Date: _____

Last name: _____ First name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____/____/_____ Sex: ☐ Male ☐ Female Age: ____ Height: _____ Weight: _____

Email address: _____ Phone # (____) _____

How were you referred to us: _____

Relationship status: ☐ Married ☐ Divorced ☐ Single ☐ In a Relationship ☐ Other: _____

Children: ☐ No ☐Yes If so, how many? _____ Age of children: _____

Occupation: _____ Employer: _____ Hours per week: _____

Preferred pharmacy: _____ Pharmacy phone# (____) _____

Emergency contact details:

1. Name: _____ Relationship: _____ Phone# (_____) _____

Main health concerns (Listed in order of importance)

1. **2.**

3. **4.**

ALLERGIES TO DUGS, FOOD, CHEMICALS (LIST):

_____

Ageless Regenerative MEDICAL

Active Medication/Supplement List

Patient Name:		DOB:		Date:	
Allergies:					
Medications/Supplements	Dose / Strength	Frequency	Indication	Date started	Prescriber

WOMEN:

☐ Menstrual Irregularities ☐ Endometriosis ☐ Infertility ☐ Fibrocystic Breasts ☐ PMS ☐ Fibroids/ovarian cysts

☐ Pelvic Inflammatory Disease ☐ PCOS ☐ Last menstrual period, or age of menopause: _____

Men:

□ Benign Prostatic □ Hyperplasia □ Infertility □ Prostate Cancer

Have you had any kidney, bladder, or prostate infections within the last 12 months? _____

Do you have any problem emptying your bladder completely? _____

Any difficulty with erection or ejaculation? Any testicle pain or swelling? _____

Did you receive a prostate or rectal exam within the last 12 months? _____

PAST MEDICAL HISTORY (Please check all that apply):

Alcoholism	Fibromyalgia	Kidney/Bladder Disease
Anxiety Disorder	GERD (reflux)	Liver/Gall Bladder Disease
Arthritis	Gout	Osteoporosis
Asthma	High Blood Pressure	Stroke/Vascular disease
Autoimmune Disease	High Cholesterol	Skin Problems
Blood Clots (or DVT)	Heart Disease	Thyroid problems
Cancer (type _____)	Hiatal Hernia or Ulcers	Other: _____
Diabetes	Irritable bowel	

How often have you taken antibiotics:

As a *child*: ☐ Less than 5 time ☐ more than 5 times - As an *adult*: ☐ Less than 5 times ☐ More than 5 times

List Major Surgeries/Injuries:

Procedure

_____ Year: _____

_____ Year: _____

FAMILY HEALTH HISTORY: (also indicate which relative – mother, father, grandparent, sibling, child, etc.)

Diabetes: ☐No ☐Yes: _____

Heart Disease: ☐No ☐Yes:_____

High Blood Pressure: ☐No ☐Yes:_____

Breast Cancer: ☐No☐Yes:_____

Prostate Cancer: ☐No☐Yes:_____

Colon Cancer: ☐No☐Yes:_____

Alzheimer's: ☐No☐Yes:_____

Other: _____

Lifestyle History

A. Birth and Childhood History:

1. Were you born: □ vaginal birth or □ C-section

2. Were you breast-fed? □ No □ Yes If yes, how long? _____

3. As a child, were there any foods that were avoided because they gave you symptoms? □ No □ Yes

If yes, what foods and what symptoms? (Ex: milk – gas and diarrhea)

4. Did you eat a lot of sugar/candy/processed foods as a child? □ No □ Yes

B. Nutrition

1. Are you following a specific nutritional program? □ No □ Yes - Check all that apply:

□Dairy free □Gluten free □Grain free □Vegetarian □Vegan □Diabetic □Low carb □High fat (keto)

□Low Glycemic □Anti-inflammatory □Other:_____

2. List other foods you avoid, i.e. soy, eggs, corn, peanuts, sugar, processed foods,

etc._____

3. Do you have symptoms such as belching bloating gas, hives, etc. immediately after eating: □ No □ Yes

Explain if yes_____

4. List known food allergies/sensitivities: _____

5. Check the factors that apply to your current lifestyle and eating habits:

□Fast eater	□Love to eat	□Eat too much
□Eat because I have to	□Late-night eating	□Time constraints
□Have negative relationship with food	□Dislike healthy foods	□Struggle with eating issues
□Don't care to cook	□Confused about nutrition advice	□Eat too little under stress
□Eat more than 50% of meals away from home	□Emotional eater (eat when sad, lonely, bored, etc.)	
□Poor snack choices	□Significant other/family members don't like healthy foods	

Explain: _____

6. Are you currently satisfied with your current weight? □ No □ Yes

Describe: _____

7. What is your ideal weight? _____lbs

8. **On a typical day,** what do you drink?

