# REWAKEN LIFE INTAKE FORM

## GENERAL INFORMATION

TODAY'S DATE ____________ HOW DID YOU HEAR ABOUT US? ____________________________

FIRST NAME ________________________ LAST NAME ____________________

DATE OF BIRTH __________________ AGE __________ GENDER: ☐ M ■ F

ADDRESS ________________________________________________

CITY ____________________ STATE ________________ ZIPCODE ____________

PHONE (HOME) ______________ (CELL) ________________ (WORK) ______________

E-MAIL ________________________________________________

EMERGENCY CONTACT NAME ________________________ RELATIONSHIP ____________

EMERGENCY CONTACT PHONE ______________ Height _____________ Weight __________

## WHAT ARE YOUR GOALS WITH SEMAGLUTIDE?

1.____________________________________________________________

2.____________________________________________________________

## GENERAL HEALTH

Are you currently seeing a physician for **any reason.** If yes, explain reason: ☐ Yes ☐ No

______________________________________________________________________

Do you have any health problems? If yes, please list ☐ Yes ☐ No

______________________________________________________________________

______________________________________________________________________

Do you have any allergies or sensitivities? If yes, please list ☐ Yes ☐ No

______________________________________________________________________

______________________________________________________________________

Do you smoke? ☐ Yes ☐ No If yes, how much/often? ________________________

Do you consume alcohol? ☐ Yes ☐ No If yes, frequency/amount________________________

Do you have a healthy diet? ☐ Yes ☐ No List any dietary concerns________________________

Do you exercise? ☐ Yes ☐ No If yes, how often?_________ Type(s)______________

Do you take vitamins? ☐ Yes ☐ No If yes, what type(s)? ________________________

Do you drink water? ☐ Yes ☐ No If yes, how many glasses per day?________________

## MEDICAL HISTORY

**Illnesses/Conditions:** ***Check appropriate Box: YES****-a condition you currently have,* ***PAST****-a condition you've had in the past*

| **Gastrointestinal** | |
|---|---|
| Irritable Bowel Syndrome | ☐ Yes ☐ Past |
| GERD (reflux) | ☐ Yes ☐ Past |
| Crohn's Disease/Ulcerative Colitis | ☐ Yes ☐ Past |
| Peptic Ulcer Disease | ☐ Yes ☐ Past |
| Celiac Disease | ☐ Yes ☐ Past |
| Gallstones | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |
| **Respiratory** | |
| Bronchitis | ☐ Yes ☐ Past |
| Asthma | ☐ Yes ☐ Past |
| Emphysema | ☐ Yes ☐ Past |
| Pneumonia | ☐ Yes ☐ Past |
| Sinusitis | ☐ Yes ☐ Past |
| Sleep Apnea | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |
| **Urinary/Genital** | |
| Kidney Stones | ☐ Yes ☐ Past |
| Gout | ☐ Yes ☐ Past |
| Interstitial Cystitis | ☐ Yes ☐ Past |
| Frequent Yeast Infections | ☐ Yes ☐ Past |
| Frequent Urinary Tract Infections | ☐ Yes ☐ Past |
| Sexual Dysfunction | ☐ Yes ☐ Past |
| Sexually Transmitted Diseases | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |
| **Endocrine/Metabolic** | |
| Diabetes | ☐ Yes ☐ Past |
| Hypothyroidism (low thyroid) | ☐ Yes ☐ Past |
| Hyperthyroidism (overactive thyroid) | ☐ Yes ☐ Past |
| Polycystic Ovarian Syndrome | ☐ Yes ☐ Past |
| Infertility | ☐ Yes ☐ Past |
| Metabolic Syndrome/Insulin Resistance | ☐ Yes ☐ Past |
| Eating Disorder | ☐ Yes ☐ Past |
| Hypoglycemia | ☐ Yes ☐ Past |
| G6PD Marker | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |
| **Inflammatory/Immune** | |
| Rheumatoid Arthritis | ☐ Yes ☐ Past |
| Chronic Fatigue Syndrome | ☐ Yes ☐ Past |
| Food Allergies | ☐ Yes ☐ Past |
| Environmental Allergies | ☐ Yes ☐ Past |
| Multiple Chemical Sensitivities | ☐ Yes ☐ Past |
| Autoimmune Disease | ☐ Yes ☐ Past |
| Immune Deficiency | ☐ Yes ☐ Past |
| Mononucleosis | ☐ Yes ☐ Past |
| Hepatitis | ☐ Yes ☐ Past |

| Other: | ☐ Yes ☐ Past |
|---|---|
| **Musculoskeletal** | |
| Fibromyalgia | ☐ Yes ☐ Past |
| Osteoarthritis | ☐ Yes ☐ Past |
| Chronic Pain | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |
| **Skin** | |
| Eczema | ☐ Yes ☐ Past |
| Psoriasis | ☐ Yes ☐ Past |
| Acne | ☐ Yes ☐ Past |
| Skin Cancer | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |
| **Cardiovascular** | |
| Angina | ☐ Yes ☐ Past |
| Heart Attack | ☐ Yes ☐ Past |
| Heart Failure | ☐ Yes ☐ Past |
| Hypertension (high blood pressure) | ☐ Yes ☐ Past |
| Stroke | ☐ Yes ☐ Past |
| High Blood Fats (cholesterol, triglycerides) | ☐ Yes ☐ Past |
| Rheumatic Fever | ☐ Yes ☐ Past |
| Arrythmia (irregular heart rate) | ☐ Yes ☐ Past |
| Murmur | ☐ Yes ☐ Past |
| Mitral Valve Prolapse | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |
| **Neurologic/Emotional** | |
| Epilepsy/Seizures | ☐ Yes ☐ Past |
| ADD/ADHD | ☐ Yes ☐ Past |
| Headaches | ☐ Yes ☐ Past |
| Migraines | ☐ Yes ☐ Past |
| Depression | ☐ Yes ☐ Past |
| Anxiety | ☐ Yes ☐ Past |
| Autism | ☐ Yes ☐ Past |
| Multiple Sclerosis | ☐ Yes ☐ Past |
| Parkinson's Disease | ☐ Yes ☐ Past |
| Dementia | ☐ Yes ☐ Past |
| **Cancer** | |
| Lung | ☐ Yes ☐ Past |
| Breast | ☐ Yes ☐ Past |
| Colon | ☐ Yes ☐ Past |
| Ovarian | ☐ Yes ☐ Past |
| Prostate | ☐ Yes ☐ Past |
| Skin | ☐ Yes ☐ Past |
| Other: | ☐ Yes ☐ Past |

**MEDICATIONS AND SUPPLEMENTS**

Please list all current prescription medications, over the counter drugs, supplements, and vitamins you take regularly that were not previously listed in earlier sections. Please include any you have taken in the past 3 months.

| Medication/OTC/Supplement | Dosage | Frequency | Last Taken |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever had Semaglutide Injections? □ Yes □ No If yes, when? ___________________

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.) Motrin, Aspirin? □ Yes □ No

Have you had prolonged or regular use of Tylenol? □ Yes □ No

Refund Policy

All sales are final and non-refundable. All treatments/prescriptions are pre paid and cannot be returned or exchanged, refunded, credited or transferred. Monthly Maintenance and or Memberships must be cancelled within 10 days before new charge or it will not be refunded.

Patient Signature: ______________________________________________ Date: _____________________