



Client: Kelly Rohde (6235)

Nov 20, 2025

1. Please note: fields with a red asterisk are mandatory.

Legal First Name: <u>Kelly</u>	Legal Last Name: <u>Rohde</u>	Date of Birth: <u>11/27/1982 (age 42)</u>		
Minor's Guardian Full Name, If Applicable: _____	Gender: <u>Female</u>	Street Address of Residence: <u>3916 NE gardenia Ln.</u>	Apt./Unit #: _____	
City of Residence: <u>Ankeny</u>	State of Residence: <u>IA</u>	Zip Code: <u>50021</u>	Mobile Phone: <u>(515) 238-8473</u>	
Email: <u>k.rohde1127@gmail.com</u>				

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to:

Appointment made?

Yes

Project Body Wellness

3. Please state the date and time of the appointment:

November 20 530pm

4. Check all treatments to have now or possibly would like in the future below: *Note: MedScape GFE does not determine the treatment route and/or dosages nor prescribes. Project Body Wellness advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☒ T-Shape 2

5. Please answer the questions below relating to the selected treatment(s) above:

Have had selected treatment(s) before?

No

Result of previous treatment(s)?

Not applicable

Goal of requested treatment(s)? Select ALL that apply.

☒ Reduce Cellulite ☒ Tighten Skin

☒ Fat loss reduction

If needed, please explain further below:

6. Under any type of medical care? (i.e. PCP, OB/GYN, allergist, naturopath, mental health, specialist)

No

7. For female assigned gender at birth:

Currently pregnant? ☒ No

Trying to become pregnant? ☒ No

Could possibly be pregnant? ☒ No

Currently breastfeeding? ☒ No

Going through IVF/Planning on IVF in the near future? ☒ No

8. List ALL medications below including homeopathic supplements and vitamins. If none apply, please write in "none".

	Name of Medication and Dose:	Start Date:
1	None	

9. List ALL surgeries and hospitalizations below. This includes ALL implantation of objects placed in the body that one is not born with ie devices, stents, piercings. If none apply, please write in "none".

	Type of Surgery/Hospitalization/Implant and Location:	Date and Year of Surgery/Hospitalization/Implant:
1	Appendix	2008

10. List ALL allergies below and/or dietary restrictions. If none apply, please write in "none".

	Type of Allergy:	Reaction:
1	None	

11. Vitals & Measurements

Height (ft/in or cm)

5'7

Weight (lbs or kg)

145

Have you noticed any recent changes in your weight?

Yes

Do you have personal wellness or body goals you'd like us to know about?

No

If "other", please specify

12. Health History - Circulatory and Respiratory System (Please select all that apply):

☒ Cold Hands and/or Feet

Poor circulation

13. Health History - Nervous System (Please select all that apply):

☒ None of these

If "other", please specify

14. Health History - Digestive System (Please select all that apply):

☒ **None of these**

If "other", please specify

15. Health History - Skin (Please select all that apply):

☒ **Melasma**

Face

If "other", please specify

☒ **Rosacea**

Slight

16. Health History - Other (Please select all that apply):

☒ **Anxiety**

If "other", please specify

17. Health History - Cancer

Have you ever been diagnosed with cancer?

No

Has any immediate family member (parents, siblings, children) been diagnosed with cancer?

Yes

If "other", please specify

If yes, please specify type, date of diagnosis, and current status (active, in remission, or treated) N/A for No.

NA

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.

Mother-skin50, uterine28, blood60

18. Health History - Mental Health & Emotional Well-Being

Do you have a history of depression, anxiety, or other mental health conditions?

Yes

Have you ever been hospitalized for a mental health condition?

No

If "other", please specify

If yes, are you currently receiving treatment (medication, counseling, or therapy)? N/A for none.

NA

If yes, please specify when and which hospital. N/A for none.

Na

19. Health History - Sexual Health & Hormones

Do you experience sexual dysfunction (low libido, erectile difficulties, vaginal dryness, or other concerns)?

No

If yes, please specify. N/A for none.

Na

Have you noticed changes in your energy, mood, or sleep patterns that you think may be hormone-related?

No

Would you like to have a hormonal evaluation via lab work?

No

If "other", please specify

Have you ever had a hormone evaluation (testosterone, estrogen, thyroid, cortisol, etc.)?

No

20. Health History - Hair & Skin Health

Do you currently experience hair loss, thinning, or shedding?

Yes

Would you like a consultation about hair loss?

No

If "other", please specify

Have you tried any treatments for hair loss in the past?

Yes

Do you have a history of skin disorders (acne, eczema, psoriasis, etc.)?

No

21. Please answer the lifestyle questions below:

Average stress level:

Moderate

On average, how many days per week for alcohol consumption?

Occasionally (a few times a month)

On average, how many glasses of fluids (including water, juice, and decaffeinated tea) are consumed daily? (Glass = 8 ounces)

Around 4-8 glasses

Smoke, vape, or chew tobacco?

Trying to quit

Recreational drugs?

None

Currently following any specific diet plan? If so, please specify which one(s): ☒ **None of these**

22. Approval and/or deferral to medical director's SOPs (description of treatment(s) that client is approved and/or deferred for). Please select all that apply treatments for approved and/or deferred to medical director's SOPs with Project Body Wellness . MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if Project Body Wellness medical director allows for off label treatment(s). For any off label administration and dosage, Project Body Wellness must follow policies and procedures as approved by your clinics medical director. If Project Body Wellness medical director does not allow for said off label treatment(s), the good faith exam note provided by MedScape GFE's and the high-level provider will be null and void.

Treatment for client is approved or denied to receive at Project Body Wellness (select ALL that apply to visit):

☒ **T-Shape 2**

Treatment is deferred to Project Body Wellness medical director's SOPs with the reason(s) for deferral. If no explanation(s) is/are necessary, please write "not applicable":

Na

Clarification(s) needed from the client before approval. The client MUST resubmit with clarification(s) requested by the good faith exam high-level provider. If the client does not provide what the good faith exam high-level provider requests, the note is void, and therefore, the client is denied. If no explanation(s) is/are necessary, please write "not applicable":

Na

Term(s) of approved treatment:

☒ 1 year (unless medical condition(s) change, medication(s) change and/or anything if anything is added to what is stated and approved in this GFE. If any of the aforementioned apply, the client must be re-seen at the time of discovery AND before their next appointment/treatment(s)

Provide explanation(s) for short-term approval(s) (under one year approval). If no explanation(s) is/are necessary, please write "not applicable":

Na

e-signature

Nov 21, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

Signed by Danielle Trenelli on Nov 21, 2025 at 02:06 PM from IP 71.127.239.***