



CLIENT HISTORY FORM

Name _____ **Date** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____

Sex _____ **Age** _____ **Height** _____ **Weight** _____

Date of birth _____ **City, State of birth** _____

Occupation _____

E-mail address _____

Please complete the following questions. This survey will give us a detailed understanding of your present health condition. If you have any questions or do not understand any portion of the questionnaire, we will be happy to assist you.

Chief Complaint – Primary reason you are seeking treatment:

Surgeries you have had and your age at time of surgery:

1. _____ **Age** _____ 3. _____ **Age** _____

2. _____ **Age** _____ 4. _____ **Age** _____

Prescription medications you are presently taking:

1. _____ 3. _____

2. _____ 4. _____

Supplements or over-the-counter medications you are taking, such as vitamins or ibuprofen:

1. _____ 3. _____

2. _____ 4. _____

Habits (Please circle all that apply):

alcohol chocolate cigarettes coffee laxative tea sugar or sugar substitutes(except Stevia)

Do you consider yourself: overweight average underweight

Describe activity level: sedentary light moderate heavy

Are you primarily responsible for preparing your own meals? Yes No

How many of your weekly meals do you eat out? _____

How many glasses of water do you drink each day? _____

List any foods you crave:

List any foods you avoid:

List any special diet or dietary restrictions or food allergies:

Are you following a dietary regimen (Weight Watchers, etc.)? Yes No

Family history of conditions (please list or mark accordingly):

| | <u>Mother</u> | <u>Father</u> | <u>Siblings</u> |
|----------------|---------------|---------------|-----------------|
| Allergies | _____ | _____ | _____ |
| Asthma | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ |
| Cancer | _____ | _____ | _____ |
| Arthritis | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ |

Thyroid Disease _____
 Diabetes _____
 Stomach _____

Toxic exposures

Spider bite _____ Tick bite _____ Pesticide _____ Chemicals _____
 Asbestos _____ Welding _____ Red tide _____ Black mold _____
 Auto body paint _____ Mosquito bites _____ Other _____
 Have an animal in your home _____

DIETARY PREFERENCES

The purpose of this survey is to discover what you usually eat and drink five days a week, not including weekends. The spaces below will help you record your dietary habits. Please be specific when indicating your food choices.

MORNING MEAL

- 1. Do you usually eat breakfast (Monday – Friday)? Yes No
- 2. When you have breakfast, is it at home? Yes No
- 3. Do you use a meal substitute, such as Slim-Fast, etc.? Yes No

Mid-morning snacks: _____

MIDDAY MEAL

- 1. Do you usually eat lunch (Monday – Friday)? Yes No
- 2. When you have lunch, is it at home? Yes No
- 3. If not, where? Carry-Out Restaurant Fast Food Cafeteria
- 4. Do you use a meal substitute, such as Slim-Fast, etc.? Yes No

Mid-afternoon snacks: _____

EVENING MEAL

- 1. Do you usually eat an evening meal (Monday – Friday)? Yes No
- 2. When you have supper, is it at home? Yes No
- 3. If not, where? Carry-Out Restaurant Fast Food Cafeteria

4. Do you regularly consume an alcohol before supper? Yes No

5. Do you use a meal substitute, such as Slim-Fast, etc.? Yes No

Evening snacks: _____

OTHER DIETARY ITEMS:

1. Do you chew gum? Yes No

2. Do you use breath mints? Yes No

3. How many cups of water do you drink a day: 1 2 3 4 5 6 7 8 9 10

SUGAR CONSUMPTION ON A REGULAR BASIS:

Check if you use any of the following:

White sugar _____ Brown sugar _____ Honey _____ Splenda _____

Nutra sweet _____ Sweet-N-Lo _____ Stevia _____ Xylitol _____

BOWEL MOVEMENTS:

Color of stools: Brown _____ Orange _____ Yellow _____ White _____ Black _____

Frequency of Bowel Movements: Less than 1 a day _____ 1 a day _____ 2 a day _____

3 a day _____ More than 3 a day _____

SECTION ONE

Group A (#5)

- ____ 1. History of spinal disc problems or back surgery
- ____ 2. Unable to tolerate stress (i.e., unable to make decisions)
- ____ 3. Irritated or receding gums or loose teeth
- ____ 4. Cold hands or feet
- ____ 5. Clicking jaw or temporomandibular joint (TMJ) pain
- ____ 6. Neck Pain

