improved your Chronic Fatigue/Fibromyalgia symptoms? _____
If yes, which? _____
How long did you take it? _____

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Sleep

____ 57). Trouble ____ falling; ____ and/or staying asleep? If yes, is it a ___ mild, ___ moderate, or ___ severe problem?
____ 58). How many hours of uninterrupted sleep do you get a night? _____
____ 59). How many times do you wake up at night? _____
____ 60). Do you wake at night to urinate?
____ 61). Do your legs jump a lot or do you kick your spouse or kick your blankets off at night?
____ 62). Do you snore? _____
___ 1) Are you more than 20lbs overweight?
___ 2) Do you have periods that you stop breathing (ask your bed partner)?
___ 3) Do you have high blood pressure?

Parasites

____ 63). Did your problems begin with a diarrhea attack?
____ 64). Do you sometimes have diarrhea? If so, is it severe? _____
____ 65). Do you sometimes have constipation?
____ 66). Do you have well water?

Vision/Dental

____ 67). Have you had temporary vision loss? one eye?_____
Which one? _____
How many times? _____
How long do they last? _____
Is your sedimentation (sed) rate blood test over 30? _____
____ 68). Dry eyes?
____ 69). Dry mouth?
____ 70). Any evidence of dental infections?

Yeast Overgrowth

____ 71). Recurrent vaginal yeast infections **(females)**. If so, how often? _____
____ 72). Toenail or fingernail fungal changes
____ 73). Skin fungal infections (i.e., athlete's foot, jock itch, rash under bra)
____ 74). Do you get in the mouth sores frequently (not on lips)?
____ 75). Do you get cold sores or Herpes attacks before or during symptom flares that seem to flare your symptoms?
____ 76). Been on birth control pills? If yes, how did you feel on them? ___ better; ___ worse; ___ no change
____ 77). Small amounts of alcohol aggravate symptoms?

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YEAST QUESTIONNAIRE

The total score for this section gives us the probability of yeast overgrowth being a significant factor in your case.

Point Score

_____ Have you been treated for acne with tetracycline, erythromycin, or other antibiotic for one month or longer?
No = 0 / Yes = 50

_____ Have you taken antibiotics for any type of infection for more than two consecutive months, or in shorter courses over three times in a twelve-month period?
No = 0 / Yes = 50

_____ Have you ever taken an antibiotic – even for a single course?
No = 0 / Yes = 6

_____ Have you ever had prostatitis or vaginitis?
No = 0 / Yes = 25

_____ Have you ever been pregnant?
No = 0 / Yes = 5

_____ Have you taken birth control pills?
No = 0 / Yes = 15

_____ Have you taken corticosteroids such as Prednisone, Cortef, or Medrol?
No = 0 / Yes = 15

_____ When you are exposed to perfumes, insecticides, or other odors or chemicals, do you develop wheezing, burning eyes, or any other distress?
No = 0 / Yes = 15

_____ Are your symptoms worse on damp or humid days or in moldy places?
No = 0 / Yes = 20

_____ Have you ever had a fungal infection, such as jock itch, athlete's foot, or a nail or skin infection, that was difficult to treat?
No = 0 / Yes = 20

_____ Do you crave sugar or bread?
No = 0 / Yes = 20

_____ Does tobacco smoke cause you discomfort (e.g. wheezing, burning eyes)?
No = 0 / Yes = 10

Please add your points and record your Total Score _____

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Screening for OBSTRUCTIVE SLEEP APNEA:

Answer the following questions to find out if you are at risk for Obstructive Sleep Apnea

STOP:

S (Snore)	Have you been told that you snore?	YES	NO
T (Tired)	Are you often tired during the day?	YES	NO
O (Obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	YES	NO
P (Pressure)	Do you have high blood pressure or on medication to control high blood pressure?	YES	NO

If you answered YES to two or more questions on the **STOP** portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete the **BANG** questions below:

BANG:

