RESTORING WELLNESS
PRIMARY CARE

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 – 72 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** _____

Restoring Wellness

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 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

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? _____

Who is your primary care provider: _____
WE WILL NOT BE ASSUMING THE ROLE OF PRIMARY CARE, WE ARE HERE TO SERVE AS A CONSULTANT ON YOUR HEALTHCARE.

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:
_____
_____
_____

Health Maintenance: Please enter the date each was last completed.

Physical Exam_____ Colonoscopy_____
Bone Density_____ Stool Cards_____
Mammogram_____ Cholesterol Screening_____
Pap Smear _____ EKG_____
PSA_____ Eye Exam_____

Immunizations:

Influenza shot_____ Pneumonia (Prevnar 13) _____
Shingles _____ Pneumonia (Pneumovax 23) _____
Hepatitis B _____ Tetanus_____
HPV Vaccine _____

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) _____

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. Please provide dosage and strengths.

_____
_____

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

_____
_____

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:

___Elevated blood cholesterol level
___Increased sensitivity to cold
___Unexplained weight gain
___Difficulty losing weight
___Puffy face
___Muscle weakness/muscle aches and pains
___Thinning hair
___Depression
___Constipation
___Dry skin
___Hoarseness
___Fatigue
___Joint pain/stiffness
___Heavy/irregular periods
___Slow heart rate
___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

Progesterone Excess

___Sleepiness

___Nervousness
___Irritable
___Anxious
___Fibrocystic breasts
___Uterine fibroids
___Weight gain in hips
___Sleep disturbance

___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? _____
COVID Vaccinations? _____

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 cause 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 nutrients 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.

Are you experiencing digestion/elimination symptoms or problems?

_____
_____
_____

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?

_____
_____
_____