New Patient Intake Form

Name

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| --- | --- | --- |
|  |  |  |

 First Middle Last

SOCIAL SECURITY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Male
* Female

Address

|  |
| --- |
|  |

 Street Address

|  |
| --- |
|  |

 Address Line 2

|  |  |  |
| --- | --- | --- |
|  |  |  |

 City State Zip

Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**As part of the American Recover & Reinvestment Act, healthcare providers are required to obtain the following information. Please select which most applies to you.**

* American Indian/Alaska Native
* Native Hawaiian/Pacific Islander
* Black/African American
* White/Caucasian
* Asian Hispanic/Latino
* Decline to specify

Insurance INFO (to be utilized for insurance purposes w/labs & meds)

Insurance Name/ID/Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer

|  |
| --- |
|  |

Occupation

|  |
| --- |
|  |

Employer Phone

|  |
| --- |
|  |

Spouse/Partner

|  |
| --- |
|  |

Spouse/Partner Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT

|  |  |  |
| --- | --- | --- |
|  |  |  |

 Name Phone Relationship

Individuals available to access health information (Name & Phone):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current (or previous) PCP/Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current (or previous) PCP/Clinic Address (City & State):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current (or previous) PCP/Clinic Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy name & phone number

|  |  |
| --- | --- |
|  |  |

**How did you hear about our practice? Select all that apply.**

* Word of mouth *Referred by*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Printed information & ad copy
* Online via webpage
* Social media

**Please answer the questions truthfully and to the best of your knowledge. This will allow the Provider to develop a personalized treatment plan. Your honest answers are greatly appreciated. If it does not apply, write N/A.**

**Personal health history**

What are your goals for treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medical conditions you have been diagnosed with:

|  |
| --- |
|  |

Surgeries (including month/date if known)

|  |
| --- |
|  |

Hospitalizations/ER/UC visits (including month/date if known – for the past yr)

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| --- |
|  |

Have you ever been on hormone replacement therapy (HRT) or weight loss treatments?

* Currently receiving treatment
* Previously received treatment

If you previously received HRT or weight loss meds, briefly describe your history of use:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications, vitamins, supplements you are taking.

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|  |

Please list any drug allergies you have.

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|  |

**Health Habits**

Exercise:

* Sedentary
* Mild exercise
* Moderate exercise
* Regular vigorous exercise

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you dieting? If so, explain.

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Please describe your alcohol intake.

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| --- |
|  |

Do you use tobacco? If so, how much.

|  |
| --- |
|  |

Do you use recreational or street drugs? If so, what?

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| --- |
|  |

**Family Health History**

**\*Please describe your family health history in the space provided. Please include conditions such as prostate cancer, heart attacks, stroke, diabetes, high blood pressure, etc. Please include their age or if they are deceased.**

* Father
* Mother
* Paternal Grandmother
* Paternal Grandfather
* Maternal Grandmother
* Maternal Grandfather
* Siblings
* Children
* UNKNOWN

**Preventive Medical Care**

**\*Please describe your preventive medical care in the space provided. Include outcome or findings of procedure(s) – if abnormal please explain. Include date & location of procedure in the space provided.**

* Medical/GYN exam within the last 1/3/5 yrs
* Mammo in the last 12 months
* Bone density in the last 12 months
* Pelvic US in the last 12 months
* Prostate Exam – PSA screening or DRE in the past 12 months
* Colonoscopy in the last 3/5/10 yrs
* **Do you need to obtain or schedule any preventive health exams? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**High Risk Past Medical/Surgical History**

**\*Please describe your high risk past medical/surgical history in the space provided. Please include details w/date of diagnosis, facility and location for treatment received.**

* Breast Cancer
* Cervical Cancer
* Uterine Cancer
* Ovarian Cancer
* Total Hysterectomy (w/removal of ovaries)
* Partial Hysterectomy (still have ovaries)
* Oophorectomy (removal of ovaries)
* Testicular Cancer
* Prostate Cancer
* Colon Cancer

**Birth Control Method**

**\*Please describe your birth control method in the space provided, if pertinent. Include date started with medication or date and facility if procedure completed.**

* Menopause
* Hysterectomy
* Tubal ligation
* Prescription birth control
* Vasectomy

**Additional Services:**

**\*Please indicate any additional wellspa services you may be interested in.**

* Men’s health niche services **OTHER** *Please list*
* Wt loss services
* Nutritional education and guidance
* Oral nutritional supplementation
* Vitamin injection therapy
* Peptide therapy
* Anti-aging services
* Botox & fillers
* Focused dermatology services (place a check by each, as appropriate, if so).
	+ ACNE TREATMENT
	+ SOLAR LENTIGO AKA age or liver spots (sun exposure treatment)
	+ CRYOTHERAPY (skin tag removal)
* FACIALS/SKIN SPA treatments
* TEEN CLUB: acne treatment, facials/skin spa treatments
* Women’s health niche services
* IV lounge
* Primary care services



PROVIDER NOTE SECTION: