

RegenHealth & Wellness

WELLNESS INTAKE PAPERWORK

CONTACT

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Revitalize, Repair & Renew

GENERAL INFORMATION

Name: _____

Preferred Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Email: _____

Age: _____ Date of Birth: _____ Gender: Female Male

Genetic Background: Caucasian African Native American Hispanic Asian
 Other _____

Marital Status: Married Separated Divorced Widowed Single Partnership

Number of Children: _____ Ages: _____

Has any other family member already been a client at the facility? _____

Occupation: _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Primary Physicians Name: _____

Phone Number: _____ Fax: _____

How did you hear about us?

Friend/Family: _____

Staff Member _____

Online: _____

Advertising/Print: _____

Current Patient: _____

Other: _____

MEDICAL HISTORY

GASTROINTESTINAL

- Irritable Bowel Syndrome _____
- Inflammatory Bowel Disease _____
- Crohn's _____
- Ulcerative Colitis _____
- Gastritis or Peptic Ulcer Disease _____
- GERD (reflux) _____
- Celiac Disease _____
- Other _____

CARDIOVASCULAR

- Heart Attack _____
- Other Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrhythmia (irregular heart rate) _____
- Hypertension _____
- Rheumatic Fever _____
- Mitral Valve Prolapse _____
- Other _____

METABOLIC/ENDOCRINE

- Type 1 Diabetes _____
- Type 2 Diabetes _____
- Low Blood Sugar _____
- Insulin Resistance/Pre-Diabetes _____
- Hypothyroidism _____
- Hyperthyroidism _____
- Endocrine Problems _____
- Infertility _____
- Weight Gain _____
- Weight Loss _____
- Frequent Weight Fluctuations _____
- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Night Eating Syndrome _____
- Eating Disorder (non-specific) _____
- Other _____

CANCER

- Lung Cancer _____
- Breast Cancer _____
- Colon Cancer _____
- Cardiac Stress Test _____
- EBT Heart Scan _____
- Ovarian Cancer _____
- Skin Cancer _____
- Prostate Cancer _____
- Other _____

GENITAL AND URINARY SYSTEMS

- Kidney Stones _____
- Gout _____
- Frequent UTI's _____
- BPH (Enlarged Prostate) _____
- Frequent Yeast Infections _____
- Erectile Dysfunction _____
- Sexual Dysfunction _____
- Other _____

MUSCULOSKELETAL/PAIN

- Osteoarthritis _____
- Fibromyalgia _____
- EKG _____
- Chronic Pain _____
- Other _____

MEDICAL HISTORY (PAGE 2)

INFLAMMATORY/AUTOIMMUNE

- Chronic Fatigue Syndrome _____
- Autoimmune Disease _____
- Lupus SLE _____
- Immune Deficiency Disease _____
- Herpes-Genital _____
- Severe Infectious Disease _____
- Lyme Disease _____
- Poor Immune Function _____
- Food Allergies _____
- Environmental Allergies _____
- Multiple Chemical Sensitivities _____
- Latex Allergy _____
- EBV _____
- Other _____

RESPIRATORY DISEASES

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Tuberculosis _____
- Sleep Apnea _____
- Other _____

SKIN DISEASES

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____
- Other _____

NEUROLOGIC/MOOD

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Schizophrenia _____
- Headaches _____
- Migraines _____
- ADD/ADHD _____
- Autism _____
- Mild Cognitive Impairment _____
- Memory Problems _____
- Parkinson's Disease _____
- Multiple Sclerosis _____
- ALS _____
- Seizures _____
- Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

- Full Physical Exam _____
- Bone Density _____
- Colonoscopy _____
- Cardiac Stress Test _____
- EBT Heart Scan _____
- EKG _____
- Hemocult Test (Test Stool for Blood) _____
- MRI _____
- CT Scan _____
- Upper Endoscopy _____
- Upper GI Series _____
- Ultrasound _____

INJURIES

- Back Injury
- Head Injury
- Neck Injury
- Broken Bones

ALLERGIES

Medication/Supplement/Food: _____

Reaction _____

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No

Describe: _____

Do you currently follow a special diet or nutritional program? Yes No

Check all that apply: Low Fat Low Carbohydrate High Protein Low Sodium

Diabetic No Dairy No Wheat Gluten Restricted Vegetarian Vegan

Specific Program for Weight Loss and Type of Program: _____

Other:

