RevitaLife

Patient Information:

Name: _____ Date of Birth: _____

Social Security #: _____ Gender: _____ Marital Status: _____

Primary Address: _____

City: _____ State: _____ Zip Code: _____

Please put a check mark next to any phone number that we may leave a message for you:

☐ Home Phone: _____ ☐ Cell Phone: _____

☐ Work Phone: _____ E-mail: _____

May we discuss your care with anyone else? If yes, please include the person's name, phone number and relation to you.

☐ Yes _____

☐ No

Employer: _____ Occupation: _____

Emergency Contact Information:

Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Pharmacy _____ Phone _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND FINANCIAL POLICY

I acknowledge that I have been offered or have received a copy of the Privacy Notice and Financial Policy.

Signature of Patient or Guardian: _____ Date: _____

RevitaLife

Patient Name: _____ DOB: _____

Patient Intake Form:

What brings you to RevitaLife Wellness Center? _____

_____

Lifestyle Information:

Tobacco use (chew, smoke, or snuff): ☐ Yes ☐ No

How often? _____ How much? _____

Alcohol use: How many drinks currently per week?

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Caffeine use (tea, coffee, or soda): How many drinks currently per week?

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Exercise: Current Exercise Activity

☐ Stretching ☐ Cardio/Aerobics ☐ Strength ☐ Yoga/Pilates ☐ Sports

Exercise: How often do you exercise each week?

☐ None ☐ 1-2 ☐ 3-4 ☐ 5-7

Sleep: Average number of hours you sleep per night

☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Sleep: How would you rate your overall sleep health? ☐ Good ☐ Fair ☐ Poor

Sleep: Do you snore or stop breathing when sleeping? ☐ Yes ☐ No

Employment: Are you currently employed? ☐ Yes ☐ No

Employment: Do you currently work 2nd or 3rd shift? ☐ Yes ☐ No

Do you consume at least 5 servings of fruits and vegetables every day? ☐ Yes ☐ No

Do you drink at least eight 8oz glasses of water every day? ☐ Yes ☐ No

Do you regularly consume soft drinks or fruit juices? ☐ Yes ☐ No

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Patient Name: _____ DOB: _____

Gastrointestinal Health:

1. Digestion and Absorption

- Frequent heartburn, burping, gas, or bloating during or immediately after meals? ☐ Yes ☐ No
- Been diagnosed with anemia or other nutrient deficiency? ☐ Yes ☐ No
- Been placed on a heartburn medication (proton pump inhibitor [PPI] or H2 Blocker) ☐ Yes ☐ No
- Frequently experience indigestion? ☐ Yes ☐ No

2. Elimination and Detoxification

- Have less than one or more than three bowl movements per day? ☐ Yes ☐ No
- Take a laxative more the twice per month? ☐ Yes ☐ No
- Sensitive to smells or fragrances? ☐ Yes ☐ No
- Have regular exposure to exhaust fumes, tobacco smoke, pesticides, commercial chemicals, paint, cleaning chemicals, or volatile fumes? ☐ Yes ☐ No

3. Microbial Balance

- Used antibiotics within the last two years? ☐ Yes ☐ No
- Experience abdominal bloating, pain, gas, constipation, or diarrhea? ☐ Yes ☐ No
- Been diagnosed with chronic fatigue syndrome, fibromyalgia, or irritable bowel syndrome? ☐ Yes ☐ No
- Experience poor memory, difficulty concentrating, or brain fog? ☐ Yes ☐ No

4. Barrier Function

- Been diagnosed with depression, anxiety, ADD, or ADHD? ☐ Yes ☐ No
- Suffer from multiple food sensitivities? ☐ Yes ☐ No
- Experience skin issues such as acne, rosacea, and eczema? ☐ Yes ☐ No

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Four Key Stressors:

1. Blood Sugar Imbalance

- Experience symptoms of hypoglycemia such as dizziness, shakiness, or brain fog between or following meals? ☐ Yes ☐ No
- Frequently miss or delay meals? ☐ Yes ☐ No
- Frequently crave sugar or carbohydrates? ☐ Yes ☐ No
- Diabetic or pre-diabetic? ☐ Yes ☐ No

2. Mental and Emotional Stress

- Frequently experience anxiety? ☐ Yes ☐ No
- Suffer from depression? ☐ Yes ☐ No
- Suffer from mood swings? ☐ Yes ☐ No
- Have difficulty getting motivated? ☐ Yes ☐ No
- Frequently experience feelings of agitation, anger, fear, or worry? ☐ Yes ☐ No

