REJUVACARE PC
Regenerative Medicine

Welcome to Rejuvacare

Rejuvacare is a regenerative medicine practice specializing in the use of prolotherapy, laser therapy, platelet-rich plasma treatments and stem cells. Our goal is to make you healthier and younger-looking by the most natural means possible. We focus on restoring healthy tissue rather than killing or removing it by drugs, surgery, or radiation.

Our techniques are not mainstream medicine. They are not covered by insurance.

In order to get the best possible results it is important that your body be prepared. Our initial examination is designed to ferret out any hidden problems that might interfere with your treatment. We will coach you on how to remedy any problem we find. Please help us better take care of your needs by completing the following comprehensive health questionnaire.

Personal Regenerative Medicine Evaluation - Women

Please answer all the following questions by either filling in short answers; checking checkboxes; or selecting from the multiple choice menus.

Your full name: _____ Today's date: _____

Your address: _____

Your phone number: _____ Your email address: _____

What are your main objectives in having this regenerative medicine evaluation?

_____

_____

_____

_____

_____

_____

Do you have any serious medical symptoms or complaints right now? Yes☐ No☐

If so, what are they? _____

Who is your primary medical doctor? Name: _____

Address: _____

Phone: _____

May we inform them of the results of this evaluation? Yes☐ No☐

May we get your medical records from them? Yes☐ No☐

Your date of birth? ____/____/_____ Age 2015 (calculated)

Your occupation? _____

Where did you first learn about Rejuvacare? _____

Please rate your ***bad 0 1 2 3 4 5 6 7 8 9 10 excellent***

overall health: . . . . . .

energy levels: . . . . . .

Please check the main problems you are having or the purpose for your consultation:

Low back pain	Neck pain	Facelift/rejuvenation	Fat reduction
Mid-back pain	Headaches	Skin rejuvenation	O-Shot
Shoulder pain	Elbow pain	Scar reduction	Snoring
Hand/wrist pain	Hip pain	Hair loss or excess hair	
Knee pain	Foot/ankle pain	Other _____	

Please tell us the details: _____

_____

_____

_____

_____

How long ago did your symptoms begin? _____

What types of treatments have you received for your condition? _____

_____

_____

Have any of these treatments been helpful, and if so, which ones? _____

_____

_____

What makes your symptoms worse, if anything? (cold, certain movements, weather changes, etc.) _____

_____

_____

If pain is not one of the major reasons for this consultation please skip this section and go on to the next page.

Please describe your pain:

Achy Sharp Dull Burning Tight Numb Stiff

Throbbing Shooting Stinging Stabbing Other ____

How often does the pain occur?

Constant Frequent Occasional Infrequent

Is it worse in the: Morning Afternoon Evening Night

After activity With movement

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

Rate the severity of your pain. . . . . .

Review of Signs and Symptoms

Please rate each of the following signs or symptoms on a scale of 0 to 10, where:
0 means you don't have the symptom at all
1 means you have the symptom but it is very mild/rare
3 means you have the symptom mildy/occasionally
5 means you have the symptom moderately/commonly
7 means you have the symptom moderately severely/frequently
10 means you have the symptom severely/continuously

General ***0 1 2 3 4 5 6 7 8 9 10***

Is your energy level decreased?. . . . . .
Do you fatigue easily? . . . . . .
Are you easily irritated? . . . . . .
Often depressed? . . . . . .
Anxious?. . . . . .
Moody?. . . . . .
Do you have poor memory? . .. .
Difficulty learning? . . . . . .
Decreased ability to focus/concentrate? . . . . . .

Your height: ___ inches Your weight: _____ pounds BMI: 0____ (calculated)
Your waist circumference ____ inches

HEENT ***0 1 2 3 4 5 6 7 8 9 10***

Headaches? . . . . . .
How many times per ___/day ___/week ___/month ___/year
Hair thinning/loss? . . . . . .
Blurry vision? . . . . . .
Do you wear corrective lenses? Yes ☐ No ☐
If so, why? nearsighted farsighted other
Difficulty hearing? . . . . . .
Trouble swallowing? . . . . . .
Facial wrinkles? . . . . . .
Excess facial hair? . . . . . .
Acne? . . . . . .

CVP ***0 1 2 3 4 5 6 7 8 9 10***

Do you get short of breath with exertion?...
Do you have breast tenderness? .. . .
Swollen/enlarged breasts? . . . . . .
Irregular heartbeat? . . . . . .
Chest pains? . . . . . .
Palpitations/fast heartbeat? . . . . . .
Cold feet or hands? . . . . . .
Numbness in your hands or feet? . . . . . .
Swelling in your ankles or feet? . . . . . .