Pregnant: Yes No

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit? _____

When was the last time you felt well? _____

Did something trigger a change in your health? _____

What makes you feel worse? _____

What makes you feel better? _____

SMOKING

Currently Smoking? Yes No

How many years: _____ Packs per day: _____ Attempts to quit: _____

Previous Smoking? Yes No How many years: _____ Packs per day: _____

Second hand smoke exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces of wine, 12 ounces beer, 1.5 ounces spirits

None 1-3 4-6 7-10 >10

Previous Alcohol Intake? Mild Moderate High

OTHER SUBSTANCES

Coffee Intake: Yes No

Coffee Cups/Day: 1 2-4 >4 Tea Cups/Day: 1 2-4 >4

Caffeinated Soda or Diet Soda: Yes No

Are you currently using any recreational drugs? Yes No If so, which one(s)? _____

Have you previously used a recreational drug? Yes No If so, when? _____

SLEEP/REST

Average number of hours you sleep per night? _____

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have a problem with insomnia? Yes No

Do you snore? Yes No Do you use sleep aids? Yes No

EXERCISE

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Yoga, Pilates, Barre			
Sports or Leisure Activities (golf, tennis, roller blading, etc.)			

LIST OF SURGERIES

CURRENT MEDICATION / MEDICATION HISTORY

FAMILY HISTORY

Mother _____

Father _____

Siblings _____

Grandparents _____

Other _____

PHARMACY INFORMATION

Pharmacy Name _____

Phone Number _____

Address _____

City _____ State _____ Zip _____

GYNECOLOGIC HISTORY

OBSTETRIC HISTORY (Check box if yes and provide number)

- Pregnancies _____ Cesarean _____
 Miscarriages _____ Abortion _____
 Post Postpartum Depression _____ Toxemia _____
 Breast Feeding? For how long? _____ Vaginal deliveries _____
 Living Children? _____ Gestational Diabetes _____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____ Pain? Yes No
 Clotting? Yes No Do you have Irregular Periods? Yes No

Last Menstrual Period: _____

Use of Contraception such as: Birth Control Pill Patch Nuva Ring IUD

Vasectomy

For how long? _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES

- Fibrocystic Breasts Infertility
 Endometriosis Painful Periods
 Fibroids Heavy Periods
 PMS

Last Mammogram: _____ Breast Biopsy/Date: _____

Last PAP Test: _____ Normal Abnormal

Last Bone Density: _____ Results: High Low Normal Range

Are you in Menopause? Yes No

Age at Menopause? _____

- Hot Flashes Mood Swings Concentration/Memory Problems
 Vaginal Dryness Decreased Libido Heavy Bleeding
 Joint Pains Headaches Weight Gain Loss of Control of Urine
 Palpitations Use of Hormone Replacement Therapy? How long? _____

MEN'S HISTORY

Have you had a PSA done? Yes No

PSA Level: 0-2 2-4 4-10 >10

- Prostate Enlargement Prostate Infection Change in Libido Impotence
 Difficult Obtaining an Erection Difficulty Maintaining an Erection
 Nocturia (urination at night) How many times at night? _____
 Urgency/Hesitancy/Change in Urinary Stream Loss of Control of Urine

SYMPTOM REVIEW

GENERAL

- Cold Hands & Feet
- Cold Intolerance
- Low Bow Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Fatigue
- Fever
- Flushing
- Heat Intolerance

HEAD, EYES & EARS

- Conjunctivitis
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Vision Problem (other than glasses)

MUSCULOSKELETAL

- Back Muscle Spasm
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Pain
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Stiffness

MOOD/NERVES

- Depression
- Seizures
- Difficulty:
 - Concentrating
 - With Balance
 - With Thinking
 - With Judgment
 - With Speech
 - With Memory

EATING

- Binge Eating
- Bulimia
- Can't Gain Weight
- Can't Lose Weight
- Can't Maintain Healthy Weight
- GERD (reflux)
- Frequent Dieting
- Poor Appetite

DIGESTION

- Anal Spasms
- Bloating of:
 - Lower Abdomen
 - Whole Abdomen
- Bloating After Meals
- Blood in Stools
- Diarrhea
- Alternating Diarrhea and Constipation
- Heartburn
- Intolerance to:
 - Lactose
 - All Dairy Products
 - Gluten (Wheat, Rye, Barley)
 - Corn
 - Eggs
 - Fatty Foods
 - Yeast

SKIN PROBLEMS

- Acne
- Athlete's Foot
- Cellulite
- Dark Circles Under Eyes
- Eczema
- Oily Skin
- Dry Skin
- Normal Skin
- Pale Skin
- Patchy Dullness
- Rash
- Hair Loss

