www.WeRejuvenate.com

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Patient Profile

Date ___________________________

Name ____ SS# ____________ -_________ - ______________

DOB ______ / ______ / ______ Age _______ Height _____'_____" Weight ________ [ ]Male [ ]Female

Address _____________________________________ City/State _______________________Zip __________

Home Phone _____-_____-______Cell Phone ______-______-______ Email ___________________________

Emergency Contact ______________________ Phone _____-_____-______ Relation ____________________

Occupation ____________________ How did you hear about us? ___________________________________

Allergies (including drugs, food, and environmental):

____

____

____

List, in order of importance, your main health concerns:

1. ____
2. ____
3. ____
4. ____
5. ____

Current Medications (include dose and time of day):

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Current Vitamins/Herbs/Supplements (include dose and time of day):

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

List all Surgeries (elective and non-elective), Injuries/Trauma & Hospitalizations, including date:

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____

____

Blood Type:

Type O ____ Type A ____ Type B ____ Type AB ____ Negative ____ Positive ___

Please note when & why you have each of the following:

X-ray: ______________________________ MRI/CAT Scan: ________________________
Ultrasound: __________________________ PET scan:_____________________________
Mammogram: ________________________ EMG: ________________________________
Pap Smear: _________________________ Rectal Exam: ___________________________
Breast Exam: ________________________ Colonoscopy: ___________________________
Prostate Exam: ______________________ Bone Density Scan: ______________________
TB Test: ____________________________ HIV Test: ______________________________
Last Eye Exam: ______________________ Last Dental Visit: _______________________
Blood Tests: ____

Did you have the following disease (D), get Immunized against (I), or Neither (N)?

Measles:	D I N	Chicken Pox:	D I N	Mumps:	D I N
Rubella:	D I N	Whooping Cough:	D I N	Tetanus:	D I N
Hepatitis:	D I N	Haemophilus (Hib):	D I N	Diphtheria:	D I N
Flu Shot:	D I N	German Measles:	D I N	Polio:	D I N

Any vaccination reactions:____

Personal and Family History:

	Self	**Mother**	**Father**	**Grandparents**	**Siblings**	**Spouse**	**Children**
AIDS/HIV:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Alcoholism:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Allergies:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Alzheimer's:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Anemia:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Arthritis:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Asthma:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Autoimmune:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Birth Defect:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Bleeding Disorder:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Cancer:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
COPD:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Depression:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Emphysema:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Epilepsy:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Glaucoma:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
IBS:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Kidney Disease:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Liver Disease:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Lung Disease:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Migraine Headaches:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Pneumonia:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Sickle Cell Anemia:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Suicide:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Tuberculosis:	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Ulcers:	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Do you use or have (circle all that apply):

Eyeglasses   Contact lenses   Hearing Aid   Brace (Neck, Back)
Pacemaker   Dentures   IUD/Diaphragm   Artificial Limb/s

Circle Yes (Y), No (N), or Past (P) regarding use of the following:

Antacids: Y N P   Steroids: Y N P   Analgesics: Y N P
Laxatives: Y N P   Coffee: Y N P   If Yes/Past cups per day:____
Smoking: Y N P   Packs per day & number of years: ____________________
Soda: Y N P   Ounces per day:____________________________________
Alcohol: Y N P   How much & how often:____________________________
Recreational Drugs: Y N P   Specify:__________________________________

Life Style and Social History:

Marital Status (circle one):
Single   Partnership   Married   Separated   Divorced   Widowed

Highest Level of Education: _________________   Hours per week worked: _________
Do you enjoy your job? Y N P   If No, Why? ________________________________
Active Spiritual practice: Y N P   Quality of significant relationship:______________

Your childhood memories are (circle all that apply):
mostly happy   mostly painful   normal   don't recall

History of sexual, mental/emotional, physical abuse: Y N P   Age:______________

Do you find your life:
satisfactory   unsatisfactory   too demanding   boring   exciting

