PATIENT HISTORY

C. ROBYN BERRY LMT · CRR · CCT · CLDT
RB Institute, Inc. • 13601 McGregor Blvd #13, Ft Myers, FL 33919 • 239-939-4646
MM7376 • MA018351 • CRR1148 • CE9985423

Date _____

Please take a moment to read carefully. If you have a specific condition or specific systems, therapies may be contradicted (not recommended). A referral from your primary care provider may be needed prior to service being provided. We reserve our rights to refuse or discontinue any treatment according to contraindications, noncompliance with ethic codes or sexual misconduct while still retaining or collecting fee for appointment.All payments will be made prior to going into treatment rooms unless otherwise arranged. ***We require a 24 hour minimal notice for cancellation to allow time to contact any standby patients. If 24 hour notice is not given or you do not show for your appointment, you, the patient, will be charged for the full cost of the therapy booked to the debit/credit card on file or will be billed to your address listed.*** All returned checks will be charged $50 fee to patient. There will be a $25 fee accessed and charged per month for any outstanding balances left unpaid on your account. All payments are due in full when and if any billing occurs. The patient is responsible to pay for any and all filing fees, postage, document and legal fees incurred by RB Institute, Inc. or C. Robyn Berry for collection of fees for appointments and/or services.

I have read and understand the above conditions:_____
signature of patient and/or person responsible for payment of services

What therapies do you plan to use or are interested in? (✔CHECK ANY)

❒ Massage therapeutic/Sports/Swedish	❒ Craniosacral/Somatic Emotional Release	❒ Heart Centered Therapy
❒ Ozone/O2 Steam Cabinet	❒ Far Infrared Sauna	❒ Visceral Manipulation
❒ Lymph Drainage	❒ Colon Hydrotherapy	❒ Reflexology
❒ Detox Foot Bath	❒ Salt Glow Exfoliation Scrubs	❒ Hands & Feet Parafin Treatments
❒ Raindrop Therapy	❒ Aroma Therapy	❒ Ear Candling

Name: _____Birth Date:_____
Address: _____ City:_____ State _____ Zip_____
Phone:_____Cell Phone _____
Fax: _____Email: _____
If paying for services by credit card #:_____
Age:_____ Marital Status:_____ Sex: ❒ Male ❒ Female
Occupation: _____
Name of Work Place: _____
Phone: _____ Fax:_____
Would you like us to send you info, newsletters, updates, etc? ❒ Yes ❒ No Thank You
How did you hear about us?_____

FOR COLONICS ONLY - PLEASE ANSWER THE FOLLOWING:

Amount of purified water you drink every day_____(You should be drinking half your body weight in ounces per day) **Number of meals per day:** _____
What do you normally eat?: _____
_____

Are you currently: ❒ Fasting ❒ Dieting ❒ On a specific cleanse? If yes: _____

How many bowel movements per day?:_____ **When was your last bowel movement?:**_____

Type of stool: ❒ Hard/Balls ❒ Constipation ❒ Soft ❒ Diarrhea ❒ Mucus ❒ Bloody ❒ Worms ❒ Gallstones

Color of stool: ❒ White ❒ Yellow/Blonds ❒ Light Brown ❒ Green ❒ Dark Brown ❒ Orange ❒ Black

What kind of laxatives are used?:_____

What kind of difficulties during bowel movement?: ❒ Gas ❒ Cramping ❒ Straining ❒ Pain ❒ Bloating ❒ Incomplete

FOR THERAPIST USE ONLY PEDIATRIC ADULT BLOOD TYPE: O B A AB

PATIENT HISTORY CONTINUED

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Please check only what applies

CARDIOVASCULAR
- ❒ Heart Problems
- ❒ High Blood Pressure
- ❒ Low Blood Pressure
- ❒ Cold Hands
- ❒ Cold Feet
- ❒ Varicose/Spider Veins
- ❒ Phlebitis
- ❒ Edema (where) _____
- ❒ Stroke (date)_____
- ❒ Angina/Chest Pains
- ❒ Rapid Heartbeat
- ❒ Irregular Heartbeat
- ❒ Congenital Heart Failure
- ❒ By Pass Surgery
- ❒ Pacemaker
- ❒ Valve Disfunctions_____
- ❒ Aneurysm (where)_____
- ❒ Mitro Valve Problems

