

Dear \_\_\_\_\_,

Date: \_\_\_\_\_

Welcome to **RESTORATIVE HEALTH AND HEALING CENTER!** We look forward to becoming your partner in assessing and improving your health.

In your first visit, Dr. Sievers will obtain a complete medical history. The key to functional medicine is treating each person as an individual and getting to the root cause of health problems. That generally entails a detailed conversation regarding the enclosed intake form. Dr. Sievers will discuss with you potential approaches, recommended laboratory workups and she may make some simple recommendations at that time. Most advice will be deferred until after lab and physical exam results are in and there has been time to thoughtfully consider your case. This visit will last approximately 45 minutes and is primarily an information gathering and sharing session. (Please note we have devised scheduled time frames for each visit, which are honored by both patient and doctor.)

The second visit is generally scheduled anywhere from 2-6 weeks later to go over test results and devise a treatment plan. Her basic approach is a 5 point wellness plan based on the following areas: hormones, nutrition, toxins, mind and body. In the beginning you may be on several supplements, but the long term plan will be to resolve the underlying cause and maintain on as minimal supplements as possible. This generally includes: a high quality multiple vitamin/mineral, Omega 3 fish oil, calcium and vitamin D. Follow-up visits are usually scheduled in approximately 8-12 weeks from this visit to evaluate progress and make any adjustments in your program. (At some point within first year a complete physical exam is performed, although a cursory basic exam is performed at either the first visit.)

How often you see Dr. Sievers after that will depend on why you are being treated. People with multiple issues are seen more often. Our goal is to get you well. Dr Sievers describes achieving this goal as a wellness journey in which you are the driver and she is the co pilot. Therefore, she is only as good a doctor as you are in helping/committing to yourself. We are all at

*different points in this journey and will go at the pace/route that best suits your needs and wishes.*

*If you have any further questions after reading the enclosed information, please call our office. We will be happy to assist you. Please be sure to complete the form and provide copies of previous tests. Please return them to our office 48 business hours before appointment. We look forward to working with you. Also, on your first visit, please bring all your medications and supplements in their original bottles to the appointment. Lastly, we do request a deposit to hold your first appointment of \$150.00. If you are unable to keep the appointment we request that you allow 24 hours notice to cancel appointments to avoid loss of deposit or no show fee of \$100.00. Unfortunately this has become necessary in order to ensure patients allow the schedule to be opened for other patients waiting to see the doctor.*

*In health,*

*Teresa A. Sievers, MD and staff*

**Restorative Health and Healing Center**  
Teresa A. Sievers, MD  
Estero Medical Center  
10201 Arcos Ave, Suite 201  
Estero, FL 33926  
Office: (239) 948.7291 Fax: (239) 948.0179

\_\_\_\_\_  
**Last Name**                      **First Name**                      **Middle Name**                      **Nick Name**

\_\_\_\_/\_\_\_\_/\_\_\_\_                      **M/F**                      \_\_\_\_-\_\_\_\_-\_\_\_\_                      **S/M/W**  
**D.O.B**                      **Gender**                      **SS#**                      **Marital Status**

(\_\_\_\_) \_\_\_\_-\_\_\_\_                      (\_\_\_\_) \_\_\_\_-\_\_\_\_ **X** \_\_\_\_                      (\_\_\_\_) \_\_\_\_-\_\_\_\_  
**Home Phone**                      **Work Phone**                      **Cell Phone**

\_\_\_\_\_  
**E-Mail Address**

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**Address**

\_\_\_\_\_  
**City**                      **State**                      **Zip Code**

**How did you hear about us?** \_\_\_\_\_

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**Emergency Contact Information**

\_\_\_\_\_  
**Last Name**                      **First Name**                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_-\_\_\_\_-\_\_\_\_  
**D.O.B**                      **SS#**

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**Alternate Address**

\_\_\_\_\_  
**City**                      **State**                      **Zip Code**

(\_\_\_\_) \_\_\_\_-\_\_\_\_                      (\_\_\_\_) \_\_\_\_-\_\_\_\_  
**Home Phone**                      **Cell Phone**







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**13. PLEASE LIST WHEN, IF EVER YOU HAVE HAD THE FOLLOWING PROCEDURES OR TESTS DONE:**