Group B (PNH3)

- ____ 1. History of having difficulty healing after athletic injuries, surgery, or trauma
- ____ 2. Edema
- ____ 3. Cold hands and feet
- ____ 4. Hot flashes, menopausal symptoms
- ____ 5. Chronic low back pain

Group C (#6)

- ___ 1. History of speech impediment, stuttering, or stammering
- ___ 2. Dry, itchy eyes or mouth
- ___ 3. Poor memory
- ___ 4. Unable to relax, become serene, or meditate
- ___ 5. Frequent sore or irritated throat, sores on tongue or in the mouth
- ___ 6. Craves sugar

Group D (#8)

- ___ 1. History of frequent canker sores, cold blisters, or boils
- ___ 2. Muscles and tendon weakness, pain in lower back and buttocks
- ___ 3. Slow morning starter, writer's cramp, or stiffness after sitting
- ___ 4. Dry skin dandruff, hair loss
- ___ 5. Painful ribs, pleurisy, or pain on inhalation
- ___ 6. Asthma

Group E (PRBS)

- ___ 1. History of spontaneous abortion, inability to conceive or to induce labor; low sperm count
- ___ 2. Tremors, stiffness after rest
- ___ 3. Dry skin, psoriasis, eczema, dermatitis, or rosacea
- ___ 4. Hair loss
- ___ 5. Chronic shoulder problems
- ___ 6. Infertility

Group F (#33)

- ___ 1. History of diabetes in family
- ___ 2. Blood sugar problems, either hypoglycemia or diabetes
- ___ 3. Uncontrollable appetite (i.e., eating when not hungry)
- ___ 4. Desire to lose weight
- ___ 5. In need of a meal replacement
- ___ 6. Mood swings

SECTION TWO**Group A (#2)**

- ___ 1. History of diabetes in yourself or family
- ___ 2. Excessive appetite
- ___ 3. High blood triglyceride levels
- ___ 4. Tongue coated with thick yellow film
- ___ 5. Frequent bitter taste in mouth
- ___ 6. Headaches in temporal area of head
- ___ 7. Pressure behind eyes

Group B (#11)

- ___ 1. History of gallbladder stones or gallbladder surgery
- ___ 2. Loss of appetite, especially for meat
- ___ 3. Frequent sour taste in mouth, intolerance of fats and spicy foods
- ___ 4. Frequent constipation with light-colored stool

- _____ 5. Discomfort or soreness under right rib cage or in lower right abdomen after eating
- _____ 6. Nausea
- _____ 7. Frequent belching

Group C (#12)

- _____ 1. History of ulcers or gastritis
- _____ 2. Frequent heartburn or indigestion with nausea and pain
- _____ 3. Acid reflux after eating
- _____ 4. Frequent use of antacids
- _____ 5. Stomach pain that is relieved by eating
- _____ 6. Frequent belching
- _____ 7. Arm, shoulder, or neck pain

Group D (#14)

- _____ 1. History of lactose intolerance or gluten intolerance
- _____ 2. Craving or thirst for cold liquids or foods
- _____ 3. Intolerance for dairy products, grains or sugar
- _____ 4. Sensitive to air pollutants (i.e. perfumes, smoke)
- _____ 5. Discomfort or soreness under the left rib cage after eating
- _____ 6. Dairy products give me gas or make me bloated

Group E (#30)

- _____ 1. History of chronic indigestion
- _____ 2. Unusual fullness after eating
- _____ 3. Lower bowel gas, unaware of what foods cause the problem
- _____ 4. Undigested food, capsules or tablets found in the stool
- _____ 5. Frequent abdominal cramping after eating

Group F (#32)

- _____ 1. History of pernicious anemia
- _____ 2. Loss of taste for meat
- _____ 3. Strong desire to eat when not hungry
- _____ 4. Indigestion, particularly two to three hours after eating
- _____ 5. Lower bowel gas

Group G (#34)

- _____ 1. Painful gas
- _____ 2. Bloating after eating dairy
- _____ 3. Diarrhea after eating dairy

Group H (Ultra-BDG)