GI ***no 0 1 2 3 4 5 6 7 8 9 10 worst***

Do you have a poor appetite? ...
Are you always hungry? . . . . . .
Always thirsty? . . . . . .
Do you have stomach pains? . . .
Constipation? . . . . . .
Diarrhea? . . . . . .
Black/tarry stools? . . . . . .
Abdominal fat? . . . . . .
Cravings for sweets? . . . . . .

GU ***no 0 1 2 3 4 5 6 7 8 9 10 worst***

Do you have to urinate frequently? . . . . . .
How many times during the daytime? ___
How many times at night? ___
Do you have leaking of urine during coughing, laughing, sneezing, walking, running, jumping or other activity? . . . . . .
Do you need to urinate urgently at times? . . . . . .
Have you lost interest in sex? . . . . . .
Do you have pain during sexual intercourse? ...
Low frequency/quality of orgasms? . . . . . .
Vaginal bleeding? . . . . . .
Vaginal dryness? . . . . . .
Vaginal discharge? . . . . . .
Approximate date of your last menstrual period? ___/____/___

NM ***no 0 1 2 3 4 5 6 7 8 9 10 worst***

Have you lost strength in recent years? .. . . . .
Lost endurance? . . . . . .
Do you have buttock/thigh fat? . . . . . .
Do you lose your balance easily? . . . . . .
Do you have joint pains/stiffness? ... .
If yes, where? _____
Back pain? . . . . . .
Numbness or tingling in your arms or legs? ...
Burning pain in your feet? . . . . . .
How often do you exercise? number of times ___ per day ___per week ___per month

ENDOCRINE

THYROID FUNCTION

This thyroid questionnaire lists symptoms and other factors most commonly found in people suffering from low thyroid, or hypothyroidism. Read each question carefully and check each symptom that applies to you.

(Check all that apply)*

Do you have fatigue? Yes No (4)
Do you have elevated cholesterol? Yes No (4)
Do you have difficulty losing weight? Yes No (2)
Do you have cold hands and feet? Yes No (2)
Are you sensitive to the cold? Yes No (2)
Do you have difficulty thinking? Yes No (2)
Do you find it hard to concentrate? Yes No (2)
Do you experience brain fog? Yes No (2)

Do you have poor short term memory? Yes No (2)
Do you have depressed moods? Yes No (2)
Are you experiencing hair loss? Yes No (2)
Do you have less than one bowel movement a day? Yes No (2)
Do you have dry skin? Yes No (2)
Does your skin itch in the winter? Yes No (1)
Do you have fluid retention? Yes No (2)
Do you have recurrent headaches? Yes No (1)
Do you sleep restlessly? Yes No (1)
Are you tired when you awaken? Yes No (2)
Do you have afternoon fatigue? Yes No (2)
Do you experience tingling or numbness in your hands or feet? Yes No (2)
Do you have decreased sweating? Yes No (2)
Have you had problems with infertility or miscarriages? Yes No (2)
Do you have recurrent infections? Yes No (2)
Do your muscles ache? Yes No (2)
Do you have joint pain? Yes No (2)
Do you have thinning of your eyebrows or eyelashes? Yes No (2)
Is your tongue enlarged with teeth indentations? Yes No (2)
Is your skin pasty, puffy or pale? Yes No (2)
Do you have decreased body hair? Yes No (2)
Is your voice hoarse? Yes No (1)
Do you have a slow pulse? Yes No (2)
Do you have low blood pressure? Yes No (2)
Do your body temperature run below the normal 98.6 degrees? Yes No (4)
Do you have sleep apnea? Yes No (2)

Thyroid score 0___ (calculated)
< 9 | It is not likely that you have Low thyroid .
9-28 | Low thyroid is a possibility.
> 28 | Low thyroid is likely.

HORMONAL IMBALANCE
This questionnaire lists symptoms and other factors most commonly found in women who are either perimenopausal or menopausal, and suffering from low estrogen. Read each question carefully and check the symptom that applies to you.
(Check all that apply)*
Do you have hot flashes? Yes No (4)
Do you have night sweats? Yes No (4)
Do you have vaginal dryness? Yes No (3)
Do you urinate frequently? Yes No (2)
Are you depressed? Yes No (2)
Do you have difficulty sleeping? Yes No (3)
Have you lost interest in sex? Yes No (2)
Have your periods ceased? Yes No (4)

Low estrogen score 0__ (calculated)
< 5 | It is not likely that you have low estrogen.
5-9 | Low estrogen is a possibility.
> 9 | Low estrogen is likely.

TESTOSTERONE

This questionnaire lists symptoms and other factors most commonly found in women suffering from low testosterone. Read each question carefully and check the symptom that applies to you.

(Check all that apply)*

Do you have fatigue? Yes No (2)
Do you have lack of drive? Yes No (3)
Do you lack initiative? Yes No (3)
Are you less assertive? Yes No (3)
Do you have a decline in your sense of well being? Yes No (2)
Do you have depressed moods? Yes No (2)
Are you frequently irritable? Yes No (2)
Has your self-confidence declined? Yes No (2)
Do you find it difficult to set goals? Yes No (2)
Do you have a difficult time making decisions? Yes No (2)
Have you had a decline in your mental sharpness? Yes No (2)
Has your stamina and endurance lessened? Yes No (2)
Have you lost muscle mass, strength or tone? Yes No (4)
Have you gained body fat around your waist? Yes No (2)
Do you have elevated cholesterol? Yes No (2)
Has your libido decreased? Yes No (2)
Has your sexual ability declined? Yes No (2)

Testosterone score 0 (calculated)
< 7 | It is not likely that you have low testosterone.
7-20 | Low testosterone is a possibility.
> 20 | Low testosterone is likely.

ESTROGEN DOMINANCE

This estrogen dominance Questionnaire lists symptoms and other factors most commonly found in women suffering from Estrogen Dominance and/or Progesterone Deficiency. Read each question carefully and check the symptom that applies to you.

(Check all that apply)*

Do you have premenstrual breast tenderness? Yes No (4)
Do you have premenstrual mood swings? Yes No (4)
Do you have premenstrual fluid retention and weight gain? Yes No (4)
Do you have premenstrual headaches? Yes No (4)
Do you have migraine headaches? Yes No (3)
Do you have severe menstrual cramps? Yes No (3)
Do you have heavy periods with clotting? Yes No (3)
Do you have irregular menstrual cycles? Yes No (3)
Do you have uterine fibroids? Yes No (3)
Do you have fibrocystic breast disease? Yes No (3)
Do you have endometriosis? Yes No (2)
Have you had problems with infertility? Yes No (2)
Have you had more than one miscarriage? Yes No (2)
Do you have joint pain? Yes No (1)
Do you have muscle pain? Yes No (1)
Do you have decreased libido? Yes No (3)
Do you have anxiety or panic attacks? Yes No (2)

Estrogen dominance score 0 (calculated)
< 5 | It is not likely that you have estrogen dominance.
5-8 | Estrogen dominance is a possibility.
9-20 | Estrogen dominance is probable.
> 20 | Estrogen dominance is likely.

ADRENAL

This adrenal questionnaire lists symptoms and other factors most commonly found in people suffering from adrenal fatigue. Read each question carefully and check the symptom that applies to you.

(Check all that apply)*

Do you have fatigue? Yes No (3)
Do you have allergies? Yes No (3)
Do you have asthma? Yes No (3)
Do you have recurrent infections? Yes No (3)
Are you under severe emotional stress? Yes No (3)
Do you suffer from chronic pain or physical stress? Yes No (3)
Do you have low blood pressure? Yes No (2)
Do you have a low pulse rate (less than 70 bpm with no exercise)? Yes No (2)
When you rise quickly, do you feel as though you might pass out? Yes No (2)
Do you have depressed moods? Yes No (2)
Do you have joint pain? Yes No (2)
Do you have muscle pain? Yes No (2)
Do you have low libido? Yes No (2)
Do you have hair loss? Yes No (2)
Do you have anxiety attacks? Yes No (2)

Adrenal score 0 (calculated)
< 7 | It is not likely that you have adrenal fatigue.
7-12 | Adrenal fatigue is a possibility.
> 12 | Adrenal fatigue is likely.

SLEEP

Do you go to bed at the same time each night? Yes No
If so, what time? _____
How long does it take you to fall asleep? _____ minutes
Do you wake often during the night? Yes No
Do you have trouble getting back to sleep? Yes No
Do you need an alarm clock to wake you? Yes No
Do you awake often feeling unrefreshed? Yes No
Are you sleepy during the daytime? Yes No
Do you need caffeine to make it through the day? Yes No
Do you use the bed for activities other than sleep or sex? Yes No
Do you sleep late on holidays or weekends? Yes No
Does your work involve night shifts? Yes No
Does your bed partner complain that you snore? Yes No
Do you move around a lot in your sleep? Yes No

Past Medical History

Please list all medications to which you are allergic:
1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
Please list all foods to which you are allergic or sensitive:
1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
Please list all environmental allergies (animals, plants, fumes, etc.):
1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
Please list all prescription medications that you take:
1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
7._____ 8. _____ 9._____
10._____ 11. _____ 12._____
Do you take any injections other than mentioned above?
1._____ 2._____3. _____
Any creams or lotions other than above?
1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
Any eye drops?
1._____ 2._____
Suppositories?
1._____ 2._____

Please list any over-the-counter medications or preparations that you take regularly:
1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
Do you take any special teas or drinks?
1._____ 2._____
Please list all nutritional supplements that you take:
1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
7._____ 8. _____ 9._____
10._____ 11. _____ 12._____

Have you had or do you have:

Type 1 diabetes?	Yes	No	Type 2 diabetes?	Yes	No
Heart attack?	Yes	No	Angina?	Yes	No
Congestive heart failure?	Yes	No	Stroke?	Yes	No
Thyroid disease	Yes	No	Arthritis	Yes	No
High Cholesterol?	Yes	No	COPD?	Yes	No
Cancer?	Yes	No	Sleep apnea	Yes	No

Hypertension/high blood pressure? Yes No
If you have had any other serious illnesses please list them:
1._____ 2._____
3._____ 4._____
5._____ 6._____

How many pregnancies have you had? ____ How many live births? _____
Please list all surgeries (including dental, i.e. root canal) you have had:

1._____ 2._____
3._____ 4._____
5._____ 6._____

Has anyone **in your family** had:

Type 1 diabetes?	Yes	No	Type 2 diabetes?	Yes	No
Heart attack?	Yes	No	Angina?	Yes	No
Congestive heart failure?	Yes	No	Stroke?	Yes	No
Hypertension/high blood pressure?	Yes	No			
High Cholesterol?	Yes	No	COPD?	Yes	No
Cancer?	Yes	No			

Have you had any major injuries? If so, please list them.
1._____ 2._____
3._____ 4._____

Do you smoke? Yes , _____ packs per day No
If you are an ex-smoker, approximately when did you quit? _____ (year)

Diet Inventory

Are you following any special or prescribed diet now? Yes No

If so, please describe it: _____

How many meals do you eat each day? ___

At what times? _____,_____,_____,_____,_____,_____,_____

What are your favorite foods? _____

What foods do you dislike? _____

Congratulations! You're done. Please save/print/scan this form and email it to info@rejuvacare.org or fax it to 844-459-2487.

Please read the following paragraphs carefully; print out these pages; and sign below if you are in agreement. Bring the signed pages with you when you come for your appointment.

Release of Medical Records

Many of our patients bring in family members (spouses, parents, etc) to their appointments. This is encouraged, as family support during your treatment is critical to your success. If you would like us to be able to communicate information (lab results, x-rays, etc) about your condition to a family member or designated person in your absence, please list them below.

I, _____ , give Rejuvacare PC my permission to share my medical information with the following people in my absence (please list names below):

1. _____

2. _____

3. _____

_____
your signature

It helps us tremendously to be able to see and evaluate your previous laboratory tests, imaging studies, and the clinical opinions of your personal physician and other physicians who you may have seen. If you would allow us to get your medical records from your physicians please list their names and sign below.

I, _____, request that the physicians named below send a copy of my medical records to Rejuvacare PC.

1. _____

2. _____

3. _____

_____
your signature

Insurance Waiver

Payment Requirements: Payment for all services is expected at the time of appointment. Visa, MasterCard, American Express, check, cash, Bitcoin or Traveler's checks are accepted.

Appointments: Please kindly give more than 24 hours notice if you must change or cancel your appointment.

I understand and agree that my health insurance is an agreement between my insurance company carrier and myself; and that all services furnished to me are charged directly to me. I further understand that I am personally responsible for all charges on my account. If I am Medicare, Medicaid, Champus, WPS, or TRICARE eligible I hereby waive my rights to file a claim and seek reimbursement for services performed through Rejuvacare PC.
I have read and understand the above statements.

_____
Please Print Name

_____
Signature **Date**