Restorative Health Center
1 North Bacton Hill Road, Suite #107
Malvern, PA 19355
610.644-4088

Member Intake Form

Please enter your information below. ***Date:*** _____
**(denotes required field)*

First Name:* _____

Middle Initial: _____

Last Name: * _____

E-Mail Address: * _____

Date of Birth:* _____

Address: * _____

_____

_____

Home Phone: _____

Mobile Phone:* _____

Work Phone: _____

Employer: _____

At which phone number may we leave a message? _____

Which phone numbers may we call?

Home: ( ) Yes ( ) No Cell: ( ) Yes ( ) No Work: ( ) Yes ( ) No

How were you referred to our office? _____

Page 2

Who is your primary care physician? _____

Did he or she refer you? ( ) Yes ( ) No

Would you like us to communicate with your primary care physician about your visit with our office? ( ) Yes ( ) No

Emergency Contact: {Name, Relationship and phone}
_____

Medical History

Main Concern: *(Onset, Frequency, Severity)*
_____
_____
_____

Detail and History of Present Illness
_____
_____
_____

Past Medical History / General State of Health
_____
_____
_____

Childhood Illness/Vaccines
_____

Adult Illness
_____

Psychiatric Illness
_____

Major Hospitalizations

_____

Past Surgical History
_____

Allergies
_____

Current Medications
_____

Current Supplements: *(Name, Dose, Cost Per Month)*
_____
_____
_____

Dates of Last Screenings/Tests: *(Pap/PSA, Mammogram, Colonoscopy, CAD Risk Factor,*
Occ. Stool)
_____
_____
_____

Family History

Mom: _____
Dad: _____
Sister: _____
Brother:
_____
Other: _____
Born Live:
_____

Social History

Major stressors in your life?
_____
_____

How do you relax?
_____

Your hobbies?
_____

Are you religious or spiritual?
_____

History of toxic exposure? Heavy metals? Chemicals?
_____

History of excessive electromagnetic field exposure?

_____

History of head trauma?

_____

Dietary History

Have you ever been on a diet, and why?

_____

Your current diet?

_____

Do you drink coffee and soft drinks?

_____

How many servings of fruit do you eat in a day? *(1 cup raw or 1/2 cup cooked = 1 serving)*

_____

How many servings of vegetables do you eat in a day? *(1 cup raw or 1/2 cup cooked = 1 serving)*

_____

How many calories (or amount of food) do you consume in a day?

_____

( ) Too much

( ) Too little

Do you ever skip meals?

_____

Your activity level?

_____

Do you smoke? ( ) Yes ( ) No

If yes, how often and how many? _____

Alcohol consumption:

_____

Restorative Health Center does **NOT** offer refunds.

To All Members with Insurance:

Restorative Health Center does **NOT** accept insurance.
Restorative Health Center does **NOT** accept Medicare.
We will provide you with a superbill if you would like to submit it to your insurance, except for Medicare. **ALL** therapies are the member's responsibility and must be paid at the time of service.

We appreciate your cooperation.

_____ _____
Member's Signature Date

I, _____, give Restorative Health Center permission for care.

This is a binding agreement between Restorative Health Center and the member that is the signer of this agreement.

If the member is not compliant with the recommendation of Restorative Health Center and staff, then they will be discharged from the practice membership.

_____ _____
Member's Signature Date

Thank you for taking the time to fill out the Member Intake Form. Please fax or email this form to the office before your initial consultation. If you have any questions about the Intake Form, call the office of Dr. Carter at 610-644-4088.

Restorative Health Center Hours:
Hours will be posted each week on our voicemail.

Fax Number: 610-644-4449
Mailing Address:
Restorative Health Center
1 North Bacton Hill Road, Suite #107
Malvern, PA 19355