

**New Life Center for Health & Wellness**

Patient Intake Form

Patient Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Age \_\_\_

Name of Spouse or Parent \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

May we give any medical information/results to your spouse? \_\_\_ Yes \_\_\_ No

May we contact your spouse at work if necessary? \_\_\_ Yes \_\_\_ No

May we leave lab/x-ray results on your answering machine? \_\_\_ Yes \_\_\_ No

May we email you with medical information? \_\_\_ Yes \_\_\_ No

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Single \_\_\_ Married \_\_\_

Spouse SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Spouse Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_ May we contact you at work? \_\_\_ Yes \_\_\_ No

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Referred By \_\_\_\_\_ Family M.D. \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Person not living in your household to contact in case of an emergency:

Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

To Our Patients:

Fees for services rendered are payable at the time of service unless previous arrangements have been made. We accept cash, check, Visa, Mastercard. We will be happy to supply you with a medical invoice for the purposes of requesting reimbursement from your insurance, however most insurance companies unfortunately do not yet cover this "alternative" or "complimentary" care. We will not provide your information to any insurance provider without your prior authorization.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**SURGERIES** (include skin, eye, orthopedic, etc):

Type of Surgery Month/Year Type of Surgery Month/Year

- 1. \_\_\_\_\_ Date: \_\_\_\_\_
- 2. \_\_\_\_\_ Date: \_\_\_\_\_
- 3. \_\_\_\_\_ Date: \_\_\_\_\_
- 4. \_\_\_\_\_ Date: \_\_\_\_\_
- 5. \_\_\_\_\_ Date: \_\_\_\_\_
- 6. \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY** (i.e.: ulcers, stroke, high blood pressure, arthritis, thyroid, cholesterol, etc.). Please DO NOT include your reason for seeing your medical provider TODAY, this will be addressed in another section.

<u>Problem or Diagnosis</u>	<u>Date of Onset or Diagnosed</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Women: Date of last period: \_\_\_\_\_  
Are your cycles regular \_\_\_ Yes \_\_\_ No    Number of Pregnancies: \_\_\_\_\_  
Number of live births: \_\_\_\_\_ Number of miscarriages/abortions: \_\_\_\_\_  
Last Mammogram: \_\_\_\_\_ Last colonoscopy: \_\_\_\_\_  
Last PAP smear: \_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATIONS:**

<u>Name</u>	<u>Dose (milligrams)</u>	<u>How Often/Day</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

**CURRENT SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS**

<u>Name</u>	<u>Dose (milligrams)</u>	<u>How Often/Day</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

**DRUG ALLERGIES:**

<u>Name of Drug</u>	<u>Type of Reaction</u> (i.e. rash, hives, shortness of breath, upset stomach, etc.)
_____	_____
_____	_____
_____	_____

**HABITS:**

Please list any special dietary restrictions or diet followed (vegetarian, vegan, diabetic, food avoidances, etc.)

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

How many cups of coffee or other caffeinated beverages do you drink per day? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ Did you use tobacco in the past? \_\_\_\_\_

What year did you quit? \_\_\_\_\_ How many packs per day? \_\_\_\_\_ How many total years have you used? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much per day? \_\_\_\_\_  
Type? \_\_\_\_\_

Have you ever used intravenous drugs? (this information will remain confidential) \_\_\_\_\_

Please check one:  Heterosexual  Bisexual  Homosexual

Exercise: Type \_\_\_\_\_ Duration \_\_\_\_\_ How often: \_\_\_\_\_

**FAMILY HISTORY** (Cancer, Diabetes, Dementia, Coronary Disease, Osteoporosis, Other):

<u>Deceased or Living</u>	<u>Age (current or at death)</u>	<u>Diagnosis or Cause of Death</u>
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
Sisters	_____	_____
Sons	_____	_____
Daughters	_____	_____

Other illnesses in family: \_\_\_\_\_

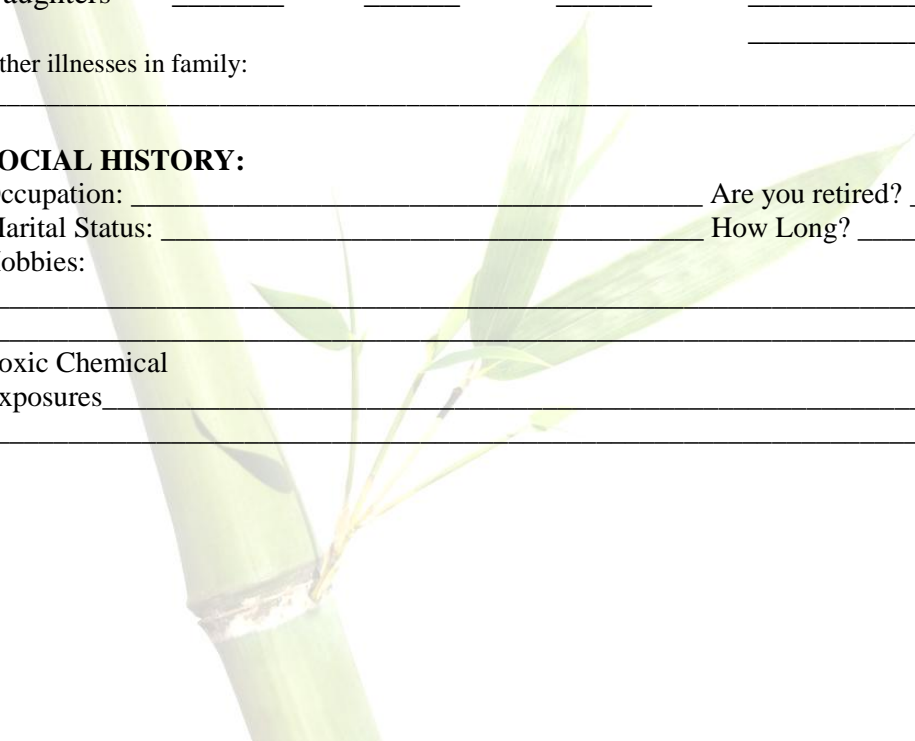
**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_ Are you retired? \_\_\_\_\_

Marital Status: \_\_\_\_\_ How Long? \_\_\_\_\_

Hobbies: \_\_\_\_\_  
\_\_\_\_\_

Toxic Chemical Exposures \_\_\_\_\_  
\_\_\_\_\_



**REASON FOR TODAY'S VISIT: PLEASE INCLUDE ANY SYMPTOMS YOU CURRENTLY HAVE, EVEN IF YOU THINK THEY ARE NOT RELATED.**

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**PLEASE ALSO TELL US IF YOU HAVE HAD ANY OR CHANGES IN THE FOLLOWING:**

Please check the box if you have had any of the following illnesses or symptoms.

1.  Recent nausea, vomiting or recurrent indigestion
2.  Recent weight change
3.  Change in bowel movements, describe: \_\_\_\_\_
4.  Excess fatigue or weakness
5.  Thyroid or other hormonal problems, describe: \_\_\_\_\_
6.  Any type of cancer, type: \_\_\_\_\_
7.  Skin rash or unusual mole, describe \_\_\_\_\_
8.  Any problem with urine flow \_\_\_\_\_
9.  Hay fever, sinusitis or season allergies
10.  Sexual dysfunctions, describe \_\_\_\_\_
11.  Previous prostate problem \_\_\_\_\_
12.  Recent menstrual problem or changes \_\_\_\_\_
13.  Arthritis or painful joints
14.  Difficulty walking
15.  Palpitation or irregular pulse
16.  Headaches
17.  Feelings of depression, anxiety, lack of motivation/ambition
18.  Insomnia