REJUVENATION
HEALTH SERVICES

ADMISSION HEALTH HISTORY

Name: _____

YES	NO	
☐	☐	Headaches (on a regular basis)
☐	☐	Previous Back Pain
☐	☐	Previous Neck Pain
☐	☐	Upper Extremity Pain (arms/shoulders)
☐	☐	Poor Posture
☐	☐	Heart Disease or Arterial Disease
☐	☐	Low/High Blood Pressure
☐	☐	Pacemaker or other Implanted Device
☐	☐	Stroke
☐	☐	Lung Disease (Asthma, Bronchitis, Emphysema, Tuberculosis)
☐	☐	Bone or Joint Disorders (Arthritis, Osteoporosis, Rheumatoid Arthritis, Lupis)
☐	☐	Do you have any metal in your tissue? (Pins, plates, screws, joint replacements)
☐	☐	Nervous System Disorder (MS, ALS, Muscular Dystrophy, Cerebral Palsy, Bell's Palsy, Parkinson's)
☐	☐	Blood Disorders (Hemophilia, HIV Positive, Leukemia, Anemia, clotting disorders)
☐	☐	Circulatory Disorders (Reynaud's, varicose veins)
☐	☐	Digestive (Bloating, Ulcers, IBS, Colitis, Gallstones, Crohn's disease, Indigestion)
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Cancer
☐	☐	Kidney Disease
☐	☐	Thyroid Problem
☐	☐	Skin Disorders (Warts, Moles)
☐	☐	Hepatitis
☐	☐	Are you pregnant or suspect pregnancy?
☐	☐	Do you use a contraceptive device (IUD)?
☐	☐	Other (Insomnia, Anxiety, Menstrual/Menopausal)

Please list any medications that you take on a regular basis (pharmaceutical or herbal): _____

_____

Please list any other information you feel may be helpful: _____

_____

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