



RESTORING
WELLNESS
PRIMARY CARE

New Patient Questionnaire

Thank you for choosing Restoring Wellness for your integrative health care needs! We look forward to caring for you and assisting you in your journey to better health! To learn more about you and your health needs, please fill out the questions below as honestly and completely as possible.

Name: _____

Age: _____ Date of Birth (month/day/year) _____ / _____
/ _____

Height: _____ Weight: _____ Max weight: _____ When? _____

What other healthcare provider(s) do you see on a routine basis? – Please list

What are your **TOP 3 health concerns**, in order of importance? Or any specific reason for today's appointment?

How committed are you to your health and healing journey? _____

Do you have financial concerns that would prevent you from entering a treatment plan? _____

Personal Medical History: Please list all "diagnoses" you have been given by other providers.

Previous Hospitalizations, Surgeries and Procedures with Dates:

Medications and Supplements: Please provide an attached list of all products (including vitamins, herbal medications) you are taking and the reason you are taking them.

Allergies or Sensitivities (medications, supplements, environmental, food):

GYN History:

Date of Last Period _____ Number of Pregnancies _____
Number of Vaginal Deliveries _____ Number of C-Sections _____
Number of Miscarriages _____ Number of Abortions _____

Implants/Devices (including hormonal devices) _____

Family Medical History: Please list any condition a family member currently has or previously had.

Social History:

What is your marital status? ____ Single ____ Married ____ Divorced ____ Widowed ____ Other
Number of Children and their ages _____

What do you do for a living? _____ If retired, from what? _____

What is the activity level at your job?

• None (seated work) • Low (some walking) • Moderate (standing, walking) • High (heavy labor)
Do you do shift work? • Yes • No What shift?

How often do you travel?

• Rarely • A few times a year • A few times a month • Weekly

What is your highest level of education? _____

Hobbies/interests: _____

Sleep

Most important part of the day for detoxification and regenerating energy.

How many hours of sleep do you get per night? _____ Solid or interrupted? _____

Do you have any trouble falling asleep? • Yes • No

Do you have any trouble staying asleep? • Yes • No

Do you wake feeling refreshed and well rested? • Yes • No

Hormones

Proper hormone balance is important for energy production and immune function.

Thyroid Hormone Assessment:

- | | |
|---|--|
| <input type="checkbox"/> Elevated blood cholesterol level | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Increased sensitivity to cold | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Unexplained weight gain | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Difficulty losing weight | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Puffy face | <input type="checkbox"/> Joint pain/stiffness |
| <input type="checkbox"/> Muscle weakness/muscle aches and pains | <input type="checkbox"/> Heavy/irregular periods |
| <input type="checkbox"/> Thinning hair | <input type="checkbox"/> Slow heart rate |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Impaired memory |

Sex Hormone Assessment

Estrogens

Estrogen Deficiency

- Hot flashes
- Night sweats
- Vaginal dryness
- Foggy thinking
- Memory lapses
- Incontinence
- Tearful
- Depression
- Sleep disturbance
- Heart palpitations
- Bone loss

Estrogen Excess

- Mood swings (Hx of PMS)
- Tender breasts
- Water retention
- Nervousness
- Irritability
- Anxious
- Fibrocystic breasts
- Uterine fibroids
- Weight gain in hips/bust
- Headaches
- Candida infections

Progesterone

Progesterone Deficiency

- Tender breasts
- Nervousness
- Irritable
- Anxious
- Fibrocystic breasts
- Uterine fibroids
- Weight gain in hips
- Sleep disturbance

Progesterone Excess

- Sleepiness
- Dizziness
- Mild depression
- Candida infections
- Headache
- Water retention

Androgens (DHEA and Testosterone)

Androgen Deficiency

- Low libido
- Low energy/fatigue/burnout
- Vaginal dryness
- Foggy thinking
- Joint aches/pains
- Loss of muscle mass/strength

Androgen Excess

- Excess body/facial hair
- Loss of scalp hair
- Increased acne
- Oily skin
- Aggression/impatience

Adrenal Hormone Assessment

___ Sleep disturbance/early morning awakening

___ Anxious/overwhelmed easily

___ Scattered/racing thoughts

___ Irritable/easily frustrated

___ Cold hands and/or feet

___ Perimenopause/Menopause

___ Low libido

___ Thyroid issues

___ Difficulty waking up in morning/being a "night owl"

___ Thinning Hair

___ Depression

___ Weight gain in abdomen

___ Crave sugar/carbohydrates

___ Crave salt

___ Need for caffeine

___ Fatigue/exhaustion

___ Dizziness/lightheadedness

___ Heart palpitations

___ Hypo/hyperglycemia

___ Insulin resistance

Infection

Hidden infection(s) can cause energy depletion and poor immune function over time.