<b>TEST</b>	<b>WHEN</b>	<b>RESULTS</b>
COLONOSCOPY		
EGD/UPPER ENDOSCOPY		
BONE DENSITY SCAN		
MAMMOGRAM		
THERMOGRAM		
STRESS TEST		
EKG		
RECTAL EXAM		
PELVIC EXAM		
PAP SMEAR		
PSA(PROSTATE CANCER SCREEN BLOOD TEST)		
OTHER:		

**14. FAMILY HISTORY** *BLOOD RELATIVES ONLY; IF POSSIBLE MATERNAL/PATERNAL SIDE*

<b>ILLNESS</b>	<b>RELATIVE</b>	<b>AGE OF DIAGNOSIS</b>	<b>AGE NOW/CAUSE OF DEATH</b>
<u>HEART ATTACK/</u>			
<u>CORONARY ARTERY DS</u>			

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**VALVULAR HEART DS**  
**ATRIAL FIBRILLATION**

**OTHER ABNORMAL HEART RHYTHMS**

**HIGH BLOOD PRESSURE**

**STROKES**

**BLOOD CLOTS**

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**ANEURYSMS/LOCATION**

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**MULTIPLE SCLEROSIS**

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**MUSCULAR DYSTROPHY**

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**MIGRAINES**

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**ADD/ADHD**

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**DEPRESSION**

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**ANXIETY**

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**BIPOLAR DEPRESSION**

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**ASTHMA**

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**ALLERGIES/HAYFEVER**

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**CANCER/LOCATION**

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**MELANOMA**

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**SLEEP APNEA**

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**RHEUMATOID ARTHRITIS**

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**LUPUS**

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**OBESITY**



DO YOU LIVE IN FLORIDA FULL TIME: Y/N.? IF NOT HOW MANY MONTHS/YEAR IN FL? \_\_\_\_\_  
PLEASE CIRCLE: ARE YOU MARRIED/ENGAGED/WIDOWED/DIVORCED/Common  
LOW/DOMESTIC PARTNER? \_\_\_\_\_  
IF YOU HAVE CHILDREN, HOW MANY DO YOU HAVE \_\_\_\_\_  
DO YOU USE BIRTH CONTROL OF ANY KIND SUCH AS PILL/CONDOMS ETC Y/N.  
IF SO WHAT? \_\_\_\_\_  
IF NOT WHY? \_\_\_\_\_  
HAVE YOU EVER HAD AN STD (IE HIV,HERPES,ETC)  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CIRCLE, DO YOU CONSIDER YOURSELF  
HETEROSEXUAL/HOMOSEXUAL/BISEXUAL/TRANSGENDER?:  
\_\_\_\_\_

HOME MAKER/DOMESTIC ENGINEER: Y/N.  
EDUCATIONAL LEVEL: \_\_\_\_\_  
PLEASE CIRCLE: RETIRED/SEMIRETIRED/WORKING/DISABLED(WHEN/WHY?)  
CURRENT/FORMER OCCUPATION: \_\_\_\_\_  
\_\_\_\_\_

RELIGIOUS/SPIRITUAL AFFILIATION:  
\_\_\_\_\_

WHAT DO YOU DO FOR REGULAR EXERCISE?  
\_\_\_\_\_

HOW MANY DAYS/WK AND FOR HOW LONG?  
\_\_\_\_\_  
\_\_\_\_\_

HOBBIES/HOW YOU SPEND FREE TIME  
\_\_\_\_\_

**16. SOCIAL HABITS:**

DID YOU EVER SMOKE CIGARETTE/CIGARS? Y/N. LIFELONG NONSMOKER: Y/N  
IF SO, ARE YOU STILL? Y/N  
IF NOT WHEN DID YOU QUIT? \_\_\_\_\_  
HOW MANY PACKS DID/DO YOU SMOKE PER DAY \_\_\_\_\_  
PLEASE CIRCLE: DO/DID YOU EVERY CHEW/SNORT TOBACCO:  
\_\_\_\_\_

HOW MANY 6-8 OZ GLASSES OF WINE \_\_\_\_\_ (CIRCLE) PER DAY/WK/MONTH/YEAR.  
HOW MANY 12 OZ BEERS \_\_\_\_\_ (CIRCLE) PER DAY/WK/MONTH/YEAR.  
HOW MANY COCKTAILS/1 OZ LIQUOR \_\_\_\_\_ (CIRCLE) PER DAY/WK/MONTH/YEAR.  
DID YOU EVER HAVE A PROBLEM WITH PRESCRIPTION PAIN MEDS OR SEDATIVES SUCH AS  
XANAX? Y/N IF SO  
DESCRIBE \_\_\_\_\_  
\_\_\_\_\_

