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:_____
mm / dd / yyyy

Email Address to receive our online newsletters / specials and appointment reminders*
(*only at your request):
_____

Home Address: _____

City: _____ Postal Code: _____

Home Telephone: ( )_____ Work: ( )_____

May we leave messages on your home phone relating to our visits? Y N

Emergency contact (name):_____ Phone: ( )_____

How did you hear about us (Referral - Whom may we thank)?

- ☐ Newspaper / magazine / Yellow pages
- ☐ Billboard
- ☐ Health food store
- ☐ Other_____
- ☐ Family Physician (Phone No._____)
- ☐ Other Health Care Providers (Phone No._____)

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 _____
Caffeine – form and amount /day _____
Recreational drugs – what and how often _____

Please indicate what immunizations have you had (✔):

☐ DPT (diphtheria, pertussis, tetanus)
☐ Hepatitis A
☐ Tetanus booster
☐ Hepatitis B
☐ MMR (measles, mumps, rubella)
☐ Small Pox
☐ Haemophilus influenza B
☐ "Flu"
☐ Polio

Did you experience any adverse reactions to past immunizations?

_____

_____

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

FAMILY HEALTH HISTORY

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

- ☐ Rashes
- ☐ Changes in hair/nails
- ☐ Eczema
- ☐ Boils / Cysts
- ☐ Color Change
- ☐ Itching
- ☐ Hives
- ☐ Moles
- ☐ Lumps
- ☐ Dryness
- ☐ Psoriasis

Head

- ☐ Head injuries
- ☐ Hair loss
- ☐ Headaches
- ☐ Dandruff
- ☐ Migraines

Eyes

- ☐ Redness
- ☐ Specks/Floaters
- ☐ Double Vision
- ☐ Cataracts
- ☐ 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 colds
- ☐ Nasal stuffiness
- ☐ Loss of smell
- ☐ Hay fever
- ☐ Nasal Discharge
- ☐ Sinus infections
- ☐ Nosebleeds
- ☐ Itching
- ☐

Mouth And Throat

- [ ] Dry mouth
- [ ] Sore tongue
- [ ] Spots/sores in the mouth
- [ ] Heat / cold intolerance
- [ ] Lumps in neck
- [ ] Tonsillitis
- [ ] Stiff neck
- [ ] Bleeding gums
- [ ] Hoarseness
- [ ] Dental cavities
- [ ] Sore throat
- [ ] Loss of taste
- [ ] Enlarged thyroid
- [ ] Cancer

Date of last dental exam?

Respiratory

- [ ] Sputum
- [ ] Coughing up blood
- [ ] Wheezing
- [ ] Asthma
- [ ] Tuberculosis
- [ ] Chest pain
- [ ] Cough
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Pleurisy
- [ ] Difficulty breathing

Results of spirometry tests or the lung tests:

Cardiovascular

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

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_____
Lunch_____
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.