

Complete all applicable fields. This intake helps the medical team understand your history, concerns, and goals.

1. PATIENT INFORMATION

First Name	Last Name	DOR	Sex at Birth
Phone	Email		
Address			
City	State	ZIP	Contact: ☐ Call ☐ Text ☐ Email
Emergency Contact	Relationship	Phone	

2. HOW DID YOU HEAR ABOUT RELIFE?

☐ Physician / Provider

☐ Friend / Family

☐ Current / Former Patient

☐ Google / Search

☐ Social Media

☐ ReLifeRegen.com

☐ Attorney / Law Firm

☐ Professional Referral

☐ Event / Ad

☐ Other

Referral name

3. REASON FOR VISIT

Primary reason for your visit

When did this concern begin?

Treatments, medications, procedures, or therapies already tried

What would you most like to accomplish through treatment?

4. SERVICES / AREAS OF INTEREST - CHECK ALL THAT APPLY

☐ Regenerative Medicine

☐ PRP Therapy

☐ Orthopedics / Joint Pain

☐ Brain Mapping / qEEG

☐ Peptide Therapy

☐ Medical Weight Management

☐ Cosmetic Surgery Recovery

☐ Not Sure - Recommend

☐ Stem Cell / Biologic Therapy

☐ HBOT

☐ Sports Injury Recovery

☐ TBI / Concussion Recovery

☐ Hormone Optimization

☐ Hair Restoration

☐ Sexual Wellness / ED

☐ Other

☐ Exosome Therapy

☐ Pain Management

☐ Brain / Cognitive Wellness

☐ Anti-Aging / Longevity

☐ IV Vitamin / Wellness

☐ Aesthetic / Cosmetic

☐ Personal Injury / Accident

Other

5. CURRENT SYMPTOMS

☐ Pain

☐ Inflammation / swelling

☐ Fatigue / low energy

☐ Headaches

☐ Weight concerns

☐ Slow healing

☐ Joint pain / stiffness

☐ Limited mobility

☐ Brain fog

☐ Dizziness

☐ Hormonal symptoms

☐ Poor recovery / performance

☐ Back pain

☐ Muscle weakness

☐ Memory problems

☐ Sleep problems

☐ Low libido / dysfunction

☐ Other

☐ Neck pain

☐ Numbness / tingling

☐ Difficulty concentrating

☐ Anxiety / stress

☐ Hair thinning / loss

Briefly describe your main symptoms

Pain now? ☐ Yes ☐ No Location 0-10 Duration

6. MEDICAL HISTORY - CHECK CURRENT OR PREVIOUS CONDITIONS

☐ High Blood Pressure	☐ High Cholesterol	☐ Heart Disease
☐ Heart Attack	☐ Stroke / TIA	☐ Blood Clots / DVT
☐ Diabetes	☐ Prediabetes / Insulin Resistance	☐ Thyroid Disorder
☐ Kidney Disease	☐ Liver Disease	☐ Asthma / Lung Disease
☐ Sleep Apnea	☐ Seizure Disorder	☐ Migraines / Headaches
☐ Traumatic Brain Injury	☐ Concussion	☐ Neurological Disorder
☐ Autoimmune Disease	☐ Arthritis / Osteoarthritis	☐ Osteoporosis
☐ Chronic Pain	☐ Cancer	☐ Anxiety
☐ Depression	☐ Bleeding / Clotting Disorder	☐ Anemia
☐ Other	☐ None	

Explain significant conditions selected above

7. SURGERIES & HOSPITALIZATIONS

Ever had surgery / significant procedure? ☐ Yes ☐ No

If yes, list procedure(s) and approximate date(s)

Hospitalized within last 5 years? ☐ Yes ☐ No

If yes, explain

8. MEDICATIONS, SUPPLEMENTS & ALLERGIES

Current prescription medications - include dose/frequency if known

Vitamins, supplements, peptides, hormones, injections, or wellness products

Medication allergies? ☐ Yes ☐ No

If yes, list allergy and reaction

Other allergies (food, latex, environmental)

9. PREVIOUS REGENERATIVE / WELLNESS TREATMENTS

☐ PRP	☐ Stem Cell / Biologic	☐ Exosomes	☐ Peptides
☐ Hormone Replacement	☐ IV Therapy	☐ HBOT	☐ Joint Injections
☐ Cortisone Injections	☐ Weight-Loss Medication	☐ None	

If applicable, describe treatment, approximate date, and results

10. LIFESTYLE

Nicotine: ☐ Current ☐ Former ☐ Never Alcohol: ☐ None ☐ Occasional ☐ Weekly ☐ Daily

Exercise: ☐ Rarely ☐ 1-2/wk ☐ 3-4/wk ☐ 5+/wk Sleep hrs Stress

11. PREGNANCY / REPRODUCTIVE SCREENING - COMPLETE IF APPLICABLE

Pregnant / possibly pregnant?

☐ Yes☐ No☐ Unsure

Breastfeeding?

☐ Yes☐ No

Trying to become pregnant?

☐ Yes☐ No

Menopausal / Perimenopausal?

☐ Yes☐ No☐ N/A

12. PRIMARY CARE & OTHER MEDICAL PROVIDERS

Primary Care Physician

Practice

Phone

Specialists currently treating you

13. RECENT TESTING

☐ Blood Work / Labs☐ Hormone Panel☐ MRI☐ CT Scan☐ X-Ray

☐ Ultrasound☐ Neurological Testing☐ Cardiac Testing☐ Other☐ None

Approximate dates and relevant details

14. PERSONAL INJURY / ACCIDENT INFORMATION

Related to accident / personal injury case?

