Restoration Health INTEGRATED CARE PROVIDER

PATIENT REGISTRATION FORM

Please Print

Patient Name (First, Middle, Last) _____ Date of Birth: _____

Preferred Name: _____ Gender: ☐ *Male* ☐ *Female* | Marital Status: ☐ *Married* ☐ *Single* ☐ *Child* ☐ *Divorced*

If child, List Mother's Name: _____ Father's Name: _____

Patient's Home Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Email: _____

Occupation: _____ Employer Name: _____

Emergency Contact: _____Phone #:_____ Relationship: ☐ Spouse ☐ Other

Primary Care Physician: _____

GUARANTOR/ RESPONSIBLE PARTY: ☐ Check if same as patient

Name: _____ Date of Birth: _____ Relationship: Spouse Other

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ ☐ Cell ☐ Home DL #: _____ State: _____ Employer:

_____ Phone: _____ SS#: _____

Primary Insurance: (provide copy of card)

Insurance Company: _____ Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Subscribers Name: _____ ID#:_____ Grp #/Name:_____

Date of Birth: _____ Last four of SS#: _____

Secondary Insurance: (provide copy of card)

Insurance Company: _____ Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Subscribers Name: _____ ID#:_____Grp #/Name:_____

Date of Birth: _____ Last four of SS#: _____

Assignment of Benefits

I hereby assign all medical benefits and hereby authorize my insurance carrier, including Medicare, private insurance, and any health plan, to issue payment(s) directly to Restoration Integrated Health for medical services rendered to myself and/or my dependents. I understand that ultimately, I am responsible for any amount(s) not covered by insurance. I hereby authorize Restoration Integrated Health to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims, pursue appeals on denied or partially paid claims that are generated in the course of examination or treatment. A photocopy or scan of this document is considered as valid as the original. This order will remain in effect until revoked by me in writing.

Printed Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ DOS: _____

Restoration Health INTEGRATED CARE PROVIDER

PAST & CURRENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ DOS: _____

Primary Compliant: _____

Secondary Complaint: _____

Please indicate Left or Right or circle Both when applicable and specify whether pain or stiffness:

Musculoskeletal & Extremities:

			FREQUENCY			
Head/Shoulders feels Heavy/Tired	Left	Right	Intermittent	Frequently	Constantly	_____
Neck Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Upper Back Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Mid Back Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Lower Back Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Hip Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Sciatica	Left	Right	Intermittent	Frequently	Constantly	_____
Pain with Cough or Sneeze	Left	Right	Intermittent	Frequently	Constantly	_____
Strain with Bowel Movement	Left	Right	Intermittent	Frequently	Constantly	_____
Jaw Pain/Clicking/Popping	Left	Right	Intermittent	Frequently	Constantly	_____
Shoulder Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Arms - Numb/Ting/Pain	Left	Right	Intermittent	Frequently	Constantly	_____
Elbow - Pain/tiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Wrist-Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Hands/ Fingers - Numb/Tingling / Pain	Left	Right	Intermittent	Frequently	Constantly	_____
Legs - Numb/Tinging/Pain	Left	Right	Intermittent	Frequently	Constantly	_____
Knee Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Foot/Ankle - Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly	_____
Feet/Toes - Numb/Tingling/Pain	Left	Right	Intermittent	Frequently	Constantly	_____

Review of Symptoms: (please check all that apply)

☐ **NOT APPLICABLE**

Constitutional:	☐ Fever / Chills	☐ Fatigue	☐ Night Sweats	☐ Other_____
HEENT:	☐ Facial Swelling	☐ Nosebleeds	☐ Visual Disturbance	☐ Other_____
Cardiovascular:	☐ Chest Pain	☐ Leg Swelling	☐ Other_____	
Respiratory:	☐ Shortness of Breath	☐ Chest Tightness	☐ Other_____	
Gastrointestinal:	☐ Blood in Stool	☐ Constipation	☐ Diarrhea	☐ Digestive Issues
Genitourinary:	☐ Difficulty urinating	☐ Pain when urinating	☐ Blood in urine	☐ Other_____
Neurological:	☐ Numbness	☐ Limb/Muscle Weakness	☐ Balance Issues	☐ Other_____
Hematologic:	☐ Bruising	☐ Easy Bleeding	☐ Other_____	
Psychological:	☐ Confusion	☐ Nervous/ Anxiousness	☐ Suicide	☐ Other_____
Skin:	☐ Changes in skin color	☐ Rashes/ Lesions	☐ Open Wounds	☐ Other_____
Allergic/Immunologic:	☐ Hay Fever	☐ Allergies to new food/ clothes/medication	☐ Other_____	

Patient SIGN: _____ DOS: _____

Provider Signature: JIMMY LABRECQUE, DC

Date Reviewed:

Provider Signature: KRISTA QUALLS AGNP-C

Date Reviewed:

Restoration Health INTEGRATED CARE PROVIDER

PATIENT HEALTH HISTORY (continued...)

