Rejuvenation and Well Being, LLC
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Client Information

Name: _____ Date of Birth: _____ Today's Date: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Occupation: _____ Marital Status (*circle one*): S M LWS D W Number of Children: _____

Type of Pets: _____ Who referred you to our office: _____

YOUR HEALTH

Please list your current health challenges in order of importance:

1. _____ Date this began: _____
2. _____ Date this began: _____
3. _____ Date this began: _____
4. _____ Date this began: _____

Are any of these conditions due to a work injury?: _____ Auto Accident?: _____ Other?: _____

Have you lost any days from work?: _____

Have you consulted other healthcare providers for any of these conditions? (*if so, please list results)*:

_____

Have you had any recent lab work or x-rays relevant to your present condition? (*If so, please list):*

_____

Do you have any permanent disabilities? *(if so, please list)*: _____

Date of your last physical exam: _____ Have you ever been hospitalized? *(if so, please describe the reason)*:

_____

Please check the drug(s) that you currently take:

___Pain pills ___Muscle pills __Diet pills ___Aspirin ___Tranquilizers ___ Birth control pills Other:_____

Dental Visits? *(check one):* ___Every 6 mos. ___Yearly ___Toothache/Emergency only ___Dentures

Please list all accidents, operations and minor surgical procedures below:

Date	***Description of accident or operation***
1._____	_____
2. _____	_____
3. _____	_____

HABITS

Smoking (per day/week)*:* _____ **Exercise** (Type)*:* _____ Duration/x per wk: _____
Alcohol (per day/week)*:* _____ **Exercise** (Type)*:* _____ Duration/x per wk: _____
Coffee (per day/week)*:* _____ **Exercise** (Type)*:* _____ Duration/x per wk: _____

Family History	***Diabetes***	***Heart***	***Kidney***	***Cancer***	***Back***	***Stroke***	***Lung***	***Other***
Mother:	_____	_____	_____	_____	_____	_____	_____	_____
Father:	_____	_____	_____	_____	_____	_____	_____	_____
Brother: (# of)	_____	_____	_____	_____	_____	_____	_____	_____
Sister: (# of)	_____	_____	_____	_____	_____	_____	_____	_____

Do you have any of the following?

_ Appendicitis	_ Whooping Cough	_ Diabetes	_ Pleurisy	_ Mental Disorder
_ Pneumonia	_ Anemia	_ Cancer	_ Alcoholism	_ Lumbago
_ Rheumatic Fever	_ Measles	_ Heart Disease	_ Venereal Infection	_ Eczema
_ Polio	_ Mumps	_ Goiter	_ Arthritis	_ HIV Positive
_ Tuberculosis	_ Chicken Pox	_Influenza	_ Epilepsy	_ Body Piercings

Please check the correct box for each item below:

Prev.	Now	General Symptoms
__	__	Allergy_____
__	__	Wheezing
__	__	Bronchitis
__	__	Chills
__	__	Convulsions
__	__	Dizziness
__	__	Fainting
__	__	Fever
__	__	Headache
__	__	Loss of Sleep
__	__	Nervousness
__	__	Neuralgia
__	__	Night Sweats
__	__	Numbness or pain In arms/legs/hands

Prev.	Now	Gastro-Intestinal
__	__	Belching or Gas
__	__	Colon Trouble
__	__	Constipation
__	__	Diarrhea
__	__	Excessive Hunger
__	__	Gall Bladder Trouble
__	__	Hemorrhoids
__	__	Jaundice
__	__	Liver Trouble
__	__	Nausea
__	__	Pain over stomach
__	__	Poor Appetite
__	__	Poor Digestion
__	__	Vomiting
__	__	Vomiting Blood

Prev.	Now	Eye/Ear/Nose/Throat
__	__	Asthma
__	__	Crossed Eyes
__	__	Deafness
__	__	Earache
__	__	Ear Discharge
__	__	Ear Noises
__	__	Enlarged Thyroid
__	__	Frequent Coids
__	__	Hay Fever
__	__	Hoarseness
__	__	Nasal Obstruction
__	__	Nose Bleeds
__	__	Pain in Eyes
__	__	Poor Vision
__	__	Sinusitis
__	__	Sore Throats
__	__	Tonsillitis

		Muscles & Joints
__	__	Backache
__	__	Foot Trouble
__	__	Hernia
__	__	Pain Between Shoulders
__	__	Painful Tail Bone
__	__	Stiff Neck
__	__	Spinal Curvature
__	__	Swollen Joints
__	__	Tremors
__	__	Twitching
__	__	Weakness

		Cardio-Vascular
__	__	High blood pressure
__	__	Low Blood Pressure
__	__	Pain over heart
__	__	Poor Circulation
__	__	Previous Heart Trouble
__	__	Rapid Heart
__	__	Slow Heart
__	__	Stroke
__	__	Swelling Ankles
__	__	Varicose Veins

		Skin or Allergies
__	__	Boils
__	__	Bruising Easily
__	__	Dryness
__	__	Eczema
__	__	Hives or Allergy
__	__	Itching
__	__	Sensitive Skin
__	__	Skin Eruptions

		Respiratory
__	__	Chest Pain
__	__	Chronic Cough
__	__	Difficulty Breathing
__	__	Spitting Blood
__	__	Spitting Phlegm
__	__	Asthma

		Genito - Urinary
__	__	Bed Wetting
__	__	Blood in Urine
__	__	Frequent Urination
__	__	Inability to Control Urine
__	__	Kidney Infection
__	__	Painful Urination
__	__	Prostrate Trouble

		For Women Only
__	__	Cramps or Backaches
__	__	Excessive Flow
__	__	Hot Flashes
__	__	Irregular Cycle
__	__	Miscarriage
__	__	Painful Discharge
__	__	Vaginal Discharge
__	__	Pregnant at this time

Please list any <u>PAST</u> health challenges:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____

When any relaxation technique is used, you should be aware that the need for medication may change. It is, therefore strongly recommended that you request the medical physician who is prescribing your medication to monitor what you require, frequently. Please sign below indication that you have read the above statement and understand it.

Date: _____ Signature: _____