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?

WHAT PHARMACY DO YOU USE?

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION DRUGS? ☐ YES ☐ NO

IF YES, WHAT ARE THEY?

DO YOU HAVE ANY PRE-EXISTING MEDICAL CONDITIONS (HYPERTENSION, ETC.)? ☐ YES ☐ NO

IF YES, WHAT ARE THEY?

DO YOU HAVE ANY ALLERGIES TO MEDICATION OR FOOD?

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A SURGERY? ☐ YES ☐ NO

IF YES, PLEASE LIST DATES AND WHAT FOR.

DO YOU SUFFER FROM ANXIETY OR DEPRESSION?

DO YOU USE TOBACCO? ☐ NEVER ☐ E-CIGARETTE ☐ CIGARETTES ☐ CHEWING TOBACCO
DO YOU DRINK ALCOHOL? ☐ NEVER ☐ RARELY ☐ OCCASIONALLY ☐ FREQUENTLY ☐ DAILY
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
HOW MANY CHILDREN UNDER 18 LIVE WITH YOU?
ARE YOU CURRENTLY BREASTFEEDING? ☐ YES ☐ NO ☐ N/A

EMERGENCY CONTACT INFORMATION

NAME:	
RELATIONSHIP:	PHONE:

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:** _____

Act On
WEIGHT & WELLNESS CARE

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