

## **PATIENT INFORMATION**

Date					
Last Name	:				
First Name	:				
Address: _					
City/State/	/Zip:				
Phone:	(H):				
	(W):				
	(C):				
Email:					
Date of Bir	th:		Gender:	Male	Female
	E/	MERGEI	NCY CONTACT INFORMATIO	N	
Last Name		First Name		Middle Initial	
Phone Nu	umber(s):				
Nearest R	Relative/Friend Not Livin	g With	You:		
Phone Nu	umber(s):				
	Above information	will be	used for verification and en	nergency	purposes only.
How did	you hear about <b>Restorc</b>	ıLif <b>e</b> ?			
o Refe	eferral	0	TV Commercial (News 13)	0	Seminar Attended
<ul><li>o Physician</li><li>o Friend</li><li>o Patient</li></ul>	o Friend	0	Space Coast Business		o Indian River Fitness
	o Patient	0	Internet Search/Website		o Carrabba's
<ul><li>Newspaper</li><li>Article</li></ul>	o Article	0	Barefoot Tattler		o Calilou / PC Keat's
(	o Insert	0	Facebook		o Brano's
o Sav	ing Safari Mail Insert	0	Senior Scene		
o Gol	f Score Card				

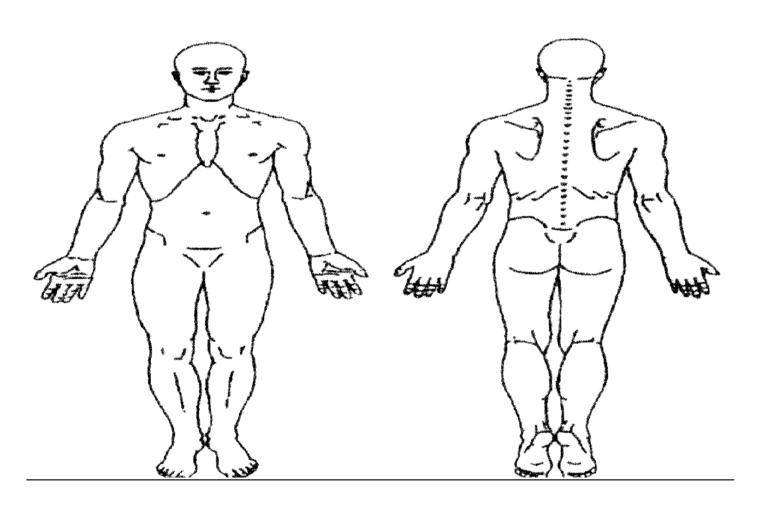


## PATIENT HEALTH QUESTIONNARE

Please list all operations you have h	nad:			
Medications:				
Current Primary Care Physician: Physician Contact Phone Number:				
Have you ever been treated by a place of the second			YES	NO
Do you smoke?	YES	NO	If so, how much?	
Do you drink alcohol?	YES	NO	If so, how much?	
Do you use recreational drugs?	YES	NO	If so, how much?	
Please list all drug allergies (medico	ations,	inhalar	nts, foods, contact c	allergies):
Please describe any other problem would like the clinician to know:	n which	n may r	not have been cove	ered above and which you



Patient Name:		 	



## Mark the areas where you are experiencing pain.

PRIMARY problem* that brought you to RestoraLife?	
SECONDARY complaints* or areas of pain?	

No Pain

10

Worst Pain



\* Please label on the diagram above the primary and secondary areas of pain

Head and N	eck	YES	NO
	Altered sense of smell		
	Nasal obstruction		
	Snoring		
	Nasal discharge		
	Nosebleeds		
	Facial Pain		
	Local skin lesions that have changed recently		
	Lumps or swelling		
	20111p3 of 347 of lift		
Eves		YES	NO
Eyes	Double vision/blurred vision		
	Dry eyes		
	Itchy/watery eyes		
	Glaucoma		
	Flashing lights		<del></del>
	Floaters		
	Retinal problems		
	Are your eyes matted/dry in the a.m.?		
	Are your eyes manea/ary in the a.m.?		
Despiratory	`vata na	YES	NO
Respiratory S		125	110
	Chronic cough		
	Wheezing, asthma		
	History of TB or lung cancer		
	Allergies		
Neurologic		YES	NO
G	Headaches		
	Transient loss of vision		
	Seizures		
	Strokes		
	Head injury		
	Anxiety or depression		



		YES	NO
Cardiovascu	Heart Murmur Chest Pain Swelling of the ankles Shortness of breath on exertion Heart surgery or angioplasty High blood pressure		
Endocrine	Diabetes Over or underactive thyroid	YES	NO
Urogenital	Frequent urination Prostate problems Kidney Disease	YES	NO
Gastrointesti	nal Heartburn or Ulcers Jaundice, Liver Disease, Hepatitis	YES	NO
General	Skin Cancer Skin Diseases Bleeding Disorder Previous blood transfusion Blood clots Have you ever been on "Acutane"? Have you ever had cold sores?	YES	NO



Please check **YES** or **NO** to the questions below

## Are you a candidate for Laser Therapy?

Laser therapy is an FDA-cleared modality for the treatment of pain and inflammation. The therapy causes a temporary increase of microcirculation. Increased microcirculation and the reduction of inflammation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

YES	NO	Do you have a pacemaker or any other implanted devices?
YES	NO	Are you pregnant?
YES	NO	Do you have cancer?
YES	NO	Are you taking medications that may increase your sensitivity to light?
YES	NO	Have you had a steroid injection in the last 7 days?
Not related	to Laser There	ару:
YES	NO	Do you have any known allergies or sensitivities to DMSO (Dimethyl Sulfoxide)? (Stem Cell Patients Only)
YES	NO	Do you have any known allergies to products from birds such as feathers, eggs and/or poultry? (HA Patients Only)
Patient signature:		Date:
Notes:		