Presenter: Bill + Clara Bolin

Referer: _____

WHOLE LIFE MATRIX

# Regenerative Therapy Consultation
## Whole Life Wellness
## (432) 837-4207

***Please return to info@wholelifealpine.com FAX (432)837-4205, or mail to: Whole Life 1003 Loop Dr., Alpine, TX 79830, you can also visit our website Healing-Revolution.com and fill out the form online***

**PERSONAL INFORMATION – To be filled out by patient** Date:_____ How did you hear about us?_____

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Phone_____ Email _____

Spouse's Name_____ Phone Number_____

Your Occupation_____ Retired? Yes No **Height**_____ **Weight**_____

**GENERAL SYMPTOMS** *please check ALL* **that apply**

- ☐ Hand pain
- ☐ Hand
- ☐ Numbness
- ☐ Neck pain
- ☐ Low Back pain
- ☐ Hip pain
- ☐ Leg pain
- ☐ Knee pain
- ☐ Foot pain
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Disc issues
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Sleep Problems
- ☐ Foot numbness
- ☐ Vascular Problems
- ☐ A-Fib
- ☐ Plantar Fasciitis
- ☐ Morton's Neuroma
- ☐ COPD
- ☐ Asthma
- ☐ Arthritis in Hand
- ☐ Arthritis in Feet
- ☐ Mobility Problems
- ☐ Sciatica Pinched
- ☐ Nerve Poor
- ☐ Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor wound healing
- ☐ Excessive thirst or urination
- ☐ Organ Transplant
- ☐ Other_____

☐ Cancer - location _____ Metastasis _____ Chemotherapy/Radiation_____ Treatment_____

**PRESENT HEALTH CONDITION**

In order of importance, list the issues you are interested in correcting.

1._____
2._____
3._____

List approximately how long you have noticed these problems.

1._____
2._____
3._____

**SOCIAL HISTORY**

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes daily? _____

Do you drink? ☐ Yes ☐ No If yes, how many drinks daily? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how much exercise daily? _____

Please give name and office phone number of your primary care physician.

Name_____Phone_____

**List previous surgeries and year:**

_____ _____

_____ _____

_____ _____

**List ALL allergies/sensitivities to medication, food etc.:** Reaction:

_____ _____

_____ _____

_____ _____

**List the prescription drugs you are currently taking (or you may attach a list):**

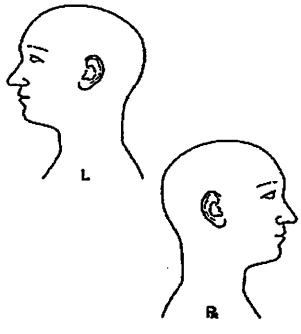
| Name | Dose(mgorIU) | Times Daily |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

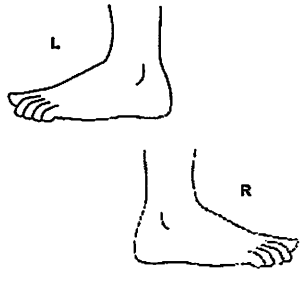
**List all nutritional supplements (vitamins, herbs, homeopathies, etc.):**

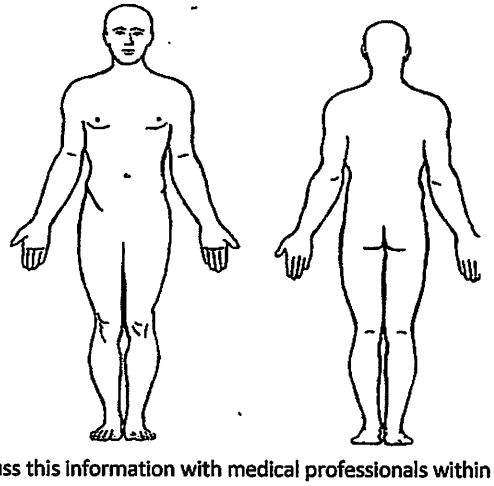
| Name | Dose(mgorIU) | Times Daily |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Please mark the area & type of pain on the drawings using the codes listed below.**

***N-Numbness*** ***T-Tingling*** ***S-Soreness*** ***P-Pain*** ***A–Ache*** ***ST-Stiffness***



This is a confidential record of your medical history. The practitioner reserves the right to discuss this information with medical professionals within our group. Copies of this record can only be released with your specific authorization.

Name_____Signature_____Date_____

*REVISED Aug. 2018*