Pertinent Travel History:
____
____
____
____
____

Major Stresses in the last 6 months: money job marital other:

____

____

Do you manage stress well? Y N P Do you allow yourself time to relax? Y N P

Do you sleep soundly? _______________ How long per night? ____________________
If you wake frequently, what is the reason? ______________________________________
Nightmares: Y N P Wake Refreshed: Y N P Snore: Y N P
Sleep Walk: Y N P Must have a nap: Y N P Grind Teeth: Y N P
Do you dream? ______________________ Do you remember your dreams? _________

How often do you exercise? _____________________ What type? _________________
What are your hobbies? ____

Is your diet healthy enough? Y N not sure needs help
How many ounces of water do you drink daily?: ________________________________
Typical Breakfast: ____
Typical Lunch: ____
Typical Dinner: ____
Typical Snacks: ____

In what way do your health concerns limit you? ________________________________
____

How committed are you to making lifestyle changes? little moderately very

Did you grow up near a farm, refinery, polluted areas, or in a home with leaded paint? If so, please specify? ____
____
Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials? ____
Have you ever had health problems when you put in new carpeting, painting your home, had new cabinets, or did refurbishing? ____
Are you particularly sensitive to perfumes, gasoline, or other vapors? ________________
Do you use pesticides, herbicides, or other chemicals around your home? ____________

Review of Symptoms:

Present weight: __________ Weight one year ago: _________ Ideal Weight: __________

Regarding the next section: Please circle (Y) if you have the problem, (N) if you've never had the problem, or (P) if you've had the problem in the past:

Good Energy: Y N P Fever/chills Y N P
Fatigue: Y N P Weakness Y N P

If you have fatigue, when in morning, afternoon, evening is it worst? ________________
If you have fatigue, can you do what you need to during the day? ___________________

Skin			
Rash	Y N P	Color change	Y N P
Hives	Y N P	Lump	Y N P
Psoriasis/eczema	Y N P	Itchy	Y N P
Dry	Y N P	Warts/moles	Y N P
Cancer	Y N P	Perspiration/Night Sweats	Y N P
Scaling	Y N P	Hair/nail change	Y N P
Head			
Headache	Y N P	Migraine	Y N P
Dandruff	Y N P	Head injury	Y N P
Oily/dry hair	Y N P	Hair loss	Y N P
Eyes			
Vision/glasses	Y N P	Blurring	Y N P
Floaters	Y N P	Cataracts	Y N P
Dryness	Y N P	Pain	Y N P
Tearing	Y N P	Discharge	Y N P
Glaucoma	Y N P	Double vision	Y N P
Strain	Y N P	Itchy	Y N P
Ears			
Ringing	Y N P	Discharge	Y N P
Difficulty hearing	Y N P	Pain	Y N P
Recurring infections	Y N P	Wax build-up	Y N P
Nose			
Frequent colds	Y N P	Nosebleeds	Y N P
Congestion	Y N P	Post nasal drip	Y N P
Polyps	Y N P	Seasonal allergies	Y N P
Sinusitis	Y N P	Discharge	Y N P
Mouth/Throat			
Canker sores	Y N P	Cold sores	Y N P
Gum disease	Y N P	Gum bleeding	Y N P
Toothache	Y N P	Cavities	Y N P
Dentures	Y N P	Bad breath	Y N P
Hoarseness	Y N P	Loss of taste	Y N P
Sore throat	Y N P	Difficulty swallowing	Y N P
Neck			
Stiffness	Y N P	Swollen glands	Y N P
Goiter	Y N P	Trauma	Y N P
Tension	Y N P	Full movement	Y N P
Respiratory			
Cough	Y N P	Chest pain	Y N P
Shortness of breath	Y N P	Difficulty breathing	Y N P
Wheezing	Y N P	TB	Y N P
Bronchitis	Y N P	Pneumonia	Y N P
Asthma	Y N P	Painful breathing	Y N P

