reboot center
FOR INNOVATIVE MEDICINE™

P 360 331 2464
F 866 277 7173

5492 MYRTLE AVE | PO BOX 554
FREELAND WA 98249

INFO@REBOOTCENTER.COM
REBOOTCENTER.COM

ADULT HEALTH FORM

Patient name: _____ Date of birth: _____

I. Purpose of visit (please be as detailed as possible)

_____

_____

Physicians most recently consulted regarding the above: _____

Primary Care Physician: _____

Please list symptoms in order of importance: Severity (1=mild, 10=severe)

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

II. Personal & Family Health History

Please circle each condition that applies to you or one of your family members. Note whether condition is resolved or current. Indicate the relationship, such as "mother", or the word "self" in the "Relationship" column.

Family Health History:

Relation	Age	Health Condition(s). If deceased, note age of death and cause
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Personal & Family Health History:

Disease	Relationship	Resolved/Current	Disease	Relationship	Resolved/Current
Alcoholism			Heart Disease		
Arthritis			High Blood Pressure		
Asthma/Allergies/ Hives			Hip Disorders at Birth		
Autoimmune Disease			HIV/AIDS		
Birth Defects			Kidney Disease		
Bleeding Tendencies			Lazy Eye		

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Cancer (***note type***)			Mental Problems		
Chemical Dependency			Strokes		
High Cholesterol			Obesity		
Depression			Suicide		
Diabetes			Thyroid Disease		
Emotional Problems			Tuberculosis		
Epilepsy/Convulsions			Other:		
Gastrointestinal Disease			Other:		

Surgeries/hospitalizations: _____

Major injuries/ illnesses: _____

Date of most recent annual physical exam: _____ Results: _____

Date of most recent dental visit: _____ Date of most recent eye exam: _____

Any other recent health exams conducted (including labs, diagnostic imaging procedures, acute exams)? Yes No

If yes, please list: _____

III. Social History & Lifestyle Habits

Please circle any of the following substances that you use regularly: Caffeine Alcohol Illegal drugs

Describe your typical day's worth of food intake:

Breakfast: _____

Lunch: _____

Dinner:_____

Snacks: _____ Liquids: _____

Describe any dietary restrictions or avoidances: _____

Do you exercise regularly? Yes__ No__

Describe your typical exercise regimen (*include type, frequency, and length of exercise)*: _____

_____

_____

Rate from 1-10 (1=low, 10=high): Life satisfaction: _____ Emotional wellness: _____ Sleep quality: ____

Job satisfaction: _____ Stress level: _____ Satisfaction with current weight: _____

Quality of diet: _____ Energy level: _____ Mental clarity: _____

Please circle your history of tobacco use: Never smoked Former smoker Current smoker Other current tobacco use

Current job: _____ Are you retired? Yes__ No__ If yes, date of retirement: _____

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IV. Medications and Allergies

Medications *and* ***supplements*** *you are currently taking, including* ***dosage***, ***frequency***, *and* ***how long taken****:*

Medicine: _____ Dose: _____ Start date: _____

Medicine: _____ Dose: _____ Start date: _____

Medicine: _____ Dose: _____ Start date: _____

Medicine: _____ Dose: _____ Start date: _____

Medicine: _____ Dose: _____ Start date: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Allergies to medications or substances: _____

Food sensitivities/allergies: _____

V. Review of Systems

Please check all of the following that apply to you:

General □ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness □ Trouble sleeping	**Nose** □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus pain	**Cardiovascular** □ Chest pain or discomfort □ Tightness □ Palpitations □ Shortness of breath with activity (dyspnea) □ Shortness of breath while sleeping □ Difficulty breathing lying down (orthopnea) □ Swelling (edema)
Skin □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes	**Throat** □ Changes in teeth □ Changes in gums □ Bleeding □ Dentures □ Dry mouth □ Sore tongue or throat □ Hoarseness □ Thrush □ Non-healing sores	**Gastrointestinal** □ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea □ Change in bowel habits □ Rectal bleeding □ Constipation □ Diarrhea □Yellow eyes or skin (jaundice)
Head □ Headache □ Head injury	**Neck** □ Lumps □ Swollen glands □ Pain □ Stiffness	**Female Genital** □ Pain with intercourse □ Vaginal dryness □ Hot flashes □ Vaginal discharge □ Itching or rash □ STDs

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Ears □ Decreased hearing □ Ringing in ears (tinnitus) □ Earache □ Drainage	**Breasts (women only)** □ Lumps □ Pain □ Discharge □ Self-exams □ Breast-feeding	**Male Genital** □ Hernia □ Penile discharge □ Sores □ Masses or pain □ Erectile dysfunction □ STDs
Eyes □ Vision □ Glasses or contacts □ Pain □ Redness □ Blurry or double vision □ Flashing lights or specks □ Glaucoma □ Cataracts	**Respiratory** □ Cough (dry or wet, productive) □ Sputum (color and amount) □ Coughing up blood (hemoptysis) □ Shortness of breath (dyspnea) □ Wheezing □ Painful breathing	**Urinary** □ Frequency □ Urgency □ Burning or pain □ Blood in urine (hematuria) □ Incontinence □ Change in urinary strength
Musculoskeletal □ Muscle or joint pain □ Stiffness □ Back pain □ Redness of joints □ Swelling of joints □ Trauma	**Hematologic** □ Ease of bruising □ Ease of bleeding	**Endocrine** □ Heat or cold intolerance □ Sweating □ Frequent urination (polyuria) □ Thirst (polydypsia) □ Change in appetite (polyphagia)
Neurologic □ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □ Tremor	**Psychiatric** □ Nervousness □ Depression □ Memory loss □ Stress	**Vascular** □ Calf pain with walking (Claudication) □ Leg cramping

VI. Anything Else?

Is there anything else that you feel we need to know in order to provide the best care?_____

_____

VII. Signature

I certify that the above information is correct to the best of my knowledge. I will not hold the Reboot Center Practitioners or Staff responsible for any errors or omissions that I may have made in the completion of this form.

Printed Name: _____ **Relationship to Patient:** _____

(Must be the patient (if able, and age 18+), guardian, or legal representative) (If you are the patient, please write "*Self*")

Signature: _____ **Date:**_____