Reforming Life
Lifestyle Program

PATIENT INFORMATION SHEET

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

Gender: ☐ Male ☐ Female

Phone: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D

Email: _____

☐ Opt OUT of gerstenberg.clinic emails

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:**

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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Adult Past Medical History

Name: _____ **Date of Birth:** _____ **Date:** _____

Circle all that apply (please specify)

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

Do you have **living will?** Yes | No
(if Yes, please provide a copy for our records)

Surgeries:
Circle all that apply (please specify)

NONE
Tonsils
Appendix
Gallbladder
Tubal ligation or hysterectomy
Other: _____
_____
_____

Females only:

Last menstrual period: _____
Birth control, if any: _____

Please list ALL drug allergies:

Check here if no known allergies: ☐

_____ _____
_____ _____
_____ _____

Please list members of household, and relationship:

_____ _____
_____ _____
_____ _____

Social:

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

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

List ALL **medications** and **supplements** currently taking: (name, dosage and instructions). Please bring your bottles **each** visit for clarification!

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____