

Date \_\_\_\_\_

Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_ Occupation \_\_\_\_\_

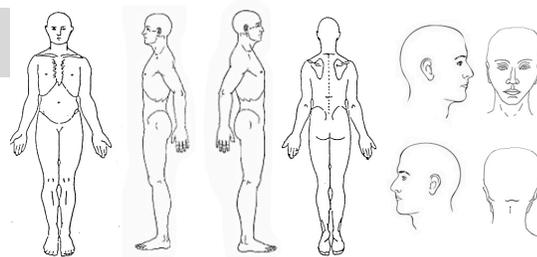
Birthdate \_\_\_\_\_ Family Physician \_\_\_\_\_

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);

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

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**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*

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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? \_\_\_\_\_

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***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: