RHL

https://reversetohealthylife.com/

Reverse To Healthy Life

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www.reversetohealthylife.com

Reclaim your health in easy ways

PLEASE FILL IN THE REQUIRED INFORMATION

We appreciate your taking the time to fill out the intake form accurately. Your cooperation is essential for providing you the highest standard of care. Please note that all the information you provide is confidential.

REGISTRATION INFORMATION

Name:				
(First)	(Middle)	(Last)		
Appointment Date:	// mm / dd / yyyy			
Date Of Birth:/ /	//	Age:	Gender:	
(*only at your request)	ive our online newsletter):			
Home Address:				
City:	Postal Co	ode:		
Home Telephone: ()	_ Work: ()		
May we leave message	es on your home phone	relating to our visits?	Y	Ν
Emergency contact (na	ame):]	Phone: ()		
How did you hear abo	ut us (Referral - Whom	may we thank)?		
 Billboard Health food stor Other Family Physician 	gazine / Yellow pages e n (Phone No. <u></u> re Providers (Phone N	<u>-</u>))	

CHIEF HEALTH CONCERNS

What are your health concerns? (List in order of importance to you):

1
2.
3
4
5
List any other concerns you may want to discuss:
If you are female, are you currently pregnant? Y N
MEDICAL HISTORY
How would you describe your general state of health? (Circle)
Excellent Good Fair Poor
Please indicate if you have had any serious conditions, illnesses, injuries, surgical procedures (including cosmetic procedures) and any hospitalizations along with approximate dates:
Do you have any allergies (medicines, environment, etc.)?
Please list all current medications (prescription, over-the-counter, vitamins, herbs,
homeopathic, etc.):
Please list all past prescription medications:

How many times have you been treated with antibiotics?			
Do you frequently use any of the following? (Circle)			
Aspirin Laxatives Antacids Diet pills Birth control pills			
Alcohol – how much / day or week			
Recreational drugs – what and how often			
Please indicate what immunizations have you had (\checkmark):			
DPT (diphtheria, pertussis, tetanus)	Haemophilus influenza B		
Hepatitis A			
Tetanus booster	"Flu"		
Hepatitis B			
MMR (measles, mumps, rubella) Polio			
Small Pox			

Did you experience any adverse reactions to past immunizations?

Do you get regular screening tests done by another doctor (Pap,	•••	
blood tests, etc)?	Y	

FAMILY HEALTH HISTORY

Ν

Indicate if a close relative (parent, child, sibling) had /has any of the following:

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin diseases	
Drug abuse		Strep throat	
Emphysema		Stoke	
Hepatitis		Tuberculosis	
Heart disease		Other	

I don't know my family medical history.

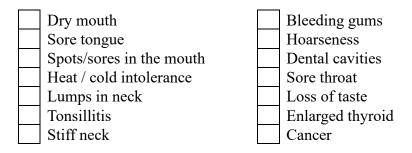
GENERAL HISTORY

Check the symptoms/conditions which apply to you:

Generals

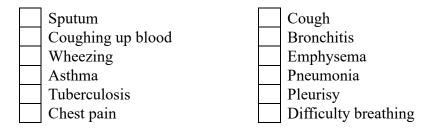
Noticeable Weight Loss Weakness	Fatigue Fever	Noticeable weight gain Lowered immunity
Skin		
RashesChanges in hair/nailsEczemaBoils / Cysts	Color Change Itching Hives Moles	Lumps Dryness Psoriasis
Head		
Head injuries Hair loss	Headaches Dandruff	Migraines
Eyes		
RednessSpecks/FloatersDouble VisionCataracts	 Pain Excessive Tearing Glaucoma Crossed eyes 	Discharge Flashing lights Blurred Vision Blind Spots
Do you wear glasses/contacts?		
Date of last eye exam?		
Ears		
Infection Discharge	Ringing in the ears (tinnitus) Earaches	Vertigo Hearing loss
Do you use hearing aids?	Y N	
Date of last hearing test?		
Nose and Sinuses		
Frequent coldsNasal stuffinessLoss of smell	Hay fever Nasal Discharge Sinus infections	Nosebleeds Itching

Mouth And Throat



Date of last dental exam?

Respiratory



Results of spirometry tests or the lung tests:

Cardiovascular

Rapid heartbeat	Slow heartbeat
High blood pressure	Heart murmurs
Low blood pressure	Rheumatic fever
Chest pain	Edema / swollen ankles
Palpitations	Difficulty breathing
The blueness of skin (cyanosis)	Cold hands/feet
Thrombophlebitis	Extremity numbness
Deep leg pain	Leg cramps

Results of electrocardiogram or other heart tests:

Gastrointestinal			
 Trouble Swallowing Heartburn Excessive Hunger / Thirst Poor Appetite / Thirst Diabetes Nausea 	 Hemorrhoids Constipation Diarrhea Hypoglycemia Abdominal Pain Food Intolerance / Allergy 		

Vomiting Regurgitation Jaundice Hepatitis Colitis Hernias	 Excessive Belching Passing Of Gas Indigestion Liver Or Gallbladder Problems Ulcers Excessive Bloating 		
Frequency of bowel movements? Color and size of stools? Change in bowel habits? Any recent bleeding or black tarry s	tools?		
Genito-Urinary			
 Dark-Colored Urine Excessive Urination Burning / Pain On Urination Pus In Urine Urgency Dribbling Urinary Infections 	 Blood In Urine Frequency At Night Kidney Infection Foul Smelling Urine Hesitancy Incontinence Kidney Stones 		
Musculoskeletal			
 Muscle Or Joint Pains Arthritis Back Pain Broken Bones General Muscle Weakness 	 Stiffness Gout Artificial Joints / Limbs Muscle Spasms / Cramps Joint Swelling 		
Neurological			
 Fainting / Blackouts Weakness Nervousness Tremors / Involuntary Motion Tension Depression Difficulties Concentrating Convulsions / Seizures 	 Loss Of Balance Paralysis Tingling / Pins and Needles Speech Problems Numbness / Loss of Sensation Memory Changes / Loss Irritability Loss Of Sleep 		
Hematological			
Anemia / Thalassemia traits Easy Bleeding	Any Past Transfusions Easy Bruising		

Any other conditions/symptoms that are not listed above:

DIET

Do you have any food allergies or sensitivities? Please list:

Do you have any dietary restrictions (religious, vegetarian / vegan, etc.)?

Describe a typical day's diet (with quantity)
Breakfast
Luncn
Dinner
Snacks
Beverages
LIFESTYLE ENVIRONMENT
Occupation
Do you exercise regularly? Y N
What do you do for exercise, how much and how often?
Are you exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:
How would you describe the emotional climate of your home?

How stressful is your work or other aspects of your life? How do you manage stress?

Is there anything that you feel that is important that has not been covered?

What are your health goals? Please list them in order of priority.

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