

**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? \_\_\_\_\_

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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

\_\_\_\_\_

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Current Medications

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

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

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**Family History**

Mom: \_\_\_\_\_

Dad: \_\_\_\_\_

Sister: \_\_\_\_\_

Brother: \_\_\_\_\_

Other: \_\_\_\_\_

Born Live: \_\_\_\_\_

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**Social History**

Major stressors in your life?

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How do you relax?

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Your hobbies?

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Are you religious or spiritual?

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History of toxic exposure? Heavy metals? Chemicals?

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History of excessive electromagnetic field exposure?

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History of head trauma?

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**Dietary History**

Have you ever been on a diet, and why?

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Your current diet?

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Do you drink coffee and soft drinks?

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

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

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

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Too much

Too little

Do you ever skip meals?

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Your activity level?

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Do you smoke?  Yes  No

If yes, how often and how many? \_\_\_\_\_

Alcohol consumption:

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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.

\_\_\_\_\_ Date

Member's Signature

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.

\_\_\_\_\_ Date

Member's Signature

**Thank you for taking the time to fill out the Member Intake Form.** Please either fax or email this form into the office prior to 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:**

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