REHABILITATE&REJUVENATE
WELLNESS STUDIO

Client Profile

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Phone: _____ Alternate Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

Known allergies (Food, Drugs, Vaccines, or environmental):

_____
_____
_____

Current health concerns (please list in order of priority):

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications (Prescription, Over the counter drugs, Vitamins, Herbs, Homeopathic Remedies):

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

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Please answer the following questions on your past or present Medical History with YES or NO. **If you are not sure, answer YES**

Could you be pregnant, or are you attempting to become pregnant? _____

Have you ever had or do you currently have…?

_____ Lung disease, any form

_____ Emphysema

_____ Pneumothorax/Collapsed Lung

_____ Chest surgery

_____ Heart failure

_____ High Blood Pressure

_____ Any Electronically implanted medical device (i.e., pacemaker, deep brain stimulator)

_____ Any diseases or conditions involving ears or sinus or surgical interventions

_____ Difficulty in clearing ears during airplanes or pressurized environments like diving

_____ Claustrophobia

_____ Epilepsy/Seizures

_____ Diabetes

_____ Cataracts

Are you presently taking prescription medications for any of the above questions? If so, please specify:

_____
_____
_____
_____
_____

I testify that the information I have provided is true and accurate to the best of my knowledge, and I have been explained the potential risks for any of the above questions that I answered "yes" to and have been given the opportunity to speak to my doctor or a healthcare provider about this.

_____ _____

Signature **Date**