reboot center
FOR INNOVATIVE MEDICINE™

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PERIODIC HEALTH UPDATE

Please take a moment to fill out this form prior to your follow-up visit. Thank you!

Patient name: _____ Date of birth: _____

Purpose of visit: _____

Current medications (*include pharmaceutical, herbal, homeopathic, other)*:

_____

_____

Other medical care since the last visit at Reboot Center: _____

_____

Check the system(s) below if there have been changes since the last visit:

__General	**__Hair**	**__Breath**	**__Digestion**	**__Genitals**
__Emotions	**__Sinuses**	**__Heart**	**__Stomach**	**__Muscles**
__Memory	**__Jaws**	**__Circulation**	**__Urination**	**__Bones**
__Sleep	**__Teeth**	**__Breasts**	**__Bowels**	**__Skin**
__Stresses	**__Throat**	**__Lungs**	**__Menses**	**__Weight**

Check any new: **__Lumps __Swelling __Rashes __Tender Points __Bleeding __Diagnoses**

Describe changes in checked systems above:

_____

_____

Describe a typical day's food and liquid intake:

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

Liquids: _____

In the goal of keeping your communication preferences updated, please designate a primary email address and **primary phone number** at which we can leave confidential communications regarding appointments, your health care, and other important information:
Confidential email address*: _____ Confidential phone number: _____

*Please note: Unless specifically requested otherwise, appointment confirmations and other confidential health information will be communicated to your **designated confidential email address**.

Additionally, if there have been other changes in demographic information or insurance coverage since the last visit, please please fill out an updated **Adult / Pediatric Demographic & Billing Information** form.

I certify that the above information is correct to the best of my knowledge. I will not hold the staff or practitioners of Reboot Center 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:** _____