Whole Body Solutions LLC

PATIENT INTAKE&REGISTRATION FORM

Patient Information:

Full Name: _____

Date Of Birth: _____ Age: _____ ☐ Female ☐ Male

Address: _____ City: _____ ZIP Code: _____

E-mail: _____ Phone: _____

Preferred Contact Method: Phone Email Text _____

Emergency Contact Name: _____

Relationship Phone#: _____

Insurance Information:

Primary Insurance Provider: _____

Policy Number: _____

Group Number: _____

Subscriber Name (if not patient): _____

Relationship to Patient: _____

Financial Responsibility

I understand that I am financially responsible for any charges not paid by my insurance. Insurance coverage does not guarantee payment. Any remaining balance is my responsibility and payment is due within fourteen (14) days of receipt of the billing statement.

_____ _____

Signature Date

Allergies:

☐ None/Known Allergies
☐ Adhesive Tape
☐ Anesthesia
☐ Aspirin
☐ Codeine
☐ Dairy Products
☐ Iodine/Shellfish/Contrast
☐ Latex
☐ Morphine
☐ Penicillin
☐ Other

Social History:

Do you drink alcohol? ☐ Yes ☐ No

☐ Daily ☐ Weekly ☐ Infrequently ☐ Recovering Alcoholic

Do you smoke? ☐ Yes ☐ No If yes, packs per day: _____

Do you drink caffeine? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Infrequently

Are you sexually active? ☐ Yes ☐ No

Do you wish to be checked for STDs? ☐ Yes ☐ No

Surgery History

Type of Surgery	Year/Date	Doctor	Location

Medical History (check all that apply):

- ☐ None of the problems listed
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis Conditions
- ☐ Asthma
- ☐ Arterial Fibrillation
- ☐ Bleeding Problems
- ☐ BPH
- ☐ CAD (Coronary Artery Disease)
- ☐ Cancer
- ☐ Cardiac Arrest
- ☐ Celiac Disease
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Erectile Dysfunction
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Heart Disease
- ☐ Hyperinsulinemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypogonadism (Male)
- ☐ Hypothyroidism
- ☐ Infection Problems
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Problems
- ☐ Menopause
- ☐ Migraines/Headaches
- ☐ Neuropathy
- ☐ Onychomycosis
- ☐ Organ Injury
- ☐ Osteoporosis
- ☐ Pulmonary Embolism
- ☐ Seizure Disorders
- ☐ Shortness of Breath
- ☐ Sinus Conditions
- ☐ Stroke
- ☐ Syndrome X
- ☐ Tremors
- ☐ Wheat Allergy
- ☐ Other:

Medication List: