

INTAKE FORM

Patient Name: _____ Date: _____ DOB: _____

Email: _____ SS #: _____ Male Female

Home phone: _____ Cell Phone: _____

Check appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's Address: _____ City _____ State _____ Zip _____

Employer Name: _____

Spouse or Patient's Guardian name: _____ Spouse's Employer: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____ Phone _____

Can we contact you via: phone email text mail May we leave a voicemail at the above numbers? Yes No

Do you have any Medical insurance? Yes No if yes, complete the following:

Name of insurance: _____ Are you the insurance carrier? Yes No

If no, name of the insurance carrier: _____ Relationship _____ DOB _____

I am interested in discussing the following programs:

Hormone Replacement Therapy Weight Loss/Semaglutide Science Based Nutrition B12 Injections

HISTORY OF PRESENT ILLNESS & HEALTH HISTORY

Past Medical History

	Personal	Family		Personal	Family		Personal	Family
AIDS/HIV			Eczema			Mental Illness		
Alcohol Abuse			Epilepsy			Migraines		
Anemia			Gallbladder Disorder			Mitral Valve Prolapse		
Anxiety			Glaucoma			Obesity		
Arthritis			Headaches			Organ Transplant		
Asthma			Heart Disease			Pancreatitis		
Back Pain			Hepatitis A B C			Pneumonia		
Bladder Infections			High Blood Pressure			Psoriasis		
Bleeding Disorder			High Cholesterol			Retinopathy		
Blood Transfusion			Hives			Stroke		
Bronchitis			Infectious Mono			Thyroid Disease		
Cancer			Insomnia			Tuberculosis		
Convulsions/Seizures			Irregular Pulse			Ulcer		
Depression			Joint Pain			Venereal Disease		
Diabetes			Kidney Disease			Other:		
Drug Abuse			Liver Disease			Other:		
Eating Disorder			Low Blood Pressure					

Primary Care Provider Information:

Name: _____ Phone: _____ Clinic: _____

Previous Hospitalizations/Surgeries/Serious Illnesses:

When?

Hospital, City, State

Allergies (food, medications, environmental) & Reaction:

Prescribed Medications: None

Over the Counter Medications/Supplements: None

Have you ever used any hormone or other anabolic steroids (prescription or otherwise) in the past? Yes No

If yes, what type, how long did you use them for, who prescribed them, and why did you stop? _____

Patient Social History & Health Habits:

Behavior Style

- You are always calm and easy going You are usually calm and easy going You are sometimes calm and easy going
- You are seldom calm and persistently driving for advancement You are never calm and have overwhelming ambition
- You are hard-driving and never relax

Excessive Exposure at home or at work to: Fumes: ____ Dust: ____ Solvents: ____ Airborne Particles: ____ Noise: ____

Exercise – please select only one

- Sedentary (no exercise) Mild Exercise (climbing stairs, walking, golf)
- Occasional Vigorous Exercise (work or recreation less than 4x/week for 30 minutes)
- Regular Exercise (work or recreation 4x/week or more for 30 minutes or more)

Diet

Are you currently dieting? Yes No

If yes, are you on a physician-prescribed medical diet? Yes No

How many meals do you eat in an average day? _____

Rank your salt intake: Low Medium High

Rank your fat intake: Low Medium High

Rank your sugar intake: Low Medium High

Caffeine

Rank your caffeine intake: None Low Medium High

What types of caffeine do you drink? Coffee Tea Soda

How many cups/12 oz cans per day? _____

Alcohol

Do you drink alcohol? Yes No

If yes, what kind? Beer Liquor Wine

How many drinks per week? _____

Tobacco

Do you use tobacco? Yes No
If yes, what kind & how much? Cigarettes – pks/day Chew – #/day Pipe - #/day Cigars - #/day
How many years? _____
If you previously use tobacco, what year did you quit? _____

Drugs

Do you currently use recreational or street drugs? Yes No
Have you ever taken street drugs with a needle? Yes No

Sex

Are you sexually active? Yes No
If yes, are you trying to get pregnant? Yes No
Are you currently pregnant or actively breast feeding? Yes No
If you are not trying to get pregnant, what contraceptive do you use? _____
How old were you at the onset of menstruation? _____ Date of last menstruation: _____
How often do you get your period (days)? _____ Number of pregnancies: _____ Number of live births: _____
Heavy periods, irregularity, spotting, pain or discharge?

Sleep

Do you have any diagnosed sleep conditions? Yes No
If yes, what? _____
Do you have trouble falling asleep or staying asleep? Yes No
How many hours of sleep do you get per night? _____

Weight History:

1. What is your current weight? What is the desired amount of weight you'd like to lose? What is your height?
2. What is the main reason you decided to lose weight?
3. When did you begin gaining excess weight? (give reasons if known)
4. Where do you carry most of your weight? (ex. stomach, hips, thighs, face, arms, etc)
5. What do you think is the main cause of your weight problem?
6. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
7. Is your significant other overweight?

8. How often do you dine out? What restaurants do you frequent? What types of food do you eat there?
9. What foods do you avoid?
10. What foods do you crave?
11. Do you awaken hungry during the night?
12. What are your worst food habits?
13. What are your snack habits?
14. Rate your body from 1-10, with 10 being perfect. How would you describe your body?
15. If you could change one thing about your body, what would it be?
16. What do you feel will be your obstacle(s) to successful weight loss?
17. What is your typical breakfast? What time? Where? With whom?
18. What is your typical lunch? What time? Where? With whom?
19. What is your typical dinner? What time? Where? With whom?
20. What are your overreaching health goals?
21. Any additional comments you think would be helpful to the provider

REVIEW OF SYSTEMS

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands/feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Bloody Stool	1 2 3 4 5
Moodiness	1 2 3 4 5
Nervousness	1 2 3 4 5

Skin

Rashes	1 2 3 4 5
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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of the Patient, Parent or Guardian

Date

Above content reviewed by provider: _____

Date: _____