Type?	How much?
□Soda	_____
□Fruit Juice	_____
□Alcohol	_____

□Coffee/Tea (caffeinated) _____

□Herbal Tea _____

□Decaf Coffee _____

□Energy/Sports Drinks _____

□Filtered Water _____

□Tap Water _____

□Other _____

9. Eating Habits: (Check all that apply)

I eat: □ 1meal per day □ 2 meals per day □ 3 meals per day □ graze – small frequent meals

□ 1-3 snacks/day □ Eat constantly whether hungry or not □ Skip meals-which one: _____

10. Does skipping a meal greatly affect you? □ No □ Yes

11. How often do you eat out? _____ times per week. Fast food restaurants? □ No □ Yes

12. Do you have food cravings? □ No □ Yes

If so, what do crave? _____

13. Briefly describe what your **typical food intake is for one day** (include beverages)

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

B. Sleep

1. On average, how many hours of sleep per night do you get? _____

2. Average bedtime: _____ Average waking time: _____

3. Do you have trouble falling asleep? □ No □ Yes

4. How often do you wake up at night? _____

5. Do you feel rested and refreshed when you wake up? □ No □ Yes

6. Do you snore? □ No □ Yes

7. Rate your quality of sleep on a scale of 1-10 (1=don't sleep, 10=sleep soundly all night) _____

8. What have you done to improve your sleep? _____

a. Do you use sleeping aids? □ No □ Yes If yes, explain: _____

C. Stress

1. Rate your current level of stress on a scale of 1-10 (1=lowest, 10=highest):_____

2. What are the major causes of your stressors?

a. _____

b._____

c._____

3. Describe how well you are currently handling your stress? _____

4. Do you use relaxation techniques? □ No □ Yes If so, which do you use? _____

5. Describe hobbies, interests, passions in your life: _____

Do you have a religious or spiritual practice? □ No □ Yes

6. Do you have a good support system □ No □ Yes

Describe: _____

7. What do you do to help deal with your stress level? _____

D. Exercise

1. Describe what you do for exercise: (check all that apply) □Aerobics (running, biking, elliptical) □Interval/Burst Training, □Strength Training, □Yoga/Pilates, □Stretching, □Other_____

2. How often do you exercise? _____Duration of exercise (minutes): _____

3. What limits you from exercising? □No time, □No energy, □No desire, □Pain/injury, □Other_____

4. Do you feel unusually fatigued or sore after exercise? □ No □ Yes If yes, explain: _____

E. Chemical/Toxin/Heavy Metal Exposure

1. Have you had a significant exposure to any harmful chemicals? □ No □ Yes

Describe: _____

2. In your work or home environment, are you regularly exposed to: (check all that apply)

□Mold □Water leaks □Renovations □Electromagnetic radiation □Damp environments □Chlorinated water □Carpets or rugs □Old paint □Smokers □Pesticides/Herbicides □Harsh chemicals (solvents, glues, gas, acids) □Cleaning chemicals □Heavy metals (lead, mercury, cadmium, etc.), □Airplane travel □Other: _____

3. Do you presently have mercury (silver) fillings? □ No □ Yes How many? _____

Did you ever have mercury fillings? □ No □ Yes: When were they removed: _____

4. Have any of your homes contain lead paint or pipes? □ No □ Yes : Age of exposure: _____

5. Do you make the use of natural/organic personal care products a priority? □ No □ Yes

6. Do you have artificial joints, implants (including tooth)? □ No □ Yes

Describe: _____

7. Do you drink most of your water from □tap, □plastic bottles, □filtered water, type: _____

8. Have you seen any black mold on your windowsills or basement? □ No □ Yes

Describe:_____

9. Do any of these significantly affect you? □Perfume/colognes, □auto exhaust fumes, □cigarette smoke

□Other: _____

10. Do you or have you every smoked cigarettes? If so, how many/day: _____for how long: _____

F. Readiness Assessment:

Rate on a scale of 5 (very willing) to 1 (not willing)

1. To improve your health, how willing are you to:

a. Significantly modify your nutrition/diet ☐5 ☐4 ☐3 ☐2 ☐1

b. Take several nutritional supplements each day ☐5 ☐4 ☐3 ☐2 ☐1

c. Keep a record of everything you eat each day ☐5 ☐4 ☐3 ☐2 ☐1

d. Modify your lifestyle (sleep habits, stress management) ☐5 ☐4 ☐3 ☐2 ☐1

e. Practice a relaxation technique ☐5 ☐4 ☐3 ☐2 ☐1

f. Engage in regular exercise ☐5 ☐4 ☐3 ☐2 ☐1

2. How confident are you of your ability to organize and follow through on the above health related activities?

_____

3. Will family and friends be supportive of your desire to make lifestyle changes? ☐No ☐Yes

Explain: _____

4. Anything else you want to share? _____

_____ **Date:** _____

Patient/Guardian's signature

_____

Print Name

Cancellation/No show/Refund Policy

Cancellations

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. If an appointment is not cancelled by 3pm the day before your scheduled time, you will be charged a $150 fee for the missed appointment.

Scheduled Appointments

We understand delays can happen; however, we must try to maintain the schedule to respect the time of the patients and clinicians alike. If a patient is 15 minutes past their scheduled time, we may have to reschedule the appointment.

No Show

Due to a full schedule, last minute no shows can cause problems such as preventing other patients from getting much needed treatment and/or added expenses for the office and staff. As a result, you will be charged a $150 fee for this missed appointment.

Refund

Services

There will be no refunds given for any services rendered.

Products

We hope you will be pleased with your purchase. Should you wish to return any products bought from Ageless Regenerative Medical, we will be happy to provide an office credit provided it is in a fully reusable condition. Exchanges should be made within a resaleable time (30 days) and in its original, undamaged packaging. If we find the that the product has not been returned to us in fully resalable condition, we reserve the right to refuse the exchange on the item.

PRINT name: _____

Patient's signature: _____

Date: _____