DID YOU EVER USE ILLICIT DRUGS? Y/N TO EXPERIEMENT OR DID YOU HAVE A PROBLEM?  
EVER GO TO REHAB OR AA?  
\_\_\_\_\_  
\_\_\_\_\_

NUTRITIONAL HISTORY:  
THINK ABOUT YOUR MEALS FOR THE PAST 3 DAYS. DESCRIBE, AS SPECIFIC AS POSSIBLE,  
TYPICAL MEALS/FOODS YOU MIGHT EAT FOR  
\_\_\_\_\_

**BKST:**

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**LUNCH:**

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**DINNER:**

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**SNACKS:**

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**WHAT DO YOU DRINK WHEN YOU ARE THIRSTY? (IE WATER, SODA, CRYSTAL LIGHT ETC)**

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**# 8OZ GLASSES OF WATER IN A DAY?** \_\_\_\_\_

**# OF SODAS/TYPE** \_\_\_\_\_ **IN A DAY/WEEK/MONTH** \_\_\_\_\_

**# OF CUPS COFFEE /CAFFINATED TEA** \_\_\_\_\_ **IN A DAY/WEEK/MONTH** \_\_\_\_\_

**WHAT PERCENTAGE OF FOOD THAT YOU EAT ARE ORGANIC?** \_\_\_\_\_

**HOW OFTEN DO YOU EAT FAST FOOD?**

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**17. EMOTIONAL/PSYCHIATRIC HISTORY**

**DO YOU HAVE ANY HISTORY OF ANXIETY, ADD/ADHD, ANOREXIA/BULEMIA, BIPOLAR DISORDER, DEPRESSION, INCLUDING POSTPARTUM DEPRESSION OR DEPRESSION RELATED TO ILLNESS, ETC? IF SO PLEASE DESCRIBE AND WHEN.**

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**WHAT TREATMENTS INCLUDING COUNSELING, MEDS ETC DID YOU RECEIVE?**

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**WERE YOU EVER HOSPITALIZED FOR MENTAL HEALTH ISSUE? Y/N. IF SO PLEASE DESCRIBE.**

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**WERE YOU EVER SUICIDAL OR ATTEMPT SUICIDE? Y/N. IF SO PLEASE DESCRIBE.**

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**DID YOU EVER EXPERIENCE:**

**PHYSICAL ABUSE? Y/N EMOTIONAL ABUSE? Y/N SEXUAL ABUSE/MOLESTATION? Y/N**

**DID/DO YOU EVER LIVE WITH SOMEONE WITH A SUBSTANCE ABUSE PROBLEM OR OTHER**

**ADDICITON ISSUE? Y/N** \_\_\_\_\_

BEING A VICTIM OF TRAGIC ACCIDENT? Y/N \_\_\_\_\_

VIOLENT CRIME? Y/N \_\_\_\_\_

TRAUMATIC EVENT? Y/N \_\_\_\_\_

IF YES TO ANYTHING, PLEASE DESCRIBE, INCLUDING HOW YOU HAVE DEALT WITH THOSE ISSUES EITHER CURRENTLY OR IN THE PAST?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ON SCALE 1 TO 10 WITH 10 THE MOST, HOW STRESSFUL IS YOUR LIFE? \_\_\_\_\_