- _____ 1. History of chronic gas, bloating and distention
- _____ 2. Unusual fullness after eating
- _____ 3. Craving or thirst for cold liquids or foods
- _____ 4. Avoidance of raw foods, especially vegetables
- _____ 5. Rapid ingestion of food without chewing food completely
- _____ 6. Abdominal tenderness

SECTION THREE

Group A (#17)

- _____ 1. History of chronic frequent yeast infections
- _____ 2. Foul odor to stool, urine and/ or breath
- _____ 3. Unusually large appetite (i.e. cannot control the urge to eat)
- _____ 4. Frequent or prolonged use of antibiotics
- _____ 5. Constipation with hard, dry stool
- _____ 6. Yellow toe nails
- _____ 7. Anxiety or depression
- _____ 8. Yellow coating on tongue

Group B (#20)

- _____ 1. History of constipation with infrequent bowel movements
- _____ 2. Frequent use of laxatives
- _____ 3. Hard, painful stools
- _____ 4. Lower abdominal pain
- _____ 5. Less than one bowel movement in a day

Group C (#21)

- _____ 1. History of colitis or other disease of the large intestine (IBS)
- _____ 2. Diarrhea with mucous or blood in the stool
- _____ 3. Frequent bowel movements
- _____ 4. Left lower bowel pain
- _____ 5. Painful bowel movements

Group D (#29)

- _____ 1. Always tired (i.e. unable to meet daily requirements)
- _____ 2. Loss of appetite or feel better when you don't eat
- _____ 3. Restless sleep, gnawing of teeth
- _____ 4. Thin, difficult to gain weight
- _____ 5. Itching around rectum and groin
- _____ 6. Feet problems
- _____ 7. Hurts sometimes when walking on feet

SECTION FOUR

Group A (#2)

- _____ 1. History of tuberculosis
- _____ 2. Skin problems, such as dermatitis or eczema
- _____ 3. Being treated for psoriasis
- _____ 4. Frequent ear infections
- _____ 5. Frequent episodes of chills
- _____ 6. Nausea after eating

Group B (#27)

- _____ 1. History of muscular weakness and/ or atrophy
- _____ 2. Inability to tolerate potassium-rich foods (i.e. olives, vegetable juices, bananas)
- _____ 3. Frequent writer's cramp, stiffness especially after rest
- _____ 4. Muscle soreness and pain resulting from exercise
- _____ 5. Loss of joint range of motion, painful stretching

Group C (#28)

- _____ 1. History of deep bone or joint pain
- _____ 2. Frequent anxiety, use or need tranquilizers
- _____ 3. Frequent infections, need for antibiotics
- _____ 4. Systems of edema (i.e. swelling of feet and ankles)
- _____ 5. Any type of acute traumatic incidents/ accidents

Group D (#35)

- _____ 1. History of osteoarthritis or gout
- _____ 2. Musculoskeletal pain, difficulty walking, etc.
- _____ 3. Bone and joint pain in the spine, hips, knees, feet, or hands
- _____ 4. Inflammation (i.e. fever, redness, welling or pain)
- _____ 5. Stiff joints/ sore muscles, diagnosed with fibromyalgia

Group E (#36)

- _____ 1. History of chronic herpes-type skin eruptions (i.e. canker sores, cold blisters, boils)
- _____ 2. Raised and red skin eruptions (i.e. hives, strong reactions to food or chemicals)
- _____ 3. Strong reactions to mosquito or insect bites
- _____ 4. Frequent histamine reactions (i.e. sneezing attacks)
- _____ 5. Painful skin irritation (i.e. sunburn, rashes, chapped lips)

Group E (ZN-MN)

- _____ 1. History of poor immune response or poor ability to heal
- _____ 2. Lack of appetite
- _____ 3. Decreased sense of taste
- _____ 4. Problems with foot odor
- _____ 5. Pain in the hip joint
- _____ 6. Copper toxicity
- _____ 7. Mind races constantly

SECTION FIVE**Group A (#15)**

- _____ 1. History of anemia or other blood disorder
- _____ 2. Fatigued, tired most of the time
- _____ 3. Pale skin, lips and nails
- _____ 4. Low resistance (i.e. frequent colds and infections)
- _____ 5. Getting sleepy after eating
- _____ 6. Red tags on skin
- _____ 7. Scalloped edges on side of tongue
- _____ 8. Frequent sore throats, mono, or other virus's

Group B (#16)

- _____ 1. History of hepatitis, jaundice, other liver disorder
- _____ 2. History of high blood pressure or medication
- _____ 3. Water retention, swelling of hands and feet
- _____ 4. Varicose veins, hemorrhoids
- _____ 5. Shoulder and neck stiffness or soreness
- _____ 6. Red eyes
- _____ 7. Elevated cholesterol or triglyceride

Group C (#18)

- _____ 1. History of reactive hypoglycemia
- _____ 2. Suffer from airborne allergies
- _____ 3. Dark circles under the eyes
- _____ 4. Nausea or vomiting-type of indigestion, morning sickness
- _____ 5. Muscular lower back pain
- _____ 6. Get car sick when traveling

Group D (#19)

- _____ 1. History of skin disorders, such as acne
- _____ 2. Dermatitis , eczema or psoriasis
- _____ 3. Have many warts or moles
- _____ 4. Frequent episodes of hives due to food allergies
- _____ 5. Excessive perspiration or lack of perspiration

Group E (#24)

- _____ 1. History of frequent bladder infections
- _____ 2. Frequent urination, urgency, or loss of control
- _____ 3. Pass small amounts of urine at each voiding
- _____ 4. Dry skin, flaking, dandruff
- _____ 5. Bladder pain or discomfort

SECTION SIX**Group A (#2)**

- _____ 1. History of gallbladder stones or surgery
- _____ 2. High blood pressure
- _____ 3. Frequent problems with dizziness or vertigo
- _____ 4. Frequent episodes of fearfulness and insomnia
- _____ 5. Frequent migraine headaches
- _____ 6. Nausea after eating
- _____ 7. Headaches on temples or forehead
- _____ 8. Eye strain or pressure
- _____ 9. Elevated cholesterol or triglyceride

Group B (#1)

- _____ 1. Type A personality (i.e. driven and aggressive)
- _____ 2. Tend to have problems with indigestion and constipation
- _____ 3. Stiff joints, especially after rest
- _____ 4. Sensitive to sudden sounds (i.e. startle easily)
- _____ 5. Headaches in back of the head and neck
- _____ 6. Insomnia
- _____ 7. Stressful job

Group C (#3)

- _____ 1. History of cataracts, glaucoma, poor vision, macular degeneration
- _____ 2. Frequent head colds, runny nose, watery eyes
- _____ 3. Bruise easily, slow healing of cuts, sore or bleeding gums
- _____ 4. Frequent redness in the eyelids, "sand in your eyes"
- _____ 5. Frequent headaches associated with eye strain, pain when moving eyes

Group D (#4)

- _____ 1. History of chronic sinus problems
- _____ 2. Loss of sense of smell or an obstruction to nasal breathing
- _____ 3. Bothered by thick mucous discharges from the nose
- _____ 4. Frequent nosebleeds
- _____ 5. Facial pain or paralysis

Group E (#9)

- _____ 1. History of taking medication for heart disease
- _____ 2. Irregular heartbeat, skipped breaths
- _____ 3. Dryness of skin and hair, itching due to dryness
- _____ 4. Have varicose veins, hemorrhoids
- _____ 5. Shoulder or chest pain on exertion

Group F (#10)

- _____ 1. History of asthma, emphysema, bronchitis, pneumonia
- _____ 2. Difficulty breathing, shortness of breath
- _____ 3. Frequent cough (dry or productive)
- _____ 4. Wheezing having difficulty breathing when lying on back
- _____ 5. Shoulder pain or arm pain or bursitis

Group G (#25)

- _____ 1. History of bone disorders, spurs, osteoporosis
- _____ 2. Muscle soreness and weakness
- _____ 3. Loose teeth or poor fitting dentures
- _____ 4. Restlessness, hyperirritability, or restless legs at night
- _____ 5. Low back pain, weak joints or ligaments, fallen arches
- _____ 6. Frequent urination
- _____ 7. Leg cramps at night

Group H (#26)

- _____ 1. History of injury to the tailbone
- _____ 2. Restlessness or insomnia
- _____ 3. Inability to concentrate, frequent daydreaming or nightmares
- _____ 4. Unresolved health problems
- _____ 5. Painful tailbone (i.e., hurts to sit down)

