Rejuva Wellness Client Intake Form
And Wellness Assessment

Last Name: _____ First Name: _____

Address: _____

Zip Code_____ Phone Number _____

Occupation: _____ How did you hear about us? _____

Birth Date:_____Email:_____

What are you three major health and wellness goals?

1. _____

2. _____

3. _____

Has there been a medical diagnosis? ❑ Yes ❑ No – Results

_____

What do you hope to accomplish with your Rejuva Wellness treatment/treatments?

1. _____

2. _____

3. _____

Do you want to improve your overall health and well-being? Yes _____ No _____

What, if any, prescription drugs are you currently taking? _____

_____

Do you have a pacemaker or other electrical device? Yes _____ No _____

Wellness Assessment

Please evaluate the following question where appropriate on a scale of 1 to 5, 5 being the highest and 1 being the lowest.

Do you feel you generally make healthy nutritional choices? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

Where is your fitness level? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

Where is your stress level? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

How well do you sleep at night? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

How many hours do you sleep at night? _____

How is your energy level? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

Do you detox on a regular basis? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

How do you detox? _____

Do you have ongoing pain in your body? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

Where is your pain? _____

Do you have digestive issues? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

Do you have migraines? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

Do you practice self-care on a regular basis? 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

What is your self-care routine? _____

If anything, what would you like to change about your life in general?

_____

Do you smoke? Yes _____ No _____

Please circle all that apply to you.

Anemia Cancer Diabetes Prostate Allergies Rashes Frequent Infections
Headaches Edema Heart Attack Stroke High Blood Pressure Dizziness
Kidney Disease Liver Disease Menstrual Irregularities Asthma Hernia
Arthritis Hypothyroid Hyperthyroid Autoimmune Disease Fainting
Bleeding Menopause Issues High Cholesterol Heartburn Numbness Osteoporosis
Constipation Diarrhea Indigestion

Massage Bed, Pulsed Electromagnetic Field (PEMF) Therapy, Vibration Therapy and Hot Stone Aroma Touch, Sound Therapy and Far Infrared Sauna Contraindications/Precautions and Release:

If you have any of the following conditions, please consult a physician prior to using.

1. Phlebitis (blood clots)
2. Fused discs or implanted spinal / scoliosis
3. Fractures or suspected fractures
1. Epilepsy
4. Metallic implants should consult with your physician about
5. Pacemaker or ICD (Internal Cardiac Device) prior to using Migun products
6. Other mechanical implants
7. Malignant tumors
8. Are currently pregnant
9. Reactive skin disorders such as prickly heat
10. Photo allergic dermatitis rods or any other spinal hardware/implants
11. Are currently being treated for cancer
12. Any condition you have that you feel you should consult with a physician before using
13. Surgery with in the past 6 months
14. Kidney or liver failure
15. Previous stroke

Acknowledgement

It is my choice to receive Rejuva Wellness services. I have completed this form to the best of my knowledge. I understand that Cathy Stopczynski and any other practitioners or employees of Rejuva Wellness LLC are not liable for any unforeseen medical issues that I may experience or complications that may arise that could be related to an undiagnosed, pre-existing medical condition prior to or after my treatment. I will disclose any concerns; health related or otherwise as well as discuss any pre-existing conditions to Rejuva Wellness prior to receiving a treatment. I understand that I am responsible for my service charges at the time of service.

I understand that Cathy Stopczynski or any practitioners of Rejuva Wellness do not diagnose, treat or cure any diseases, illness or injuries.

I acknowledge that these services are not a substitute for medical examination or diagnosis, and that it is recommended I see a primary health care provider for that service.

Signature_____ Date_____

Name Printed _____

Legal Guardian Signature if under 18 years' old

_____ Date_____

Name Printed_____