☐ Yes☐ No

Date

Type:

☐ Auto☐ Slip/Fall☐ Work☐ Sports☐ Other

Attorney / Law Firm

Phone

Attorney / Case Manager

Receiving treatment elsewhere for this injury?

☐ Yes☐ No

Provider

15. HEALTH GOALS

☐ Reduce Pain☐ Improve Mobility☐ Recover From Injury

☐ Avoid / Delay Surgery☐ Improve Memory / Focus☐ Increase Energy

☐ Improve Sleep☐ Lose Weight☐ Improve Metabolic Health

☐ Balance Hormones☐ Improve Sexual Wellness☐ Restore Hair

☐ Improve Appearance / Skin☐ Recover From Surgery☐ Improve Athletic Performance

☐ Healthy Aging / Longevity☐ Improve Overall Wellness☐ Other

If treatment is successful, what would you most like to see improve?

16. ADDITIONAL INFORMATION

Anything else the ReLife medical team should know?

17. INTAKE ACKNOWLEDGMENT

I certify that the information provided is complete and accurate to the best of my knowledge. I understand that completion of this intake does not guarantee that I am a candidate for any particular treatment. Treatment recommendations will follow an appropriate medical evaluation. I will inform ReLife Regenerative of relevant changes to my health information.

Full Name

Date

Signature

ReLife Regenerativ

18. NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

ReLife Regenerative provides a Notice of Privacy Practices explaining how protected health information may be used and disclosed, patient privacy rights, ReLife's responsibilities, and how to contact the practice regarding privacy matters. By signing below, you acknowledge receipt of or access to the current Notice. This acknowledgment is not an authorization for disclosures that otherwise require separate authorization.

- ☐ I received or was given access to ReLife Regenerative's Notice of Privacy Practices.
- ☐ I understand I may request a paper copy.

Full NameDateSignature

19. COMMUNICATION AUTHORIZATION

ReLife may contact me regarding appointments, scheduling, billing, care coordination, and practice-related matters using the methods I select. I understand ordinary text and email may carry privacy risks and I may update my preferences.

- ☐ Phone Call
- ☐ Text / SMS
- ☐ Email
- ☐ Voicemail
- Phone

Email

Full NameDateSignature

20. FINANCIAL POLICY

I understand that I am financially responsible for charges for services provided to me except as otherwise required by law, payer contract, or written agreement. Insurance verification or authorization is not a guarantee of payment. I am responsible for applicable non-covered services, deductibles, copayments, coinsurance, and patient-responsibility amounts. Some regenerative, wellness, longevity, aesthetic, and other services may be self-pay or not covered by insurance. Charges and applicable payment terms will be communicated before services. Unpaid balances may be subject to reasonable billing and collection efforts consistent with applicable law.

- ☐ I have read and understand the Financial Policy.

Full NameDateSignature

21. CANCELLATION / NO-SHOW POLICY

Please provide at least 24 hours' notice to cancel or reschedule. A late cancellation or missed appointment may result in a fee when permitted by law and disclosed by the practice. Procedure deposits, prepaid services, or special-order products may have separate written terms. Emergencies and exceptional circumstances may be reviewed by the practice.

Current late cancellation / no-show fee (if applicable)

- ☐ I understand the cancellation / no-show policy.

Full NameDateSignature

22. GENERAL CONSENT TO EVALUATION & ROUTINE CARE

I voluntarily consent to evaluation by ReLife Regenerative's licensed health care professionals and to routine clinical services appropriate for my visit. No specific outcome can be guaranteed. Procedures, medications, injections, biologic/regenerative treatments, HBOT, hormone or peptide therapies, weight-management treatment, IV therapy, aesthetic procedures, and other treatment-specific services may require separate screening and informed-consent documents before treatment.

☐ I consent to evaluation and routine care as described above.

Full Name _____ Date _____ Signature _____

23. TELEHEALTH CONSENT - COMPLETE IF TELEHEALTH IS USED

I consent to health care services through telehealth when offered and clinically appropriate. Telehealth uses electronic communications between a patient and provider in different locations. Potential limitations include technology failure, reduced ability to perform a hands-on examination, and privacy/security risks inherent in electronic communication. An in-person evaluation, testing, urgent care, or emergency services may be recommended when appropriate. I may ask questions and may decline or stop a telehealth encounter, subject to clinical and legal limitations.

☐ I consent to telehealth services when applicable.

Full Name _____ Date _____ Signature _____

24. AUTHORIZATION TO DISCUSS CARE WITH ANOTHER PERSON - OPTIONAL

Complete only if you want ReLife Regenerative to discuss scheduling, billing, or health information with another person. You may revoke this permission by notifying ReLife, except to the extent action has already been taken in reliance on it.

Authorized Person _____ Relationship _____

Phone _____ May discuss: ☐ Scheduling ☐ Billing ☐ Medical

Full Name _____ Date _____ Signature _____

25. FINAL PACKET ACKNOWLEDGMENT

I had the opportunity to review this packet and ask questions. I understand these are general administrative policies and consents and do not replace treatment-specific informed consent. I understand ReLife Regenerative may update policies as permitted by law and will make current versions available.

- ☐ Privacy acknowledgment
- ☐ Communication authorization
- ☐ Financial Policy
- ☐ Cancellation Policy
- ☐ General Consent
- ☐ Telehealth, if applicable

Full Name _____ Date _____ Signature _____

Guardian relationship, if applicable _____

Before publishing: insert ReLife's actual cancellation/no-show fee, privacy contact information, effective date, and any practice-specific payment/deposit terms. Post the full Notice of Privacy Practices separately.