18. PLEASE RATE YOUR OVERALL SCALES 1 TO 10 WITH 10 BEING THE BEST/1 THE WORST:

ENERGY SCALE \_\_\_\_\_ HAVE YOU BEEN TOLD THAT YOU SNOOR: Y/N

SLEEP SCALE \_\_\_\_\_ WITH SLEEPING AIDES (INCLUDING OTC): Y/N

MOOD SCALE \_\_\_\_\_ WITH MEDICATIONS: Y/N \_\_\_\_\_

MEMORY /CONCENTRATION/FOCUS: \_\_\_\_\_

LIBIDO/SEX DRIVE *INDEPENDENT OF PARTNERS ABILITY TO PERFORM* \_\_\_\_\_

HOT FLASHES (MEN OFTEN GET THESE AS WELL): \_\_\_\_\_

ABILITY TO HAVE AN ERECTION? Y/N OR N/A \_\_\_\_\_

IF YOU DO HAVE AN ISSUE WITH ERECTIONS DO YOU EVER WAKE UP WITH AN ERECTION? Y/N

\_\_\_\_\_  
ABILITY TO HAVE AN ORGASM? Y/N \_\_\_\_\_

DO/DID YOU HAVE VAGINAL BLEEDING AFTER GOING ONE YEAR WITHOUT A PERIOD? Y/N

\_\_\_\_\_  
**GENERAL:**

IN PAST 6 MONTHS HOW MUCH WEIGHT HAVE YOU GAINED/LOST (CIRCLE)? \_\_\_\_\_

IN PAST FEW YEARS HOW MUCH WEIGHT HAVE YOU GAINED/LOST (CIRCLE)? \_\_\_\_\_

UNEXPLAINED FEVERS? Y/N \_\_\_\_\_

**EYES:**

GLAUCOMA?Y/N \_\_\_\_\_

MACULAR DEGENERATION? Y/N \_\_\_\_\_

CATARACTS? Y/N \_\_\_\_\_

**EARS:**

HARD OF HEARING?Y/N \_\_\_\_\_

DEAFNESS?Y/N \_\_\_\_\_ RINGING IN THE EAR?Y/N \_\_\_\_\_

VERTIGO? Y/N \_\_\_\_\_

**CARDIAC/RESPIRATORY:**

CHEST PAIN/PRESSURE/TIGHTNESS/DISCOMFORT? Y/N

\_\_\_\_\_  
SYNCOPE/PASSING OUT?Y/N \_\_\_\_\_

PALPITATIONS?Y/N \_\_\_\_\_

SHORTNESS OF BREATH? Y/N \_\_\_\_\_

WHEEZING? Y/N \_\_\_\_\_

CHRONIC COUGH? Y/N \_\_\_\_\_

COUGHING UP BLOOD?Y/N \_\_\_\_\_

**GI:**

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT? \_\_\_\_\_

ARE YOUR STOOLS FORMED OR LOOSE? \_\_\_\_\_

HEARTBURN? Y/N \_\_\_\_\_  
BLOODY OR BLACK STOOLS?Y/N \_\_\_\_\_ NAUSEA/VOMITING?Y/N \_\_\_\_\_  
ABDOMINAL PAIN? Y/N \_\_\_\_\_

**GU/URINE:**

URINARY URGENCY/URGE INCONTINENCE? Y/N \_\_\_\_\_  
STRESS INCONTINENCE? Y/N \_\_\_\_\_  
BLOOD IN URINE OR HISTORY OF THIS? Y/N \_\_\_\_\_

**NEUROLOGY/MUSCULOSKELETAL:**

HEADACHES? Y/N TYPE? FREQUENCY/DURATION?  
\_\_\_\_\_

NUMBNESS/TINGLING? Y/N IF SO DESCRIBE  
\_\_\_\_\_

WEAKNESS/PARALYSIS?Y/N IF SO DESCRIBE  
\_\_\_\_\_

PLEASE CIRCLE ACUTE/CHRONIC PAIN? Y/N FROM WHAT? DIAGNOSIS GIVEN? TREATMENT  
TRIED? WHAT MAKES IT BETTER OR WORSE?  
\_\_\_\_\_  
\_\_\_\_\_

**ENDOCRINE:**

COLD HANDS/FEET? Y/N \_\_\_\_\_  
PLEASE CIRCLE: ALWAYS COLD/HOT/N/A \_\_\_\_\_  
HAIR LOSS?Y/N \_\_\_\_\_ BRITTLE NAILS?Y/N \_\_\_\_\_

**BLOOD:**

PLEASE CIRCLE: EASY BRUISING/BLEEDING/NOSE BLEEDS/GUM BLEEDING? PLEASE DESCRIBE  
\_\_\_\_\_  
\_\_\_\_\_

**SKIN:**

RASHES: \_\_\_\_\_  
ACNE: \_\_\_\_\_

**OTHER CONCERNS OR THINGS THAT I SHOULD BE MADE AWARE OF?**

**EMOTIONAL:**

MOOD SWINGS? Y/N \_\_\_\_\_  
IRRITABILITY/ANGER? Y/N \_\_\_\_\_  
LACK OF MOTIVATION? Y/N \_\_\_\_\_  
CRYING EASILY?Y/N \_\_\_\_\_

**NAME (PRINT/SIGNATURE: \_\_\_\_\_**

**DATE: \_\_\_\_\_**