SYMPTOM REVIEW

LYMPH NODES

- Enlarged/Neck
- Tender/Neck
- Other Enlarged/Tender
- Lymph Nodes

NAILS

- Fungus-Fingers
- Fungus-Toes
- Pitting

RESPIRATORY

- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat
- Post Nasal Drip
- Sinus Fullness
- Snoring
- Wheezing

CARDIOVASCULAR

- Angina/Chest Pain
- Breathlessness
- Heart Murmur
- Irregular Pulse
- Swollen Ankles/Feet
- Varicose Veins

URINARY

- Bed Wetting
- Hesitancy (trouble getting started)
- Infection
- Kidney Disease
- Leaking
- Pain/Burning
- Prostate Infection
- Urgency

MALE REPRODUCTIVE

- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps in Testicles
- Poor Libido (sex drive)

FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (sex drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex

PreMenstrual

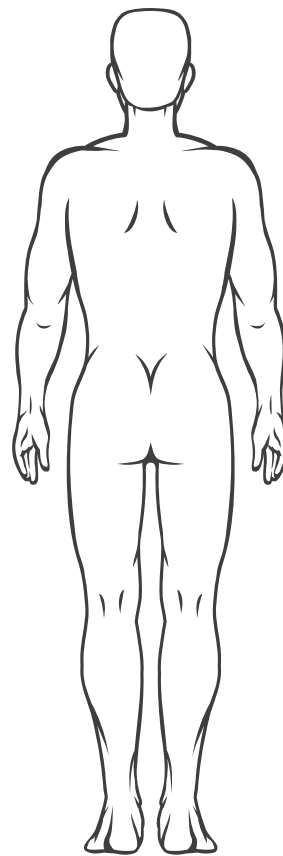
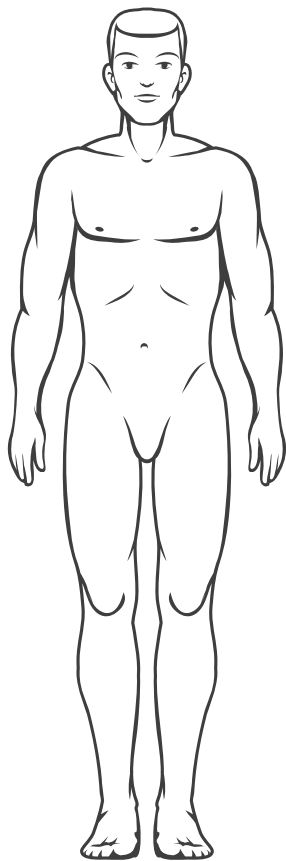
- Bloating
- Breast Tenderness
- Carbohydrate Cravings
- Chocolate Cravings
- Constipation
- Decreased Sleep
- Diarrhea
- Fatigue
- Increased Sleep
- Irritability

Menstrual

- Cramps
- Heavy Periods
- Irregular Periods
- No Periods
- Scanty Periods
- Spotting Between

WHOLE BODY SYMPTOM

Please mark any and all areas you are currently experiencing pain and/or discomfort with the corresponding symptom descriptions. If this does not apply to you, leave blank. *When using the Writable PDF, tab or click to select area then use your space bar to place text in appropriate area of discomfort.



Symptom Key:

0000	Numbness
TTTT	Tingling
XXXX	Burning
////	Stabbing
====	Aching
CCCC	Cramping
SSSS	Sensitive
PPPP	Other

Injuries and Pain Description: (Include any relevant dates and details of specific pain patterns and injuries.)

SYMPTOMS

We want to better understand your current symptoms when it comes to improving your well-being at RegenHealth & Wellness.

- Fatigue
- Body Pain
- Low Energy
- Weight Gain
- Weight Loss
- Depression
- Anxiety
- Changes in appetite
- Chronic pain
- Digestive issues
- Low sex drive
- Lack of nutritional guidance
- Food allergies/sensitivities
- Poor posture
- Urinary Incontinence
- Vaginal discomfort/dryness
- Sagging skin
- Facial Wrinkles
- Dull Complexion
- Dry Skin
- Oily Skin
- Blotchy Skin
- Skin Redness
- Acne
- Hair Loss
- Hair Thinning
- Cellulite
- Veins

WELLNESS SERVICES

Please check the Health & Wellness services you may be interested in learning more about:

- Bio-Identical Hormone Replacement
- Thyroid Therapy
- Testosterone Therapy
- Food Sensitivity Testing
- Genetic Testing
- Nutrition
- Regenerative Cell Therapy
- Acute Care
- Health Maintenance