Rejuv Medical Patient Demographics

First Name: ______________________ Last Name: ______________________

Sex (Circle): Male or Female DOB:___/___/___ Social Security Number: ____-____-____

Email: ______________________

Cell Phone: ______________________ Home Phone: ________________

Street Address: ______________________________________

City: __________________

State: ______________ Zip Code: ______________

Marital Status: ____________ Employer: ___________________________

Occupation: ____________________ Work Phone: _________________________

Employment Status (Circle): Full-Time Part-Time Disabled Retired Student Not-Employment N/A

Race (Circle): White Black/African American American Indian Asian Other

Ethnicity (Circle): Hispanic/Latino Not Hispanic or Latino Asian Other

Emergency Contact: ________________ Relationship: ____________ Phone Number: __________

Please Initial The Statements Below:

___ Rejuv Medical cannot guarantee insurance coverage by your insurance provider

___ I certify that the information I am providing is true and correct. I understand and agree that I am ultimately responsible for payment that may not be covered by my insurance.

_____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Signature: ____

(Patient/Responsible Party Signature) (Date)

Acknowledgement of Receipt of Notice of Privacy Practices

The Notices of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Rejuv Medical's health care operations. The Notice of Privacy Practices also describes my rights and Rejuv Medicals' duties with respect to my protected health information. The Notice of Privacy Practices is available from your therapist.

Rejuv Medical reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revises Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

____

Name of Patient of Personal Representative Date

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Description of Personal Representative's Authority

Initial Consultation

Name: ______________________________ **Date:** ________________

Main Complaints:

1.)____________________ 2.)____________________

3.)____________________ 4.)____________________

How long have you suffered from these problems?

1.)____________________ 2.)____________________

3.)____________________ 4.)____________________

Any other complaints?

____

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Medications:

1.)____________________ Condition:____________________

2.)____________________ Condition:____________________

3.)____________________ Condition:____________________

4.)____________________ Condition:____________________

5.)____________________ Condition:____________________

Thyroid Patients Only:

1.) How long did you have symptoms prior to being diagnosed? ____________________
2.) If on Thyroid medication, how long have you been taking? ____________________
3.) Has your medication been adjusted frequently? ____________________
4.) Do you have symptoms of brain fog or memory difficulty? ____________________
5.) Do you have joint inflammation? ____________________
6.) Do you consume grains? Y / N Do these foods irritate your bowels? Y / N
7.) Heart Palpitations? Y / N
8.) Hot Flashes or Sweat attacks? Y / N
9.) Have you been diagnosed with an autoimmune condition? ____________________

Would you like improvement with any of the following?

- ☐ Digestion: Reflux, Gas, Constipation
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of Well Being
- ☐ Energy

What have you tried doing to resolve this problem that *DID NOT* work?

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Have you become discouraged or stressed about handling this problem?

____

____

When your problem is at its worst, how does it make you feel?

____

____

How does this problem interfere with the following areas in your life?

Work: ____

Family: ____

Hobbies: ____

Life: ____

When it's at its worst, how much older does this make you feel? ______________________

Do you know how this problem may have started? ______________________

What effect does this have on your body functions? ______________________

Why are you here visiting us today?

A) Resolve my immediate problems

B) Lifestyle program for optimized living

C) Both

D) Other: ____

How have you taken care of your health in the past?

Medications	Holistic	Vitamins
Routine Medical	Diet and Nutrition	Exercise
Chiropractic	Other: ____________	

How did the previous methods work for you?

____

____

Without making a change, what are you afraid will be affected? Please circle all that apply.

Job	Freedom	Kids
Future abilities	Marriage	Time
Finances	Sleep	

Are there any health conditions you are afraid this might turn into?

Thyroid Dysfunction	Stress	Weight Gain
Cancer	Surgery	Arthritis
Diabetes	Depression	Heart Disease

Other: ____

Where do you picture yourself being in the next 3-5 years if this problem is not resolved? Please be specific.

____

____

____

What would be different or better without this problem? Please circle all that apply.

Diminished Stress	Sleep	Work
More Energy	Self Esteem	Outlook
Family	Confidence	

If we were to sit down and discuss your life *3 years* from now and look back at today, what would have had to happen for you to be happy with your progress? Please take your time and don't sell yourself short! (Include anything that is part of your happiness: i.e. health, family, work, finances, travel, bucket list, marriage, etc.)

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What potential barriers do you foresee that would prevent these things from happening?

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____

Do you feel it is possible to eliminate or prevent these potential barriers?

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____

What are your strengths that will enable you to accomplish your goals?

____

____

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Rate on a scale of 1 -10:

__________ How important is it for you to resolve your health concerns?

__________ Do you feel that you are coachable and would enjoy a mentor in helping you?

__________ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

THANK YOU!