Reclaim Health

Client: Melissa Price (6172) Nov 14, 2025

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

Legal First Name: Melissa

Legal Last Name: Price

Date of Birth: 2/28/1978 (age 47)

Minor's Guardian Full Name, If Applicable:

Gender: Female

Street Address of Residence: 1004 Sterling Dr

Apt./Unit #:

City of Residence: Waxhaw

State of Residence: NC

Zip Code: 28173

Mobile Phone: (352) 281-8899

Email: mizu28@gmail.com

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

Appointment made? Yes

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

11/14/25 @ 10:00am

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

☑ T-Shape 2 Cellulite Reduction

☑ T-Shape 2 Skin Tightening

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

If needed, please explain further below:

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

Yes

7. "Yes" for medical care was selected. Please list the provider's name(s) and their speciality.

	Name	Speciality
1	Dr Salisbury	Primary Care

8. For female assigned gender at birth:

Currently pregnant? ☑ No

Could possibly be pregnant? ☑ No

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

Trying to become pregnant? ☑ No

Currently breastfeeding? ☑ No

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

	Name of Medication and Dose:	Start Date:
1	Adderall ER 10mg BID	05/01/23
2	Trulicity 1mg Sub Q Weekly	03/01/2025

10. 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	Appendectomy	01/1992
2	Ex-Lap/Laporodomy w/ Ovarian Cystectomy for Orvarian Torsion	06/1997
3	C-section	02/2012
4	Lap Chole	03/2013
5	C-section	11/2016

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

	Type of Allergy:	Reaction:
1	Bananas	Hives
2	Demerol	nausea/Vomiting
3	Metronidazole	Swelling
4	Ionositol	Hives

12. Vitals & Measurements

Height (ft/in or cm)
5'6"

Weight (lbs or kg)
230

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?
Looking to lose another 30lbs.

If "other", please specify

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

☑ Asthma
Stress induced peri-menopause

☑ Other
Diabetes

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

☑ None of these

If "other", please specify

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

☑ Diarrhea
IBS

☑ Gallstones
Lap Chole

☑ Irritable Bowel Syndrome

If "other", please specify

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

☑ Acne

☑ Hives
Allergy related

☑ Rosacea

☑ Sensitive

If "other", please specify

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

☑ Diabetes Type 2

If "other", please specify

18. 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.
N/A

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.
Father

If "other", please specify
NHL @ 68y

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

Do you have a history of depression, anxiety, or other mental health conditions?
No

If yes, are you currently receiving treatment (medication, counseling, or therapy)? N/A for none.
No

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

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

If "other", please specify

20. 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.
N/a

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

Have you ever had a hormone evaluation (testosterone, estrogen, thyroid, cortisol, etc.)?
No

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

If "other", please specify

21. Health History - Hair & Skin Health

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

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

Would you like a consultation about hair loss?
No

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

If "other", please specify
Rosacea

22. Please answer the lifestyle questions below:

Average stress level:
High

Smoke, vape, or chew tobacco?
None

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): ☑ None of these

23. 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 Reclaim Health. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if Reclaim Health's medical director allows for off label treatment(s). For any off label administration and dosage, Reclaim Health must follow policies and procedures as approved by your clinics medical director. If Reclaim Health's 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 Reclaim Health (select ALL that apply to visit):

☑ T-Shape 2 Cellulite Reduction ☑ T-Shape 2 Skin Tightening

Treatment(s) deferred to Reclaim Health 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 Nov 14, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

*Signed by Danielle Trenelli on Nov 14, 2025 at 09:12 AM from IP 71.127.239.****