CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____ Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____City_____State____
Zip Code____

Home Phone (___)_____

Email Address_____

Emergency Contact Name and Phone_____

How were you referred to us?_____

MEDICAL HISTORY

Are you currently under the care of a physician? ❑ Yes ❑ **No**

If yes, for what:_____
_____

Do you have any of the following medical conditions? (Please check all that apply)

❑ Diabetes ❑ High blood pressure ❑ Seizure disorder ❑ Thyroid Disease ❑ Cardiac Disease ❑ Lung Disease ❑ Gastrointestinal Disease

Do you have any other health problems or medical conditions? Please list:_____

Allergies

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑ Food ❑ Medication ❑Others:_____

_____

_____

MEDICATIONS

What oral prescription medications are you presently taking? (It is required you list all of them):_____

_____

What herbal supplements do you use regularly?_____

For our female clients:

Are you pregnant or trying to become pregnant? ❑ Yes ❑ No

Are you breastfeeding? ❑Yes ❑No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures. The treatments I receive here are voluntary. I understand there is a risk, including but not limited to, allergic reaction, skin irritation, nausea, vomiting, gastrointestinal upset, and flushing. I release Recovery Hydration Therapy, INC and my provider from liability and assume full responsibility.

Signature_____**Date**_____

FOR PROVIDERS ONLY: **Treatment given:**

VITALS:

Blood pressure_____

Heart rate _____

I acknowledge that I was offered a copy of The Health Insurance Portability and Accountability Act (HIPPA) Privacy Rights. I understand that I may obtain a copy of my privacy rights from Recovery Hydration Therapy, INC.

Signature_____ Date_____