PATIENT INFORMATION

Date______________________________

Last Name: ____

First Name: ____

Address: ____

City/State/Zip: ____

Phone: (H): ____

(W): ____

(C): ____

Email: ____

Date of Birth: ____________________________ Gender: ____ Male _____ Female

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EMERGENCY CONTACT INFORMATION

Last Name___________________ First Name_____________________ Middle Initial_____________________

Phone Number(s):____

Nearest Relative/Friend Not Living With You:____

Phone Number(s):____

Above information will be used for verification and emergency purposes only.

How did you hear about ***RestoraLife***?

- Referral
  - Physician
  - Friend
  - Patient
- Newspaper
  - Article
  - Insert
- Saving Safari Mail Insert
- Golf Score Card
- TV Commercial (News 13)
- Space Coast Business
- Internet Search/Website
- Barefoot Tattler
- Facebook
- Senior Scene
- **Seminar Attended**
  - Indian River Fitness
  - Carrabba's
  - Calilou / PC Keat's
  - Brano's

PATIENT HEALTH QUESTIONNAIRE

Please list all operations you have had:

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____

Medications:

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____

Previous treatment for conditions:

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____

Current Primary Care Physician: ______________________

Physician Contact Phone Number: ______________________

Have you ever been treated by a pain center? YES NO

If yes, please list doctor. ______________________

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 (medications, inhalants, foods, contact allergies):

____

____

____

Please describe any other problem which may not have been covered above and which you would like the clinician to know:

____

____

____

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Patient Name: ____

____

Mark the areas where you are experiencing pain.

Please circle the amount of pain you are in: 0 (no pain) to 10 (severe pain).

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

PRIMARY problem* that brought you to RestoraLife? ____

____

SECONDARY complaints* or areas of pain? ____

____

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

Head and Neck	YES	NO
Altered sense of smell		
Nasal obstruction		
Snoring		
Nasal discharge		
Nosebleeds		
Facial Pain		
Local skin lesions that have changed recently		
Lumps or swelling		

Eyes	YES	NO
Double vision/blurred vision		
Dry eyes		
Itchy/watery eyes		
Glaucoma		
Flashing lights		
Floaters		
Retinal problems		
Are your eyes matted/dry in the a.m.?		

Respiratory System	YES	NO
Chronic cough		
Wheezing, asthma		
History of TB or lung cancer		
Allergies		

Neurologic	YES	NO
Headaches		
Transient loss of vision		
Seizures		
Strokes		
Head injury		
Anxiety or depression		

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Cardiovascular System	YES	NO
Heart Murmur		
Chest Pain		
Swelling of the ankles		
Shortness of breath on exertion		
Heart surgery or angioplasty		
High blood pressure		

Endocrine	YES	NO
Diabetes		
Over or underactive thyroid		

Urogenital	YES	NO
Frequent urination		
Prostate problems		
Kidney Disease		

Gastrointestinal	YES	NO
Heartburn or Ulcers		
Jaundice, Liver Disease, Hepatitis		

General	YES	NO
Skin Cancer		
Skin Diseases		
Bleeding Disorder		
Previous blood transfusion		
Blood clots		
Have you ever been on "Acutane"?		
Have you ever had cold sores?		

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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.

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

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 Therapy:

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: