

Rejuvenations Total Health Center

1575 Pine Ridge Rd. Suite #6 Naples, FL 34109
(239) 331-5886

RejuvenationFL.com

Dear Client,

Welcome! ... And thank you for choosing Dr. Repice's TeleHealth Coaching.

HOW THE PROCESS WORKS:

STEP 1:

During your initial Interview, Dr. Repice will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2:

Once you have completed your lab tests, Dr. Repice will explain the meaning of your test results to you in a follow up consultation. He will create an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

STEP 3:

Subsequent consults are scheduled to monitor your progress. Dr. Repice will also design an on-going wellness program to be reviewed and updated with our staff at no charge every six months.

We invite you to contact us via text, email should you have any questions during the course of your treatment. We may also be reached at (239) 331-5886 Hours are by appointment only.

We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

In health,

Dr. Repice and Staff

New Client Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Dr Repice & Rejuvenations, Incorporated to release my personal medical information to me.

Clients Signature: _____

Date: _____

Name:			Date:		
Address:				Country:	
City:		State:		Zip/Postal Code:	
Home Phone:		Cell:		Work:	
E-mail:			Emergency Contact:		
Please mark your preference for occasional follow up communication from our office: <input type="checkbox"/> Email <input type="checkbox"/> Phone					
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:	
Occupation:		Employer:		Years Employed:	
Spouse's Name:		Occupation:		Employer:	
Person responsible for this account:			Referred by:		
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ **Height** _____ **Blood Pressure** (if known) _____ **% Body Fat** (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____
please list (attach sheet if necessary)

2. In the past, have you used birth control pills and/or antibiotics? _____

a. For how long? _____

3. If you have fillings, please list material(s) used: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often? _____

b. How often do you drink caffeinated beverages? _____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.): _____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

a. Do you “miss” these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

12. What methods have you tried to lose/gain weight _____

13. How is your energy level? _____

a. Are there times in the day that you feel best? _____ worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress _____

16. How do you deal with your stress? _____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes _____ No _____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes _____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes _____ No _____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes _____ No _____

e. Now and then I think I am a secret eater. Yes _____ No _____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes _____ No _____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes _____ No _____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No _____

i. I feel shaky if I don't eat on time or if I don't snack. Yes _____ No _____

j. I often find myself irritable or angry. Yes _____ No _____

18. Check off any of the following that have applied to you within the last 30 days:

<input type="checkbox"/> Do you feel nauseous?	<input type="checkbox"/> Do you have abdominal/intestinal pain?
<input type="checkbox"/> Do you have bloating?	<input type="checkbox"/> Do you get bloated after meals?
<input type="checkbox"/> Do you get heartburn?	<input type="checkbox"/> Do you have diarrhea?
<input type="checkbox"/> Do you have constipation?	<input type="checkbox"/> Do you travel outside of the U.S.?
<input type="checkbox"/> Do you have gas?	<input type="checkbox"/> Are your stools compact/hard to pass?
<input type="checkbox"/> Do you belch following meals?	<input type="checkbox"/> Do you have gurgles in your stomach?
<input type="checkbox"/> Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit _____ Below average _____ Average _____ Above average _____ Very fit _____

25. How often do you exercise? _____

a. What is your regimen? _____

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? _____

27. What are your fitness goals? (circle all that apply)

General fitness endurance	Muscle toning
Weight loss/maintain weight	Muscle strengthening
Osteoporosis prevention	Muscular coordination/balance
Specific sport enhancement	Other
Flexibility	

28. Surgeries, starting with most recent: _____

29. Hospitalizations: _____

30. Briefly describe where you have lived since childhood: _____

31. What is your heritage? (Irish, German, Spanish, etc.) _____

32. Circle “Now” or “Past” for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	Do you often:
Now Past Satisfactory	Now Past Feel depressed
Now Past Boring	Now Past Have anxiety
Now Past Demanding	Do you often:
Now Past Unsatisfactory	Now Past Have irrational fears
	Now Past Feel upset
Do you worry over:	Do you often:
Now Past Home life	Now Past Feel things go wrong
Now Past Marriage	Now Past Feel things go wrong
Now Past Children	Now Past Feel shy
Now Past Job	Now Past Cry
Now Past Income	Now Past Feel inferior
Now Past Money problems	Have you:
	Now Past Seriously considered suicide
	Now Past Attempted suicide

POLICIES AND PROCEDURES

(please retain pg. 6 for your records)

New Clients

First Appointment

Your first Client Interview will be 45 minutes – 1 hour (\$300). During this time Dr. Repice will determine the appropriate lab tests you should order to address your specific health concerns.

Fee Schedule

New Client Coaching Program: (\$300) (45 minutes - 1 hour)

1 hour: (\$300)

30 minutes: (\$150)

15 minutes: (\$75)

- ☞ Payment is due at time of the Coaching Call
- ☞ Methods of payment are: All Major Credit Cards

- ☞ All Coaching Calls are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments

- ☞ Follow-up Coaching may be scheduled in 15, 30, or 60-minute blocks of time.
- ☞ We encourage you to book your appointments 2 weeks in advance.
- ☞ As a courtesy to you, our office will message you to confirm your appointment in advance. You may also receive a reminder via email.

Lab Tests

- ☞ The results of your lab test(s) will be sent to Dr. Repice 2 to 4 weeks after mailing your specimens to the lab.
- ☞ Dr. Repice will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.
- ☞

Cancellations

- ☞ If you are unable to keep your scheduled appointment, you must notify our office a minimum of 48 hours before your scheduled time or you may be charged for that appointment.

Returned Products

- ☞ **PRE-APPROVAL is REQUIRED on ALL RETURNS!!**
- ☞ Prepaid lab tests can be returned for credit within 30 days of purchase.

Important Notes

- ☞ Dr. Repice is not a medical doctor; he does not service medical emergencies.
If you have a medical emergency, you must contact your primary care physician or dial 911!
- ☞ Please contact the office if you are not clear on any of our policies or procedures.

I _____ have read and understood
Dr. Repice and Rejuvenations, Inc Policies and Procedures.

(please print name)

Date _____

Signature _____

Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: Dr. Ronald Repice & Rejuvenations, Incorporated

Address: 1575 Pine Ridge Rd. Suite #6 Naples, FL 34109

I, _____ request the following information:

- | | | | |
|---------------------------------------|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Test results | <input type="checkbox"/> History | <input type="checkbox"/> Records | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Reports | <input type="checkbox"/> Progress | |

concerning my: Accident Injury Illness

Other _____

To be released to: _____
(Name of Practitioner, Doctor, family member etc.)

Address: _____

Fax: _____

For the purpose of: _____
(Specify)

According to Florida Statute, these records must be provided within 15 days of receipt of this notice.

Signed: _____ **Date:** _____

- | | | | |
|----------------------------------|---------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent | <input type="checkbox"/> Guardian |
|----------------------------------|---------------------------------|---------------------------------|-----------------------------------|