MUSCLE/JOINT
- ❒ Arthritis (where)_____
- ❒ Bursitis_____
- ❒ Back Pain
- ❒ Neck Pain
- ❒ Sprains_____
- ❒ Swollen Joints_____
- ❒ Numbing Limbs_____
- ❒ Herniated Disc
- ❒ Broken Bones_____
- ❒ Fusions_____
- ❒ Sciatica
- ❒ Rotator Cuff
- ❒ Joint Replacements_____
- ❒ Metal Parts_____

GENITO URINARY
- ❒ Kidney Infection
- ❒ Kidney Stones
- ❒ Kidney Failure
- ❒ Nephritis
- ❒ Painful Urination
- ❒ Cystitis

MEN
- ❒ Prostate Problems
- ❒ Frequent Urination
- ❒ Prostate Cancer

WOMEN
- ❒ Abnormal VG Discharge
- ❒ Breast Pain
- ❒ Pregnant (Due Date)_____
- ❒ Last Period_____
- ❒ Painful Menses
- ❒ Miscarriages/Abortions_____
- ❒ Hysterectomy_____

GENERAL
- ❒ Headache/Migraines
- ❒ Insomnia
- ❒ Dizziness
- ❒ Fainting Spells
- ❒ Seizures
- ❒ Chronic Fatigue
- ❒ Depression
- ❒ Thyroid Dysfunctions_____
- ❒ Blurred/Double Vision
- ❒ Cramping_____
- ❒ Loss of Balance
- ❒ Tinnitus/Ringing of ears
- ❒ Contagious Diseases_____
- ❒ Cancers (What Type) _____

SKIN
- ❒ Open Wounds
- ❒ Psoriasis
- ❒ Eczema
- ❒ Bruise Easy
- ❒ Dryness
- ❒ Fungus
- ❒ Itching/Burning
- ❒ Rash
- ❒ Cysts/Fibrous Tumors
- ❒ Acne
- ❒ Rosaceae
- ❒ Shingles

RESPIRATORY
- ❒ Shortness of Breath
- ❒ Chronic Cough
- ❒ Emphysema
- ❒ Bronchitis
- ❒ Asthma
- ❒ Sinusitis
- ❒ Tuberculosis
- ❒ Pneumonia

GASTROINTESTINAL
- ❒ Abdominal Hernia
- ❒ Colitis
- ❒ Constipation
- ❒ Diarrhea
- ❒ Crohn"s Disease
- ❒ Diabetes
- ❒ Hypoglycemia
- ❒ Ulcers
- ❒ Diverticulitis/Diverticulosis
- ❒ Hemorrhoids Internal/External
- ❒ Fissures/Fistulas
- ❒ Liver Problems
- ❒ Cirrhosis
- ❒ Rectal Bleeding
- ❒ Vomiting of Blood/Bile
- ❒ Colon Cancer (Diagnosis)
- ❒ Gallstones/Surgery_____
- ❒ Appendectomy_____

ANY SURGERIES NOT CHECKED IN THE PAST 5 YEARS

_____
_____
_____
_____

LIST MEDICATIONS AND WHAT THEY ARE FOR

_____
_____
_____
_____

Nutritional Supplements: (Herbs. Probiotics, Enzymes, Vitamins/Minerals, Homeopathics: _____

_____

_____

Physical Activities/Exercise: ❒ Light ❒ Moderate ❒ Heavy ❒ Never/None **Do you use:** ❒ Alcohol ❒ Drugs ❒ Tobacco ❒ Caffeine

How many hours of sleep do you generally get?_____ **How is your appetite:** ❒ Fair ❒ Light ❒ Moderate ❒ Heavy

Do you have specific food cravings?: _____

List any allergies and your reaction to these: _____

_____

_____

Position you assume or repeated motion daily: _____

Reason for appointment or major complaint:_____

_____

_____

How did this condition develop?: ❒ Auto Accident ❒ Domestic Accident ❒ Work Related Incident ❒ Other _____

_____