



**THE REJUVENATION CENTER
PATIENT CONSULT QUESTIONNAIRE**

CONSULT DATE ____/____/____

Name _____ Sex _____ DOB _____ Age _____

Address _____ Occupation _____

Phone Home _____ Work _____ Cell _____ Referred By _____

Primary Care Doctor _____ Neuro/Ortho Doctor _____

Past Medical History: (i.e. Diabetes, High Blood Pressure, Arthritis, etc.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Past Surgical History: (i.e. Tonsillectomy, Back Surgery, Appendix, etc.)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Family History: (i.e. List those in your immediate & extended family who have had back, neck or joint pain)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Social History:

- | | | | |
|------------------------|---------|---------|-------------------------|
| Do you smoke, chew ? | _____ Y | _____ N | If yes, how much: _____ |
| Do you drink alcohol ? | _____ Y | _____ N | If yes, how much: _____ |
| Do you drink coffee ? | _____ Y | _____ N | If yes, how much: _____ |
| Do you use drugs ? | _____ Y | _____ N | If yes, how much: _____ |

Current Medications: (i.e. pain, heart, arthritis, psych meds, vitamins, etc.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Allergy to Medications:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |