Nourish'd
Wellness Center and Spa

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Intake Form:

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Other: _____

Date of Birth: _____ (MM/DD/YY) Age _____ Sex: M/F Marital Status: M/S/W/D

Email: _____ How did you hear about our office: _____

Occupation: _____ Employer: _____

In case of emergency, please contact: Name: _____ Number: _____

What are your main complaints?

- Fatigue or low energy
- Stress
- Poor diet due to busy lifestyle
- Brain fog or trouble concentrating
- Low mood or depression
- Headache or migraines
- Weight gain or difficulty losing weight
- Slow metabolism
- Asthma and Allergies
- Recent surgical procedure
- Recent illness
- Cold or flu symptoms
- Facial wrinkles or fine lines
- Dull or dry skin
- Malabsorption issues
- Other _____

Which statements best describe why you are here today?

- I want to have more energy and feel better overall
- I want to do everything I can to nourish my body
- I want to do everything I can to enhance my weight loss efforts
- I want to prevent getting sick
- I want to recover quickly from my surgery or illness
- I want to slow he aging process
- I want to fee and look younger
- I want to have smother, brighter and more vibrant skin
- I want to cleanse my body of toxins
- I want to recover quickly from a hangover
- Other _____

Medical History

Are you pregnant or breastfeeding? Yes / No Date of last Lab testing _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

Please check all that apply

- High magnesium levels
- High Calcium levels
- Low Potassium levels
- High iron levels
- Other _____

Are you a diabetic? YES / NO Are you a smoker? Yes / No IF yes, how much? _____

Do you drink Alcohol? Yes / No IF yes how much and how often? _____

Do you use any recreational drugs? Yes / No IF Yes, What and when did you last use? _____

Please list everything you are currently taking:

Prescription Medication-Strength-Frequency-Condition being treated

_____
_____
_____
_____

Over the Counter Drugs-Strength-Frequency-Condition being treated Vitamins and Other Supplements-Strength-Frequency-Condition being treated

_____
_____
_____
_____
_____
_____

 Name and Date of Birth: _____

Medical History Continued

Do you have any medication or food allergies? Yes / No If Yes, please list: _____

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No

Do you take any steroids, i.e., Prednisone? Yes / No

Do you have any of the following conditions? (Please check all that apply)

- Blood pressure problems (High or Low)
- Heart Problems
- Stroke or "mini-stroke"
- Kidney Problems
- Kidney Stones
- Asthma
- Optic Nerve Atrophy or Leber's Disease
- Sickle Cell Anemia
- G6PD Deficiency
- Sarcoidosis
- Parathyroid problems (High levels)

List any other medical conditions you have (not mentioned above):

_____

_____

_____

_____

List of all surgical procedures you've had with approximate dates:

_____

_____

_____

_____

Is there anything else you'd like the nurse and physician to know?

_____

_____

_____

 Name and Date of Birth: _____