Restorative Health Center
201 Exton Commons
Exton, PA 19341
610.363.2897

Patient Intake Form

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

First Name:* ________________________________

Middle Initial: _____________

Last Name: * ________________________________

Social Security Number:* ___________________________

E-Mail Address: * ________________________________

Date of Birth: _________________

Address: ________________________________

____

____

Home Phone: ________________________________

Mobile Phone: ________________________________

Work Phone: ________________________________

Employer: ________________________________

At which phone number may we leave a message? ________________________________

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

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

____

Page 3

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?

____

Page 4

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

Alcohol consumption: ____

Page 5

Thank you for taking the time to fill out the Patient 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 610-363-2897.

Restorative Health Center Hours:
Tuesday: 10 am–6pm
Wednesday: 10am – 4pm
Thursday: 10am – 6pm

Fax Number: 610-363-5782
Mailing Address:
Restorative Health Center
201 Exton Commons
Exton, PA   19341

____________________________________ ________________
Patient Signature Date