

# THE RENKENS CENTER

3811 Bedford Ave. Suite 104  
Nashville, TN 37215  
(615) 915-3188

## New Patient Information

Welcome! Please print clearly and read all information carefully. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### ABOUT YOU

Full Name: \_\_\_\_\_ Gender:  M  F Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

WHOM MAY WE THANK FOR THE REFERRAL? \_\_\_\_\_

### REASON FOR YOUR VISIT

If you have no specific symptoms or complaints, and you are here for Performance Care and Wellness Services, please check (X) here \_\_\_\_ and skip to the Past History section of this form. All others please answer the following questions pertaining to your complaint.

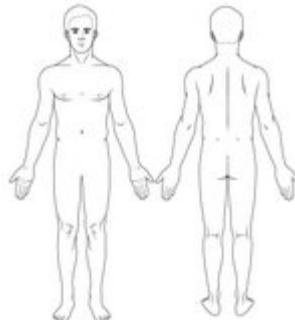
Please briefly describe your chief complaint: \_\_\_\_\_

When was the onset of your complaint: \_\_\_\_\_

Have you had this condition or one similar to it in the past?  Yes  No

If you are experiencing pain, is it...  Sharp  Dull Ache  Numbness  Tingling  Burning

Please use the figures below to accurately mark the areas in which you feel these sensations.



Rate your pain on a scale of 1-10, 10 being the worst: \_\_\_\_\_

Since the problem started, it is...  Getting Better  Getting Worse  About the Same

How frequent is the condition?  Constant  Intermittent  Worse in the morning  Worse at night

Is the condition interfering with your:  Work  Sleep  Training  Daily Routine

What makes it worse? \_\_\_\_\_

Is there anything you can do to relieve the problem? \_\_\_\_\_

Has another doctor treated you for this problem?  Y  N

Chiropractors: \_\_\_\_\_

Medical Doctors: \_\_\_\_\_

Others: \_\_\_\_\_

Were X-rays and/or other imaging procedures performed?  Y  N

Are there any other conditions or symptoms that may be related to your major symptom?  Y  N

If yes, what? \_\_\_\_\_

Have you ever been in an auto accident?  Past Year  Past 5 Years  Over 5 Years  Never

## PAST HISTORY

At The Renkens Center we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and optimal daily performance. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to achieving your optimal health and performance.

Please check all symptoms you are currently experiencing, or have had significant difficulty with in the past.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headache               | <input type="checkbox"/> Constipation                | <input type="checkbox"/> Numbness in Feet           |
| <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Trouble Urinating           | <input type="checkbox"/> Joint Stiffness / Soreness |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Kidney Stones or Infections | <input type="checkbox"/> Swollen Ankles             |
| <input type="checkbox"/> Sciatica               | <input type="checkbox"/> Stomach Upset After Eating  | <input type="checkbox"/> Rapid Heart Rate           |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> Heartburn                   | <input type="checkbox"/> Slow Heart Rate            |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Weak Muscles                | <input type="checkbox"/> Chest Pain                 |
| <input type="checkbox"/> Tired After Eating     | <input type="checkbox"/> Paralysis                   | <input type="checkbox"/> Wheezing                   |
| <input type="checkbox"/> Blurred Vision         | <input type="checkbox"/> Shakiness / Tremors         | <input type="checkbox"/> Chronic Cough              |
| <input type="checkbox"/> Earache                | <input type="checkbox"/> Hip Pain                    | <input type="checkbox"/> Dizziness / Lightheaded    |
| <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Knee Pain                   | <input type="checkbox"/> Bruise Easily              |
| <input type="checkbox"/> Loss of Smell          | <input type="checkbox"/> Shoulder Pain               | <input type="checkbox"/> Varicose Veins             |
| <input type="checkbox"/> Trouble Swallowing     | <input type="checkbox"/> Cold Feet                   | <input type="checkbox"/> Skin Eruptions (Rash)      |
| <input type="checkbox"/> Sinusitis              | <input type="checkbox"/> Cold Hands                  | <input type="checkbox"/> Depression                 |
| <input type="checkbox"/> Trouble Sleeping       | <input type="checkbox"/> Frequent Urination          | <input type="checkbox"/> Mood Swings                |
| <input type="checkbox"/> Teeth Grinding         | <input type="checkbox"/> Dry Hands                   | <input type="checkbox"/> Fractures                  |
| <input type="checkbox"/> Cold Sweats            | <input type="checkbox"/> Irritability                | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Hot Flashes            | <input type="checkbox"/> Nervousness                 | <input type="checkbox"/> Sprain / Strain            |
| <input type="checkbox"/> Menstrual Irritability | <input type="checkbox"/> Pins and Needles in Arms    | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Irregular Cycle        | <input type="checkbox"/> Pins and Needles in Legs    | _____   |
| <input type="checkbox"/> Infertility            | <input type="checkbox"/> Numbness in Hands           |   |

## SCARS / SURGICAL PROCEDURES:

Please list all scars and surgical procedures you have had: \_\_\_\_\_

**YOUR HABITS:**

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke / Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**WORK ACTIVITY:**

- Heavy Labor       Light Labor
- Mostly Sitting     Mostly Standing
- Driving             Walking / Moving

**SUPPLEMENTS:**

Do you take vitamins / minerals or herbs?     Y     N

If yes, please list them here: \_\_\_\_\_

If yes, who recommended them? \_\_\_\_\_

Do you take muscle gain or weight loss supplements?     Y     N

Do you take any prescribed medications?     Y     N

If yes, please list all and why you take them here:

\_\_\_\_\_

**YOUR DAILY ROUTINE:**

Do you wear orthotics?     Yes     No

How often do you exercise?     5-7 days / week     3-4 days / week     1-2 days / week     None

What kind?     Running     Walking     Hiking     Cycling     Duathlon / Triathlon  
 Elliptical Trainer     Stair Climber     Weight Lifting     Circuit Training  
 Kickboxing     Yoga / Pilates     Dancing     Other: \_\_\_\_\_

What is your average water intake per day?     64+ oz.     32-64 oz.     16-32 oz.     < 8 oz.

How many meals do you eat per day?     5+     4     3     2     1

How many hours of sleep do you get at night?     8+ hrs.     7-8 hrs.     6-7 hrs.     5-6 hrs.     < 5 hrs.

On a scale of 1-10, 10 being the best, rate your overall level of health: \_\_\_\_\_ out of 10.

**TREATMENT:**

Are you interested in  TEMPORARY RELIEF or  PERMANENT SOLUTIONS to your problem(s)?

Are you healthier than you were 5 years ago?  Yes  No

If not, what has contributed to the decline of your health?

---

Will you be healthier 5 years from now than you are today?  Yes  No

If yes, what are the action steps you will take to make it happen?

---

I understand that the above information and the statements made on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in medical status. I authorize Dr. Josh Renkens to perform any necessary services during diagnosis and treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Authorization for care of a minor:

I hereby authorize The Renkens Center and its doctor to administer care as they so deem necessary to my son / daughter.

\_\_\_\_\_  
Signature of parent / guardian

\_\_\_\_\_  
Date