

# Intake Form

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell phone : (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Primary care provider: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Other doctors or practitioners you have seen in the past year: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds BMI: \_\_\_\_\_

Highest weight in the last two years: \_\_\_\_\_ pounds

Lowest weight last two years: \_\_\_\_\_ pounds

Desired Weight: \_\_\_\_\_ pounds

## HEALTH HISTORY

Are you pregnant? Yes \_\_\_ No \_\_\_ Due Date \_\_\_\_\_

### Personal Medical History:

High cholesterol	yes	no	Arthritis	yes	no
High blood pressure	yes	no	Cancer	yes	no
Diabetes	yes	no	Osteoporosis	yes	no
Heart Disease	yes	no	Thyroid disorder	yes	no
Obstructive Sleep Apnea	yes	no	Gout	yes	no
Depression	yes	no	Anxiety	yes	no
Insomnia	yes	no	Kidney Disease	yes	no
Stroke	yes	no	Migraine Headache	yes	no

Other: \_\_\_\_\_

Please list all previous surgeries: \_\_\_\_\_

Please list any food intolerances or allergies: \_\_\_\_\_

Please list any medication intolerances or allergies: \_\_\_\_\_



## Intake Form *(continued)*

Please list all prescription medications, supplements and over-the-counter medications:

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### Family Medical History (Parents, Grandparents, Siblings, Children):

High cholesterol	yes	no	Arthritis	yes	no
High blood pressure	yes	no	Cancer	yes	no
Diabetes	yes	no	Osteoporosis	yes	no
Heart Disease	yes	no	Thyroid disorder	yes	no
Obstructive Sleep Apnea	yes	no	Gout	yes	no
Depression	yes	no	Anxiety	yes	no
Insomnia	yes	no	Kidney Disease	yes	no
Stroke	yes	no	Migraine Headache	yes	no

Other: \_\_\_\_\_

### Social History:

Do you use tobacco products? Yes No If yes, please describe: \_\_\_\_\_

How many alcoholic beverages do you drink in a week?: \_\_\_\_\_

Are you living alone? Yes No

If you don't live alone, who lives with you? \_\_\_\_\_

Who does the grocery shopping? \_\_\_\_\_

How often? \_\_\_\_\_

Who does most of the cooking? \_\_\_\_\_

If given a recipe would you prefer: (a) someone else cook it? (b) Cook it yourself?

How often do you eat out? \_\_\_\_\_ Where? \_\_\_\_\_

Have you made any changes to your diet recently? Yes No

If yes, please explain \_\_\_\_\_

Is there anything else you feel we should know? \_\_\_\_\_

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