CENTER FOR WELLBEING
REGENERATE. REJUVENATE. RESTORE.

CONFIDENTIAL PATIENT INFORMATION

Date: _____ Full Name: _____

Height: _____ Weight: _____

Email Address: _____

Birth Date:_____Male:_____Female:_____Marital Status: S___M___D___W____

Name of Wife, Husband, or Guardian:_____

Address:_____

City:_____State:_____Zip Code: _____

Telephone Number: ( )_____Cell Phone Number: ( ) _____

Name and Phone # of Emergency Contact: _____

How did you hear about our office? _____

Appointment Reminders? ☐ Voice Home ☐ Voice Cell ☐ Text ☐ Email ☐ None

Are you Currently Pregnant? _____

Current/Past hormone therapies: _____

Present Symptom(s) that you have: _____

When Symptoms Started____/____/____How Symptoms Started_____

Severity of Pain from 1 (mild pain) to 10 (severe pain): _____

What is your pain/condition holding you back from doing (i.e. sleeping, exercising, traveling, time with family, hobbies, eating healthy, etc.)? _____

What have you found that helps your symptoms? _____

What have you found that makes your symptoms worse? _____

Please list all ***known drug allergies:***

Drug Name:	Reaction:
_____	_____
_____	_____
_____	_____

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List **ALL** medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check **ALL medical conditions** that you *may* have had or currently *have* now:

___ADD/ADHD
___Alcoholism
___Allergy
___Alzheimer's
___Anemia
___Appendicitis
___Asthma
___Arthritis
___Cancer
___Celiac Disease
___Chronic Fatigue
___Depression
___Diabetes
___Eczema
___Emphysema
___Epilepsy/seizures
___Fibromyalgia
___Gall Bladder
___Goiter
___Gout
___Heart Attack
___Heart Disease
___Hepatitis
___High Blood Pressure
___High Cholesterol
___High Blood Sugar
___HIV/AIDS
___Irritable Bowel
___Kidney infections/stones
___Low Blood Pressure
___Low Blood Sugar
___Lyme Disease
___Lupus
___Migraine
___Miscarriage
___Multiple Sclerosis
___Parkinson's
___Pneumonia
___Raynaud's
___Rheumatoid Arth.
___Ringing in ears
___Sinus infection
___Stroke
___Thyroid Problems
___Ulcers
___Vertigo/Dizziness

Other: _____

Please list all previous surgeries & Dates:

_____

_____

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially

Tobacco use? Yes / No PPD _____ How many years? _____

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Please check all symptoms that you currently have:

- ☐ Fatigue
- ☐ Aches & Pains
- ☐ Cold hands & feet
- ☐ Decreased sweating
- ☐ Excessive sweating
- ☐ Need excessive sleep
- ☐ Weight Gain
- ☐ Depression
- ☐ Losing scalp hair
- ☐ Dry Skin
- ☐ Mental Slowness
- ☐ Constipation
- ☐ Diarrhea/IBS
- ☐ Acne
- ☐ Back Pain
- ☐ Frequent nausea
- ☐ Heart palpitations or rapid rate
- ☐ Nervousness, anxiety or panic attacks
- ☐ Weight loss, can't gain weight
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Hypoglycemia, must eat frequently
- ☐ Frequent colds and other infections
- ☐ Low blood pressure, light headedness
- ☐ Low tolerance for stress, slow recovery
- ☐ Salt Cravings
- ☐ Sugar Cravings

Females Only:

Date of last period _____

- ☐ Heavy blood flow
- ☐ Irregular Periods
- ☐ Brest swelling, tenderness or cysts
- ☐ PMS
- ☐ Swelling of face, fingers or ankles
- ☐ Infertility
- ☐ Hot Flashes or night sweats
- ☐ Moodiness, cries easily
- ☐ Painful intercourse
- ☐ Vaginal dryness, pain or itching
- ☐ Dry or irritated eyes
- ☐ Disinterest in sex
- ☐ Facial Hair growth

Males Only:

- ☐ Apathy, low motivation
- ☐ Decreased physical stamina
- ☐ Loss of muscle mass or strength
- ☐ Joint stiffness
- ☐ Moodiness, irritability
- ☐ Decrease in libido
- ☐ Few or no spontaneous AM erections
- ☐ Prostate enlargement
- ☐ Increased fat around waist and hips

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Please list your top 3 major health concerns in order of importance:

1. _____
2. _____
3. _____

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____No _____

I fully understand that my signature is consent & authorization to be examined by the Center for Wellbeing medical team.

Patient Signature:_____Date: _____

Please Print Name:_____