B (BMI)	Is your body mass index greater than 25?	YES	NO
A (Age)	Are you 50 years old or older?	YES	NO
N (Neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	YES	NO
G (Gender)	Are you a male?	YES	NO

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

Questionnaire provided by: Derek S Lipman MD

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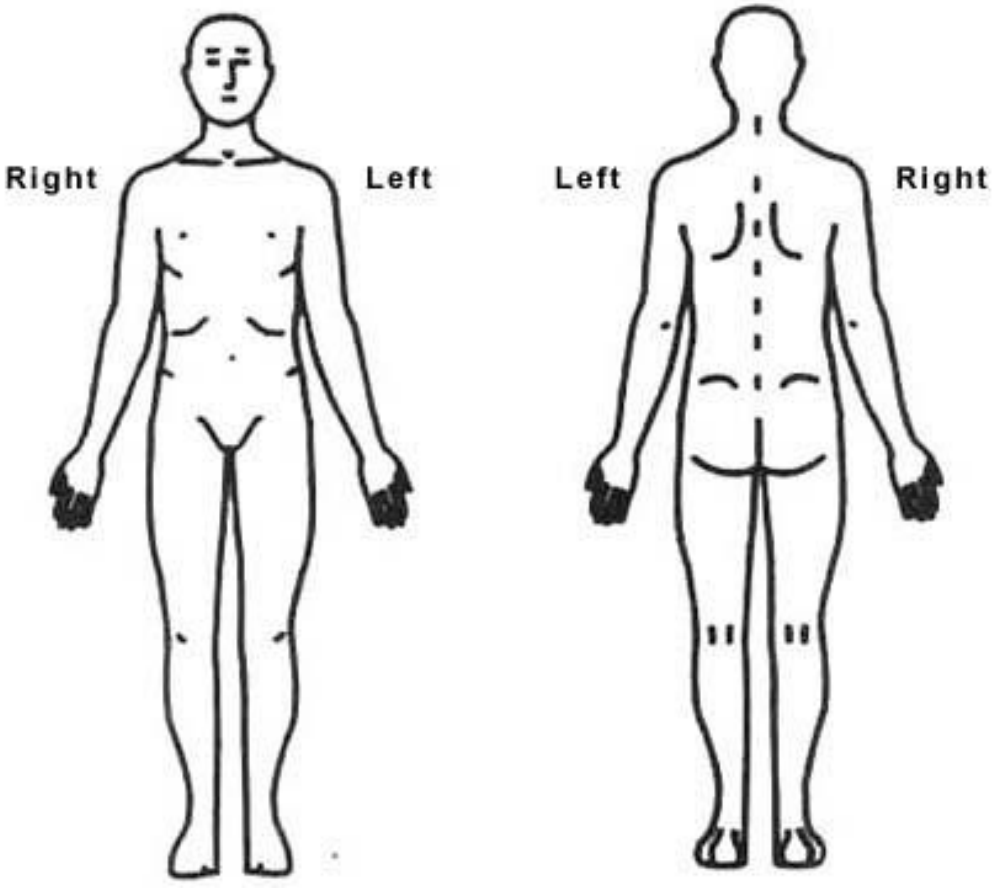
Pain and Scar Diagram

On the diagram below, please mark where you feel pain as well as the location of scars.



Mark with an X for painful areas
Mark with ≠ for scar location

Please describe your pain (Circle as many as apply)"

Dull Aching Sharp Stabbing Throbbing Constant Tingling Cramping Radiating

Intense Deep Intense Surface Stiff Tender to touch Pinching Electric Episodic

Other

_____
_____
_____

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Food Questionnaire:

Please list below the most common foods that represents:

Breakfast:

- _____
- _____
- _____
- _____
- _____

Lunch:

- _____
- _____
- _____
- _____
- _____

Dinner:

- _____
- _____
- _____
- _____
- _____

Snack:

- _____
- _____
- _____
- _____
- _____

Beverages:

- _____
- _____
- _____
- _____
- _____