SECTION SEVEN**Group A (#7)**

- _____ 1. History of or taking medication for thyroid gland disorders
- _____ 2. Fast heartbeat (i.e. can feel heart racing)
- _____ 3. Swollen or painful breasts
- _____ 4. Moist, warm skin (i.e. sweat easily)
- _____ 5. Neck, shoulder, arm, hand pain
- _____ 6. History of Breast cancer
- _____ 7. Cold hands or feet
- _____ 8. Hair thinning or falling out
- _____ 9. Less than one bowel movement a day
- _____ 10. Thinning eyebrows

- _____ 11. Rough skin on elbows
- _____ 12. Vertical ridges on nails
- _____ 13. Dry skin
- _____ 14. Missing patches of skin pigmentation
- _____ 15. Wide tongue
- _____ 16. Rough skin on heels of feet
- _____ 17. Frequent headaches
- _____ 18. Decreased sex drive
- _____ 19. Clears throat a lot
- _____ 20. Energy drop in the afternoon
- _____ 21. On birth control pill or takes one aspirin a day
- _____ 22. Depression
- _____ 23. Irregular or painful periods

Group B (#13)

- _____ 1. History of low blood pressure problems
- _____ 2. Awake after a few hours of rest and cannot go back to sleep
- _____ 3. Suffer from frequent periods of depression or the inability to think clearly
- _____ 4. Become light-headed when meals are missed
- _____ 5. Suffer from frequent nightmares or panic attacks (heart racing)
- _____ 6. Wake up at 3 a.m. in the morning
- _____ 7. Feel dizzy when standing
- _____ 8. Dark circles under the eyes
- _____ 9. Crave salty foods
- _____ 10. Lots of allergies
- _____ 11. Hot flashes
- _____ 12. Hard to get up in the morning
- _____ 13. Weight gain around the waist line
- _____ 14. Don't feel like doing anything after work
- _____ 15. Elevated cholesterol
- _____ 16. Poor memory recall
- _____ 17. I often feel tired after exercising instead of being energized
- _____ 18. I am often edgy or pessimistic
- _____ 19. My nose is often running or draining

Group C (#22)

- _____ 1. History of prostate disorders or medication
- _____ 2. Frequent night urination
- _____ 3. Dribbling
- _____ 4. Loss of sexual urge
- _____ 5. Pain radiating into the groin or testes

Group D (#23)

- _____ 1. History of hysterectomy or estrogen replacement therapy
- _____ 2. Vaginal discharge
- _____ 3. Excessive menstrual flow
- _____ 4. Lack of menstruation, scanty flow, irregular periods
- _____ 5. Painful periods, symptoms of PMS

_____ 6. Hot flashes

Group E (#31)

- _____ 1. Generally tired and lacking ambition or purpose
- _____ 2. Frequent lack of motivation, inability to get started
- _____ 3. Fatigued, easily tired
- _____ 4. Failure to meet ordinary requirements of daily activities
- _____ 5. Failure to respond to specific nutritional schedules
- _____ 6. Memory loss
- _____ 7. Leg cramps at night

Thank you for taking the time to fill out this survey accurately and honestly. Your answers will assist us in making a thorough examination of your health and will help us to more completely identify your health issues.

I understand I am receiving wellness coaching. I agree I am only receiving suggestions to improve my health. I understand the rejuvenation staff are not medical doctors. If I have a medical problem I will go to my physician.

Signature

Witness

for office use only

Lying BP _____ Sitting BP _____ Standing BP _____ Temp _____ PH _____

Breath hold in seconds _____ ANKLEe Reflex _____ T: _____ E: _____ N: _____

3+: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35

2+: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35

1: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35

LYMPH: TB LAP RAP LLQ RLQ _____

VME (3 2 1) LE(3 2 1) RE(3 2 1) LK(3 2 1) RK(3 2 1) LRE1(3 2 1) RRE1(3 2 1) LRE2(3 2 1) RRE2(3 2 1)

LEFT MAS:B (3 2 1) RIGHT MAS:B (3 2 1) LEFT MAS:F (3 2 1) RIGHT MAS:F (3 2 1) Hair analysis: _____

Shoulder test: + or - _____ Compression test _____ Traction test _____ TBS _____ SS _____

24 HOUR URINE ORDERED: _____ CHALLENGE DONE: _____ (SEE ATTACHED TEST RESULTS)

Notes: _____

