REGENESIS
STEM CELL

Client: Cole Rasmussen (6319) Dec 03, 2025

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

Legal First Name: Cole
Legal Last Name: Rasmussen
Date of Birth: 2/20/1991 (age 34)
Minor's Guardian Full Name, If Applicable:
Gender: Male
Street Address of Residence: 612 w cedar hill dr
Apt./Unit #:
City of Residence: Saint George
State of Residence: UT
Zip Code: 84790
Mobile Phone: (801) 673-8650
Email: onlineleads07@gmail.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to: Regenesis Wellness
Appointment made? Yes

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

Today

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. Regenesis Wellness advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☑ Regenerative IV Therapy
☑ Peptide Therapy/Weight Loss

5. Please answer the questions below relating to Regenerative IV Therapy

Have had selected treatment(s) before? No
Result of previous treatment(s)? Not applicable
Goal of requested treatment(s)? Select ALL that apply.
☑ Boost energy and stamina
☑ Support overall wellness and performance
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. List ALL medications below including homeopathic supplements and vitamins. If none apply, please write in "none".

	Name of Medication:	Start Date:
1	None	

8. 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:	Date and Year of Surgery/Hospitalization:
1	None	

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

	Type of Allergy:	Reaction:
1	Fish	Stomach ache

10. Vitals & Measurements

Height (ft/in or cm)
6ft

Weight (lbs or kg)
193

Have you noticed any recent changes in your weight?
No

Do you have personal wellness or body goals you'd like us to know about?
No

If "other", please specify

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

☑ Other

Narcolepsy

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

☑ Fatigue ☑ Narcolepsy

If "other", please specify

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

☑ Bloating

If "other", please specify

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

☑ Cold Sores

If "other", please specify

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

☑ Anxiety

If "other", please specify

16. Health History - Cancer

Have you ever been diagnosed with cancer?
No

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

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

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.
Dad, skin cancer, prostate cancer. Approximately 60 years old.

If "other", please specify

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

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

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

Have you ever been hospitalized for a mental health condition?
No

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

If "other", please specify

18. Health History - Hair Health

Do you currently experience hair loss, thinning, or shedding?
No

Have you tried any treatments for hair loss in the past?
No

If "other", please specify

19. Please answer the lifestyle questions below:

Average stress level:
High

Smoke, vape, or chew tobacco?
Trying to quit

On average, how many days per week for alcohol consumption?
None

Recreational drugs?
None

On average, how many glasses of fluids (including water, juice, and decaffeinated tea) are consumed daily? (Glass = 8 ounces)
Around 4-8 glasses

Currently following any specific diet plan? If so, please specify which one(s): ☑ Low-Fat

20. 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 Regenesis 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 Regenesis Wellness medical director allows for off label treatment(s). For any off label administration and dosage, Regenesis Wellness must follow policies and procedures as approved by your clinics medical director. If Regenesis 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(s) client is approved and/or denied to receive at Regenesis Wellness (select ALL that apply to visit):
☑ Regenerative IV Therapy ☑ Peptide Therapy/Weight Loss

Treatment(s) deferred to Regenesis 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(s) (select ALL that apply):
☑ 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 treatment name(s) and 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 Dec 03, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Tangular Barnes, FNP-BC

*Signed by Tangular Barnes on Dec 03, 2025 at 09:29 AM from IP 45.17.88.****