Cardiovascular			
High blood pressure	Y N P	Low blood pressure	Y N P
Arrhythmia	Y N P	Murmur	Y N P
Palpitations	Y N P	Chest pain	Y N P
Edema/Swelling	Y N P	Rheumatic fever	Y N P
Blue hands or feet	Y N P	Dizziness	Y N P
Leg pain with walking	Y N P	Sleep with 2 pillows	Y N P
Gastrointestinal			
Heartburn	Y N P	Indigestion	Y N P
Bloating	Y N P	Nausea	Y N P
Vomiting	Y N P	Change in appetite	Y N P
Pancreatitis	Y N P	Abdominal pain	Y N P
Hemorrhoids	Y N P	Gallbladder disease	Y N P
Liver disease	Y N P	Ulcer	Y N P
Bowel movement changes	Y N P	BM frequency	
Hernia	Y N P	Rectal bleeding/discomfort	Y N P
Constipation	Y N P	Diarrhea	Y N P
Urinary Tract			
Incontinence/dribbling	Y N P	Pain with urination	Y N P
Frequent infections	Y N P	Kidney stones	Y N P
Urgency	Y N P	Discharge/blood	Y N P
Awake at night to urinate	Y N P	Frequent urination	Y N P
Male			
Testicular pain/swelling	Y N P	Sexually active	Y N P
Hernia	Y N P	STD	Y N P
Discharge	Y N P	Prostate disease/symptoms	Y N P
Impotency	Y N P	Sore/lesion	Y N P
Female Menstrual Cycle and History			
Age period began		How often period occurs	
How long period lasts		Clotting	Y N P
Menstrual cramping	Y N P	Menstrual pain	Y N P
PMS	Y N P	Food cravings	Y N P
Breast tenderness	Y N P	Mood changes	Y N P
Headaches	Y N P	Heavy bleeding	Y N P
Times pregnant		How many births	
Miscarriages		Abortions	
Last Pap Smear		Was it regular?	Y N
Any abnormal paps	Y N P	When?	
Female			
Healthy libido	Y N P	Sexually active	Y N P
Pain with intercourse	Y N P	STD	Y N P
Mammography	Y N P	Vaginitis/yeast infections	Y N P
Breast masses	Y N P	Breast pain	Y N P
Nipple discharge	Y N P	Vaginal dryness	Y N P

Menopause	Y N P	Since what age	
Irregular menses	Y N P	Vaginal discharge	Y N P
Hot flashes	Y N P	Spotting	Y N P
Use of hormones	Y N P	Type of hormones	
Birth control usage	Y N P	Ages used	
Endocrine			
Hormonal problems	Y N P	Thyroid problems	Y N P
Diabetes	Y N P	Fatigue	Y N P
Heat/cold intolerance	Y N P	Excessive thirst	Y N P
Musculoskeletal			
Weakness	Y N P	Arthritis	Y N P
Stiffness	Y N P	Leg cramps	Y N P
Tremors	Y N P	Pain	Y N P
Injury	Y N P	Swelling	Y N P
Nervous			
Paralysis	Y N P	Sciatica	Y N P
Tingling/numbness	Y N P	Carpel tunnel syndrome	Y N P
Seizures	Y N P	Fainting	Y N P
Mental/Emotional			
Anxiety	Y N P	Depression	Y N P
Anger/irritability	Y N P	Tension/stress	Y N P
Mood swings	Y N P	High strung/ tense	Y N P
Fear/panic	Y N P	Eating disorder	Y N P
Psychiatric hospitalization	Y N P	Suicidal	Y N P

Any other symptom not listed:

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I understand that I am financially responsible for payment of this account and/or charges not covered by my insurance.

Signature: ______________________________

*** Physician's notes ***

Tongue color: ____________________ Tongue coating: ____________________

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