NEW PATIENT INTAKE FORM

PATIENT INFORMATION

FIRST NAME:	LAST NAME:
DATE OF BIRTH:	SEX: ☐ MALE ☐ FEMALE ☐ PREFER NOT TO SAY
PHONE:	EMAIL:
STREET ADDRESS:	CITY:
STATE: ZIP CODE:	OCCUPATION:
HEIGHT: WEIGHT:	AGE:
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED	
HOBBY:	HOW DID YOU HEAR ABOUT US?

HEALTH & WELLNESS HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A PRIMARY CARE PHYSICIAN? ☐ YES ☐ NO
IF YES, WHAT IS THEIR NAME AND PHONE NUMBER?
ARE YOU CURRENTLY TAKING ANY PRESCRIPTION DRUGS? ☐ YES ☐ NO
IF YES, WHAT ARE THEY?
DO YOU HAVE ANY PRE-EXISTING MEDICAL CONDITIONS (DIABETES, HYPERTENSION, ETC.)? ☐ YES ☐ NO
IF YES, WHAT ARE THEY?
WHAT PHARMACY DO YOU USE?
DO YOU HAVE ANY ALLERGIES TO MEDICATION OR FOOD?
DO YOU DRINK ALCOHOL? ☐ NEVER ☐ RARELY ☐ OCCASIONALLY ☐ FREQUENTLY ☐ DAILY
DO YOU USE TOBACCO? ☐ NEVER ☐ E-CIGARETTE ☐ CIGARETTES ☐ CHEWING TOBACCO

DO YOU SUFFER FROM ANXIETY OR DEPRESSION?
DO YOU FEEL STRESSED? ☐ YES ☐ NO
DO YOU SUFFER FROM UNCONTROLLABLE CRAVINGS? ☐ YES ☐ NO
DO YOU EAT BECAUSE OF YOUR EMOTIONS? ☐ YES ☐ NO
DO YOU FEEL TIRED OR OUT OF ENERGY? ☐ YES ☐ NO
HAS YOUR DOCTOR ADVISED YOU TO LOSE WEIGHT? ☐ YES ☐ NO
HAVE YOU EVER BEEN ON A WEIGHT LOSS PROGRAM BEFORE? ☐ YES ☐ NO
HAVE YOU EVER TRIED MEDICATIONS AND/OR DIET SUPPLEMENTS FOR WEIGHTLOSS? ☐ YES ☐ NO
DOES YOUR WEIGHT PROBLEM CAUSE YOU ANY PHYSICAL PAIN? ☐ YES ☐ NO
HOW OFTEN DO YOU EAT FAST FOOD? ☐ NEVER ☐ ONCE/WEEK ☐ 2-3 TIMES/WEEK ☐ 4+ TIMES/WEEK
DESCRIBE YOUR ACTIVITY LEVEL: ☐ INACTIVE ☐ LIGHT ☐ MODERATE ☐ VIGOROUS
DOES YOUR FAMILY SUPPORT YOUR WEIGHT LOSS EFFORTS? ☐ YES ☐ NO

IN CASE OF EMERGENCY, PLEASE PROVIDE AN EMERGENCY CONTACT.

NAME:	
RELATIONSHIP:	PHONE:

WHAT IS THE MOST IMPORTANT ELEMENT IN DECIDING TO USE OUR SERVICES?

Circle ONE of the four

EFFECTIVENESS: "My results are my top priority."
TIME: "I want results quickly."
SERVICE: "I need extra support along the way."
AFFORDABILITY: "I need this to be affordable."

I do hereby agree and give consent to the physician to furnish medical care and treatment considered necessary and proper in diagnosing and treating my condition.

SIGNATURE: _____ **DATE:** _____

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