Did your symptoms start or worsen after:

Severe Viral illness? _____

Tick bite? _____

Surgical procedure? _____

Complicated Child Birth? _____

Hospitalization? _____

Dental infection or procedure such as a root canal? _____

Have you EVER been diagnosed with....?

- Severe mononucleosis/recurrent strep throat
- Rheumatoid arthritis
- Lupus/Scleroderma/Sjogrens
- Psoriasis/Psoriatic arthritis
- Hashimotos or Graves thyroid disease
- Inflammatory bowel disease; Crohns or Ulcerative Colitis
- Gastrointestinal parasites/worms
- H. Pylori gastritis/Peptic ulcer disease
- Chronic prostatitis
- Frequent UTI/ureaplasma
- Frequent vaginal infections (Yeast, BV)
- Interstitial cystitis (Painful Bladder Syndrome)
- Endometriosis/Adenomyosis
- Chlamydia or other sexually transmitted infection
- Other _____

Nutrition

Deficiency of nutrients, toxin build up and food allergy/intolerance can cause tiredness and body aches.

Diet:

How much water do you drink per day? _____

How much coffee do you drink per day? _____ Per week? _____

How much soda do you drink per day? _____ Per week? _____

What, if any, are your food cravings? _____

How many times per week do you eat restaurant food? _____

How often do you eat fast food or frozen foods? _____

Food Allergy/Intolerance

Do you have a severe food allergy that causes symptoms of rash, swelling of lips/tongue/airway? _____

If yes, which foods and what symptoms do they cause?

Do you have food sensitivities/intolerances that cause symptoms of gas, reflux, bloating, belching, heartburn, cramping, diarrhea, or constipation? _____

If yes, which foods and what symptoms?

Do you have any nutrient deficiencies that you have previously been diagnosed with?

Iron Deficiency or Overload (circle which one)

B12 Deficiency

Vitamin D Deficiency

Toxic Exposure

How often do you eat seafood and what type? _____

Do you have metal/mercury dental fillings? How many? _____

Are you currently smoking cigarettes/tobacco?

• No • Yes – How many per day? _____ How long? _____

Are you an ex-smoker? _____

• No • Yes – How many years did you smoke? _____ How many per day?

When did you quit?

Are you exposed to secondhand smoke? • No • Yes – How often?

Do/did you fly in airplanes often or live near an airport, farm, golf course, or waste management site?

Do/did you have exposure to mold or a musty environment, such as a water damaged building? If so, when? _____

Do you consume alcohol?

• No • Yes – What type of alcohol do you consume? _____

How many drinks per week? _____

Do you use recreational drugs? • No • Yes – What type(s) and how often?

Emotion/Energy

Serotonin deficiency is a common cause of anxiety and depression. This neurotransmitter can often become depleted from on-going stress, illness, poor diet or intestinal malabsorption leading to nutritional deficiencies.

What level of personal stress are you experiencing currently? If 1 = low and 10 = high
What are the top 3 stressors in your life?

What is your energy level, if 1 = low and 10 = high? _____
At what time of day is your energy the best? _____ The worst?

Any history of mood disorder that required treatment? _____
If so, when and what were you treated with? _____

Exercise:

Are you currently exercising regularly (at least 2x/week)? • Yes • No

What type of exercise (weight training, steady cardio, interval cardio, sports) do you do and how many times per week do you do this exercise?

Digestion/Elimination

Frequent constipation and/or diarrhea, may lead to malabsorption of important nutrients. This can lead to deficiencies of certain nutrients and can increase our toxic burden.

Have you ever been diagnosed with or treated for IBS, GERD, SIBO, Peptic Ulcer, or severe gastritis or infectious gastroenteritis? If so, how were you treated?



