ReVive Health Solutions
RENEW | RECLAIM | RESTORE

Health History Intake Form

Date _____

Name _____ Email _____

Address _____

Primary Phone _____ Seconday Phone _____ Occupation _____

Birthdate _____ Family Physician _____

Emergency Contact Name _____ Phone _____

Please describe your current concerns

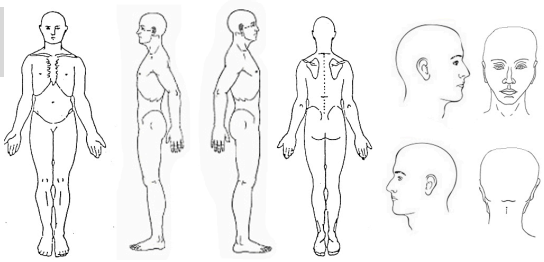
How did your condition begin & date condition began

_____

_____

_____

_____



Mark your area(s) of concern

How often are your symptoms present: ☐ constantly ☐ frequently ☐ occasionally ☐ intermittently

_____

Describe your current pain/symptoms: ☐ sharp ☐ stabbing ☐ burning ☐ throbbing ☐ shooting ☐ tingling ☐ numbness ☐ dull & achy ☐ pins & needles ☐ weakness

_____

Since it began, is your condition: ☐ improving ☐ getting worse ☐ no change

What makes the condition better? ☐ nothing ☐ lying down ☐ standing ☐ walking ☐ sitting ☐ movement ☐ exercise ☐ inactivity or rest _____

What makes the condition worse? ☐ nothing ☐ lying down ☐ standing ☐ walking ☐ sitting ☐ movement ☐ exercise ☐ inactivity or rest _____

Can you perform your daily home activities: ☐ yes ☐ only with help ☐ not at all

Describe your job requirements: ☐ mainly sitting ☐ light labor ☐ heavy labor

Can you perform your daily work activities: ☐ yes, all activities ☐ only some ☐ not at all

Describe your stress level: ☐ none to mild ☐ moderate / high

Hospitalization / Surgeries/Fractures / Serious Illnesses / Accidents (please specify);

_____

_____

_____

Present involvement in other healthcare (please specify);

_____

_____

_____

Medications and current supplements including vitamins/minerals (please specify);

_____

_____

_____

Please check all conditions you have experienced:

Joint/Soft Tissue Pain;
- ☐ Neck
- ☐ Upper Back
- ☐ Mid Back
- ☐ Lower Back
- ☐ Degenerative Discs
- ☐ Jaw
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Legs
- ☐ Hips
- ☐ Knees
- ☐ Feet
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Sciatica

General Systems;
- ☐ Fainting
- ☐ Dizziness
- ☐ Loss of Sleep ☐ Fatigue
- ☐ Nervousness
- ☐ Sudden Weight Loss/Gain
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis
- ☐ Headaches (Tension)
- ☐ Migraines / Frequency;

_____

Reproductive (Females);
- ☐ # of Pregnancies
- ☐ Painful Menstruation
- ☐ Heavy Flow
- ☐ Irregular Cycle
- ☐ Swollen Breasts
- ☐ Menopausal
- ☐ Pre-menopausal
- ☐ Post-menopausal
- ☐ Birth Control / Type;

Cardiovascular;
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Coronary Heart Disease
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke / CVA
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Swelling of Ankles
- ☐ Poor Circulation
- ☐ Diabetes

Respiratory;
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Pneumonia

Skin;
- ☐ Rashes
- ☐ Itching
- ☐ Bruise easily
- ☐ Dryness
- ☐ Boils
- ☐ Other;

Infectious;
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes
- ☐ Cold/Flu
- ☐ Athlete's Foot
- ☐ Warts

Eye, Ear, Nose, Throat;
- ☐ Swollen Glands
- ☐ Allergies
- ☐ Frequent Colds
- ☐ Glasses or Contacts
- ☐ Hearing Aids
- ☐ Hearing Loss
- ☐ Sinus Infection

Digestive;
- ☐ Poor Appetite
- ☐ Belching/Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Ulcer
- ☐ Vomiting
- ☐ Food Sensitivities

Other;

Do you have any internal pins, wires, artificial joints or special equipment? (If yes, please specify below)

Other Conditions / Additional Information

_____

_____

_____

Do you eat regularly? Yes ◯ No ◯ How many meals/day _____ Do you smoke? Yes ◯ No ◯

Do you exercise regularly? Yes ◯ No ◯ What type of exercise and how often_____

Do you sleep well? Yes ◯ No ◯ How many hours a night_____

Do you consume alcohol and/or caffeine? _____

Your personal information is strictly confidential and will become part of your health record.
Your written authorization is legally required before any information can be released.

Please read carefully and sign below:

1. I understand the information I have provided on this form is confidential and will not be released without my written consent.
2. The information that I provided is true and complete to the best of my knowledge.
3. I consent to treatment by my healthcare provider and understand that all treatments are intended to be of therapeutic value.
4. I understand that I am responsible for any charges incurred during the course of my treatment.
5. Please respect the allergy sensitivities of others and refrain from wearing strong scents in order to maintain a fragrance-free environment.
6. Please turn your cell phone to 'vibrate mode' while in the facility.

Appointment Cancellation & Missed Appointment Policy

- Patients are required to give 24 hours notice for appointment cancellations to avoid being charged. Charges may be equivalent to the treatment amount.

- Cancellations will be accepted due to illness and other emergencies. If unable to attend a booked appointment, kindly notify the clinic with as much notice as possible.

I have read and comply with all items above and have been advised of ReVive Health Solutions' cancellation and missed appointment policy. I authorize a full service charge should this be enforced.

Name (Please Print): *Signature:* *Date:*