Patient Name: _____ Date of Birth: _____ DOS: _____

General Health Issues:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Seasonal Allergies
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance Issues
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Blood Clots
- ☐ Cancer: _____
- ☐ Chemical Dependency
- ☐ Diabetes- Type:_____
- ☐ Digestive Issues

☐ **NO SIGNIFICANT MEDICAL HISTORY**

- ☐ Emphysema/ COPD
- ☐ Epilepsy
- ☐ Feeling Foggy
- ☐ Fatigue
- ☐ Fibromyagia
- ☐ Fractures
- ☐ Glaucoma
- ☐ Gout
- ☐ Gallbladder
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ High /Low Blood Pressure
- ☐ High Cholesterol
- ☐ Headache/Migraines
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker as of:_____
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pinched Nerve
- ☐ Polio
- ☐ Prostate Issues
- ☐ Prosthesis
- ☐ Rheumatic Arthritis
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Whooping Cough
- ☐ Other:_____

_____

_____

Previous Hospitalizations/Surgeries History: *(please indicate a date to your surgery)*

☐ **NO SURGERY HISTORY**

- ☐ Arthroscope (circle)- Hip / Knee / Shoulder / Other:_____ Right | Left
- ☐ Brain Surgery: _____
- ☐ Breast Surgery: _____
- ☐ Heart Bypass: _____
- ☐ Gall Bladder Removed: _____
- ☐ Colon Surgery: _____
- ☐ Cosmetic Surgery: _____
- ☐ Fracture Surgery: _____ *Location*
- ☐ Gastric Bypass/Banding: _____
- ☐ Hip Replacement: _____
- ☐ Hysterectomy (circle) - Full / Partial : _____
- ☐ Knee Replacement(circle) - Right / Left : _____
- ☐ Kidney Stone Surgery:_____
- ☐ Prostate Surgery :_____
- ☐ Spine Surgery: _____ *Date* | _____ *Type*
- ☐ Tonsil/ Adenoid Surgery: _____
- ☐ Valve Replacement Surgery:_____
- ☐ Other: _____

_____

Patient/Guardian Signature: _____ DOS: _____

Provider Signature:
JIMMY LABRECQUE, DC

Date Reviewed:

Provider Signature:
KRISTA QUALLS AGNP-C

Date Reviewed:

Restoration Health INTEGRATED CARE PROVIDER

PATIENT HEALTH HISTORY (continued...)

Patient Name: _____ Date of Birth: _____ DOS: _____

Family Medical History ***(circle all that apply)*** **Living / Deceased**

FATHER:	Heart	Cancer	Diabetes	High/Low Blood Pressure	Other: _____	Living	Deceased
MOTHER:	Heart	Cancer	Diabetes	High/Low Blood Pressure	Other: _____	Living	Deceased
SIBLING:	Heart	Cancer	Diabetes	High/Low Blood Pressure	Other: _____	Living	Deceased

Social History & Lifestyle (please check box)

Use of Alcohol	☐ Daily	☐ 1-2 x week	☐ Socially	☐ N/A	Other: _____
Recreational Drugs	☐ Daily	☐ 1-2 x week	☐ Socially	☐ N/A	Other: _____
Smoking	☐ Daily	☐ 1-2 x week	☐ Socially	☐ N/A	Other: _____
Caffiene	☐ Daily	☐ 1-2 x week	☐ Never	☐ N/A	Other: _____
Exercise	☐ Daily	☐ 1-2 x week	☐ Never	☐ N/A	Other: _____

Medications *(include non-prescription)* ☐ **NO MEDICATION**

1. _____ Dosage: _____ Frequency: _____

2. _____ Dosage: _____ Frequency: _____

3. _____ Dosage: _____ Frequency: _____

4. _____ Dosage: _____ Frequency: _____

5. _____ Dosage: _____ Frequency: _____

6. _____ Dosage: _____ Frequency: _____

Allergies *(include all known allergies; food, medication, environmental)* ☐ **NO KNOWN ALLERGIES**

1. _____ *Reaction:* _____

2. _____ *Reaction:* _____

3. _____ *Reaction:* _____

4. _____ *Reaction:* _____

Vitamins/ Supplements *(include brands)* ☐ **NO SUPPLEMENTS**

1. _____

2. _____

3. _____

4. _____

5. _____

Patient/Guardian Signature: _____ DOS: _____

Provider Signature: JIMMY LABRECQUE, DC

Date Reviewed:

Provider Signature: KRISTA QUALLS AGNP-C

Date Reviewed:

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