PLEASE PROVIDE INSURANCE CARD(S) & PHOTO ID OR DRIVERS LICENSE

Today's Date: _____ SS #: _____ DOB: _____

PATIENT INFORMATION:

Patient's Name: _____
(First Name) (M.I.) (Last Name)

I preferred to be addressed as / My nickname is: _____ Sex: M F

Address: _____
(Street Address) (City/State) (Zip Code)

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION:

Did a Physician Refer You? NO YES Name: _____

Who is your Primary Care Physician? _____

FOR MINORS ONLY: PARENT OR LEGAL GUARDIAN INFORMATION –

Parent or Legal Guardian Name: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (_____) _____

DEMOGRAPHICS:

1) **Race:** American Indian or Alaska Native Asian Black or African American White
 Native Hawaiian Other Pacific Islander More than One Race Decline to answer

2) **Ethnicity:** Hispanic or Latino Not Hispanic Unknown

3) **Preferred Language:** English Spanish Creole Other

4) **Preferred Notification Method:** Postal Mail Phone Email

5) **Marital Status:** M S D W Full time student

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: (_____) _____

PATIENT EMPLOYMENT INFORMATION

Patient's Employer Name & Address: _____

Employer's Phone (_____) _____ Full Time Part Time Retired Not Employed

INSURANCE COVERAGE: (we will need to make a copy of your cards – please provide your cards)

Primary Company Name: _____

Secondary Company Name: _____

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

- Same as Emergency Contact.
- I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends.
- I authorize release of medical information to my primary care, referring doctors and consultants.
- I authorize you to send me practice related emails and text messages.
- These are the additional persons I give my permission to disclose information about my medical treatment:

Name: _____ Relationship: _____ Phone #: (____) _____
 Name: _____ Relationship: _____ Phone #: (____) _____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE?

YES NO

PHARMACY INFORMATION (we transmit all prescriptions through the computer!)

PLEASE BE ADVISED WE HAVE A 72 HOUR REFILL POLICY

Local Pharmacy Name: _____ **Phone #:** (____) _____

Address: _____

Mail Order Pharmacy Name: _____ **Phone #:** (____) _____

Address: _____

Please sign for consent to obtain pharmacy records:

X _____

Cancellation Policy

Our cancellation policy is 48 hours' notice. Your credit card will be billed for any late cancellations or no show for appointments.

X _____

Credit Card Information

By providing my credit card information I give consent for it to be processed for my appointments and supplements purchases.

Card number _____ Exp Date _____ CVC _____

We also order advanced laboratory testing that are relevant and necessary to identify deficiencies and imbalances in order to better advise you on your best path to wellness and health. I acknowledge that I am fully responsible for all balances due to the rendering lab after insurance payments and adjustments.

X _____ **Date** _____



Dr. Jaimie Mickey

INTEGRATIVE MEDICINE: INFORMATION AND CONSENT FOR TREATMENT

Patient's name: _____ **D.O.B.** _____

WHAT IS INTEGRATIVE MEDICINE?

Integrative Medicine encompasses a broad spectrum of practices that, until recently, were not discussed at North American medical schools and were generally not available in North American hospitals.

Restoring Wellness Primary Care, LLC ("Restoring Wellness") utilizes integrative medicine techniques, with additional inclusion of methods such as nutritional and botanical medicine, intravenous nutrition, detoxification, bio-oxidative medicine and chelation therapies.

PATIENT CONSENT

I, _____, seek the medical and health care services of Restoring Wellness Primary Care, LLC ("Restoring Wellness"). I acknowledge that Restoring Wellness has designated Jaimie Mickey, M.D. ("Dr. Mickey") as my treating physician. I understand that, in addition to conventional medicine, Dr. Mickey also uses some diagnostic and treatment methods that may be considered "complementary", "holistic" or "alternative" and that I am interested in exploring these treatments in collaboration with Dr. Mickey. I understand that the benefits of these treatments are only accepted by a minority of the medical community and it is considered "experimental" by most physicians. I understand that Dr. Mickey must rely upon my observations and feedback as well as her clinical judgment and experience to evaluate the effectiveness of these tests and treatments in my care. Since these methods have not been accepted by consensus of the mainstream medical community, they may be considered by some physicians to be either unnecessary, of questionable value or carry with them certain risks that some physicians and patients may not find acceptable.

Initials: _____

I further acknowledge that Dr. Mickey has explained to me that due to the nature of her integrative medical practice they are not often FDA-approved and therefore considered off-label for treatments. Therefore, I agree to bear the financial responsibility for all costs related to my treatment, and agree to not submit to my insurer or other health plan any bill, invoice or claim for payment or reimbursement of such costs.

Initials: _____

I fully understand that Dr. Mickey is not making any warranties, assurances or guarantees of successful treatment administered to me. I fully understand that the choice to undergo such treatments is my decision and I am choosing to undergo treatments with Dr. Mickey after having considered the information provided to me by my treating physician, and through materials provided to me by the office to educate me about these treatments.

Initials: _____

We also order advanced laboratory testing that are relevant and necessary to identify deficiencies and imbalances in order to better advise you on your best path to wellness and health. I acknowledge that I am fully responsible for all balances due after insurance payments and adjustments.

Initials: _____

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE