Reforming Life
Lifestyle Program

# PATIENT INFORMATION SHEET

**Last Name:** **First Name:** **DOB:**

Birth Sex: ☐ Male ☐ Female

Phone: ____________________

Marital Status: ☐ S ☐ M ☐ W ☐ D

Email: ____________________

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Street Address: ____________________

Zip: ____________________

City: ____________________

State: ____________________

Emergency Contact Name: ____________________

Emergency Contact Phone: ____________________

How did you hear about us?

☐ TV Commercial ☐ Web Ad

☐ Yard Sign ☐ Facebook

☐ Word of Mouth ☐ Google

☐ Other: ____________________

## FEMALES ONLY

Are you currently pregnant or breastfeeding? ☐ Y ☐ N

When was your last menstrual cycle? ____________________

**Patient Signature:** **Date:**

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# LAYING THE GROUNDWORK What is Your Motivation?

**Patient Name:** ______________________ **Date:** ______________

## What are your primary goals for living a healthier lifestyle?

- ☐ Weight loss
- ☐ Falling asleep faster / Better quality of sleep
- ☐ Having more energy / feeling better overall
- ☐ Feeling more clear-headed
- ☐ Relief from chronic pain / headaches & migraines
- ☐ Relief from constipation
- ☐ Feeling less bloated
- ☐ Relief from loose bowls
- ☐ Find foods that may be causing digestion issues
- ☐ Having less “sick days” / Better immune system health
- ☐ Lower Blood Pressure
- ☐ Lower Blood Sugar

## Combatting one or more of the following (check all that apply):

- ☐ Seasonal Allergies
- ☐ Asthma
- ☐ Type II Diabetes
- ☐ Eczema
- ☐ Adult Acne
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Other: ______________________

## Comments:

______________________

______________________

______________________

______________________

______________________

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# HEALTH SCREEN

**Patient Name:** **Date:**

Are you diabetic ☐ Y ☐ N ☐ Unsure

Do you consider yourself to be healthy? ☐ Y ☐ N

Do you feel that you eat nutritious foods most of the time?
☐ Y ☐ N

How many meals and/or snacks do you have per day?

______________________

What are your favorite restaurants?

______________________

______________________

What restaurants do you visit most frequently?

______________________

______________________

What is your favorite type of food/comfort food?

______________________

How often do you cook at home?
☐ 5-7 times/week ☐ 1-2 times/week
☐ 3-4 times/week ☐ Rarely/Never

Do you cook for other household members? ☐ Y ☐ N
If yes, how many? ______________________

Do you have any allergies or dietary restrictions? ☐ Y ☐ N
If Yes, explain: ______________________

Do you need to daily monitor sugar, salt, or fluid intake?
☐ Y ☐ N

Have you ever had surgery for weight loss? ☐ Y ☐ N
If Yes, explain: ______________________

What makes you feel stressed?

______________________

What are your leisure activities?

______________________

What is your current occupation?

______________________

Do you work night shifts? ☐ Y ☐ N

Does your job require that you sit at a desk? ☐ Y ☐ N

Do you have a regular sleep schedule? ☐ Y ☐ N

What time do you normally:
Go to bed: ______________ Wake up: ______________

On average, how many hours of sleep do you get each night?

______________________

In the past year, how often do you exercise?
☐ 5-7 times/week ☐ 1-2 times/week
☐ 3-4 times/week ☐ None

Are you currently involved in regular exercise? ☐ Y ☐ N

Do you have any issues with mobility? ☐ Y ☐ N
If yes, explain: ______________________

What are your personal barriers to exercise?

______________________

______________________

What type of physical activity do you consider fun? ☐ None

______________________

Do you have any negative feelings toward, or have you had any bad experiences with a nutrition or exercise program? ☐ Y ☐ N
If yes, explain: ______________________

______________________

Specifically describe what you would like to accomplish through monitoring your health during the next:

1 month: ______________________

______________________

4 months: ______________________

______________________

1 year: ______________________

______________________

To improve your health in the past, what programs, “diets”, supplements, medications, or professionals have you had success with? ______________________

______________________

Do you start a plan and find it hard to stick to? ☐ Y ☐ N

Are you ready to commit to a plan? ☐ Y ☐ N

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2927 Nall Street • Port Neches, Texas 77651 • Phone: 409.210.3336 • Fax: 409.527.3969 • www.gerstenberg.clinic

# ADULT PAST MEDICAL HISTORY

Full Name: ______________________ DOB: __________ Date: __________

## Check all that apply (please specify)

- ☐ Seasonal or food allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic lung disease (COPD)
- ☐ Carotid artery blockage
- ☐ Stroke
- ☐ TIA
- ☐ Congenital heart disease
  Type: __________
- ☐ Congestive heart failure (CHF)
- ☐ Heart disease – Type: __________
- ☐ High blood pressure or hypertension
- ☐ Blood vessel disease or blood clots
  Specify: __________
- ☐ High cholesterol
- ☐ Diabetes | ☐ Type 1 | ☐ Type 2
- ☐ Thyroid disease – Type: __________
- ☐ Heartburn
- ☐ Reflux
- ☐ Stomach ulcers
- ☐ Headaches
- ☐ Migraines
- ☐ Anemia – Type: __________
- ☐ Liver disease – Type: __________
- ☐ Colon Disease – Type: __________
- ☐ Bladder/Kidney disease – Type: __________
- ☐ Alzheimer's Disease/Memory trouble
- ☐ Seizures
- ☐ Muscle disorder – Type: __________
- ☐ Joint trouble/arthritis – Type: __________
  ☐ Osteoarthritis
- ☐ Sickle cell
- ☐ Skin disease – Type: __________
- ☐ Cancer – Type: __________
- ☐ Autoimmune – Type: __________
- ☐ Other: __________

## Surgeries -Check all that apply (please specify year)

- ☐ NONE
- ☐ Appendix
- ☐ Tubal ligation
- ☐ Tonsils
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Other: __________

## Please list members of household, and relationship

__________

## Please list ALL drug allergies

- ☐ No known allergies

## Social

- ☐ Place of employment, if any: __________
- ☐ Alcohol use (how much) __________
- ☐ Tobacco use – Type: __________ How long? __________

## Do you have a living will?

☐ No ☐ Yes - if yes, please provide a copy for our records

## Females only

- ☐ Last menstrual period:
- ☐ Birth control, if any: __________

| Family History | Father | Mother | Paternal Grandfather | Paternal Grandmother | Maternal Grandfather | Maternal Grandmother |
|---|---|---|---|---|---|---|
| Heart attack | | | | | | |
| Heart disease – Type: | | | | | | |
| High blood pressure | | | | | | |
| High cholesterol | | | | | | |
| Stroke or TIA | | | | | | |
| Sudden death | | | | | | |
| Thyroid disease – Type: | | | | | | |
| Cancer – Type: | | | | | | |
| Diabetes – Type: | | | | | | |
| Other (specify) | | | | | | |

## List ALL medications and supplements currently taking - name, dosage and instructions

Please bring your bottles each visit for clarification!



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