3. Sleep Cycle Disruptions

- Experience problems falling asleep? ☐ Yes ☐ No
- Experience difficulty staying asleep? ☐ Yes ☐ No
- Suffer light cycle disruption or shift work issues? ☐ Yes ☐ No
- Frequently feel drowsy during the day? ☐ Yes ☐ No

4. Inflammation

- Musculoskeletal: Do you suffer from headaches, muscle, back, or joint pain? ☐ Yes ☐ No
- Gastrointestinal: Do you suffer from IBS, Crohn's disease, or diverticulitis? ☐ Yes ☐ No
- Dermatological: Do you suffer from hives, eczema, or psoriasis? ☐ Yes ☐ No
- Respiratory: Do you suffer from asthma, bronchitis, seasonal allergies, or hay fever? ☐ Yes ☐ No
- Autoimmune: Do you suffer from any auto-immune condition such as MS, Lupus, or Rheumatoid Arthritis? ☐ Yes ☐ No
- Immunological: Do you suffer from food allergies, chronic infections, or frequent illness? ☐ Yes ☐ No

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Patient Name: _____ DOB: _____

Hormone Therapy/Weight Loss: Please check if you have had these symptoms in the past 6 months

- ☐ Decreased sense of well being
- ☐ Difficulty sleeping
- ☐ Decreased energy
- ☐ Decreased memory
- ☐ Heat or cold intolerance
- ☐ Night sweats
- ☐ Mood swings
- ☐ Decreased sex-drive
- ☐ Decreased muscle strength
- ☐ Increased fat deposits
- ☐ Thinning or loss of hair
- ☐ Sadness, depression
- ☐ Hot flashes
- ☐ Prolonged exercise healing

Past and Current History:

Are you currently seeing any other doctors? ☐ Yes ☐ No

If yes, please list below Doctor's names:

_____

Allergies: Please list all allergies and what reaction occurred (if any)

	Reaction
1.	
2.	
3.	

Herbal/Supplements: Please list all Herbal/Supplements that you are currently taking

	Reason for use
1.	
2.	
3.	
4.	
5.	
6.	

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Patient Name: _____ DOB: _____

Medication: Please list all prescription medications you are currently taking

	Dose	Frequency	Reason for Use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Medical condition: Please list all medical conditions that you have or had in the past:

1.
2.
3.
4.
5.

Surgeries: Please list all surgeries you have had:

Date	Surgery

Preventative/Diagnostic Testing: Please check the box if you have had any of the following

☐ Colonoscopy Date: _____ ☐ Bone Density Date: _____

☐ Cardiac Stress Test Date: _____ ☐ Hemoccult Test Date: _____

☐ Cholesterol Date: _____ Level: _____

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Patient Name: _____ DOB: _____

MEN'S Preventative Testing: Please check box if yes and provide the date

☐ PSA date: _____ PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

☐ Prostate exam (rectal) date: _____

WOMEN'S Preventative Testing: Please check box if yes and provide the date

☐ Mammogram date: _____ ☐ Need a Biopsy? date: _____

☐ PAP Test date: _____ ☐ Normal ☐ Abnormal

Family History:

Please list any illness that the following members of your family have/had:

Mother: _____ Age of death if applicable: _____

Father: _____ Age of death if applicable: _____

Siblings: _____ Age of death if applicable: _____

Children: _____ Age of death if applicable: _____

Women Only

Age of first period: _____ Age of last period: _____ Date of last period: _____

Are your periods regular? ☐ Yes ☐ No Any PMS symptoms? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Men Only

Have you ever had trouble passing urine or had to take Flomax or Avodart? ☐ Yes ☐ No

Have you completed your family? ☐ Yes ☐ No

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RevitaLife Advanced Beneficiary Notice (ABN)

DOB: _____ **Patient Name:** _____

This notice is to inform you that your insurance company may not pay for all of the services that you receive in the course of your treatment at our clinic. This may include, but is not limited to:

- Genova Testing
- Additional Blood Testing
- Pellets
- Injections
- Medical Weight Loss Programs
- Food
- B12 Medication
- Cosmetic Services
- Supplements
- Skin Care
- Office Visits
- EKG
- IV Nutrition

Each insurance's out of network benefits are unique as to what services you could be reimbursed for. Treatments that are not reimbursable by any insurance to you will be your full responsibility at the time of service.

By signing this notice, you agree to take financial responsibility for the costs of supplies or services provided.

Patient Signature: _____

Date Signed: _____

* A copy of this notice will be kept in your patient file. You may request a copy of this notice at any time.

RevitaLife

Patient Consent to Treatment

By reading and signing this document ,I, the undersigned patient (or authorized representative) consent to, agree and authorize RevitaLife to perform treatments, examinations, prescribe medications, medical services and diagnostic procedures as ordered and approved by the physician and discussed with me. I understand that I may have other conditions that will continue to be cared for by my primary care physician. I acknowledge and consent to the following:

1) I am at least 18 years of age and I have provided a full and accurate medical history to RevitaLife. I acknowledge that the medical history I provided to RevitaLife is true and accurate and I am aware that any information I did not provide prior to treatment cannot hold RevitaLife personnel treating me responsible for loss or liability that my result due to my failure to provide such information.
2) I understand and agree that as a condition to my receiving treatment with RevitaLife I will continue to visit my primary care physician, regardless of the extensive follow ups specific to the diagnosis discussed by my RevitaLife physician or treating personnel.
3) RevitaLife physician, personnel, and healthcare professionals cannot guarantee any specific results of any examination, treatment, procedure, or medical care. I release RevitaLife, its providers, and healthcare professionals from any and all liability for any accident or injury that is not directly caused by the negligence of RevitaLife or its employees. I further understand that the overall diagnosis and treatment my involve risks or injuries. As a result, I understand and agree to hold RevitaLife personnel and RevitaLife physicians harmless and free of liability if I should encounter and adverse event related to the treatment or medications prescribed that could result in my incurring additional medical costs.
4) During the course of my care and treatment, I understand that various types of examinations, tests, and diagnostic or treatment procedures may be necessary. These procedures may be performed by physicians, nurses, technicians, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures; I will ask my healthcare professional or physician to provide me with additional information. I understand RevitaLife personnel and or physicians may ask me to sign additional informed consent documents relating to specific procedures and treatments.
5) I agree not to give, sell, or allow anyone other than myself to use any medication provided to me through my treatment with RevitaLife.
6) I understand that RevitaLife has contracts with pharmacies for compound medications.
7) I understand that hormones and the ancillary use of medications while taking hormones or undergoing treatment for a specific diagnosis observed by a RevitaLife physician can result in the unknown side effects which may not become evident until a future date. As a result, I agree to take my medications exactly in the manner prescribed to me by my RevitaLife physician and agree to release RevitaLife , or RevitaLife personnel and RevitaLife physicians from any liability for nay misuse, unintended use, or unauthorized use of the medication prescribed.
8) If the medications prescribed may be injected and I chose to inject myself, I agree to hold harmless RevitaLife, RevitaLife personnel and /or RevitaLife physicians if the same results in injury or harm to myself. I understand that RevitaLife and /or its affiliates will provide as much information and instruction as possible to assist in minimizing harm to myself.
9) I authorize and agree to allow RevitaLife to utilize by lab results, observations and or outcomes of my treatment in future studies which will not disclose my demographic information.
10) I understand that RevitaLife physicians may have elected to opt out of medical malpractice insurance due to the unique and unconventional nature of the medical treatment, and I cannot hold them responsible and will not attempt to hold them responsible for the diagnosis and treatment, risks, potential harms or injuries or outcomes that may result from initiation or continuation of therapy indefinitely.

11) I understand that RevitaLife may utilize independent contractors for office, outpatient or inpatient treatment /procedures. These include but are not limited to, assistants, consulting and referral physicians. Healthcare professions that are independent contractors are not agents or employees of RevitaLife and are responsible for their own actions. I understand that RevitaLife shall not be liable for the acts or omissions of the independent contractors. This consent to treatment also applies to any independent contractor utilized by my RevitaLife physician.

I understand that the RevitaLife professionals involved in my care will rely on my documented medical history , as well as other information provided by me, my immediate family, or others having information about me ,in determining whether to perform or recommend certain procedures or treatment. Throughout the course of my treatment I agree to provide accurate, updated and thorough information regarding my medical history and any conditions or events, which my impact medical decision making.

By signing this document, I certify that I have read and understand its contents and the information provided by me is accurate and complete.

Patient's signature_____

Patients printed name _____

Date_____

Witness_____

Optional: I hereby authorize RevitaLife to use any of my comments as testimonials for future marketing and advertising that may occur. Initials ____
Updated 7/2016