INTAKE & BILLING INFORMATION

PATIENT INFORMATION

_______________________ _______________________ ____ _____________ _____ _____
First Name | Last Name | M.I. | Date of Birth | Age | Sex

____________________________________ ___________________________ _____ _______________
Street Address | City | State | Zip Code

____________________________ _____________________________ ____________________________
Primary Phone Number | Secondary Phone Number | E-mail

_____________________ ________________________ ___________________ ___________________
Occupation | Emergency Contact Name | Relationship | Phone Number

Preferred method of contact: ☐E-mail ☐ Primary Phone ☐ Secondary Phone

How did you hear about us? ☐Friend/Family ☐Doctor ☐ Insurance ☐Internet ☐Other: _______________

Medical History

Allergies: ____

Current Medications (psychiatric & medical - including over the counter medications, vitamins, & herbal supplements):

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Past Surgeries:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Medical Conditions (Check all that apply):

___ Anemia
___ Diabetes Type 1/2
___ Hypertension/High blood pressure
___ Liver problems (inc. fatty liver disease)
___ Kidney conditions
___ Respiratory conditions (asthma, COPD)
___ Heart problems
___ Stroke/TIA
___ Seizures
___ Gout
___ HIV/AIDS
___ GI problems
___ Polycystic Ovarian Syndrome
___ Pain
___ Mental Health (anxiety, depression, bipolar disorder)
___ Clotting disorders/blood clots
___ High cholesterol/triglycerides
___ Sleep apnea
___ Thyroid conditions
___ Heart conditions
___ Eye conditions (glaucoma)
___ Pregnancy
___ Arthritis
___ Cancer
___ Skin conditions/rashes
___ Gallbladder Disease
___ Drug/alcohol abuse
___ Other: __________________

CONVENTIONS
wellness

Family Medical Conditions (Please check all that apply)

___ Anemia
___ Diabetes Type 1/2
___ Hypertension/High blood pressure
___ Liver problems (inc. fatty liver disease)
___ Kidney conditions
___ Respiratory conditions (asthma, COPD)
___ Heart problems
___ Stroke/TIA
___ Seizures
___ Gout
___ HIV/AIDS
___ GI problems
___ Polycystic Ovarian Syndrome
___ Mental Health (anxiety, depression, bipolar disorder)
___ Clotting disorders/blood clots
___ High cholesterol/triglycerides
___ Sleep apnea
___ Thyroid conditions
___ Heart conditions
___ Eye conditions (glaucoma)
___ Drug/alcohol abuse
___ Arthritis
___ Cancer
___ Skin conditions/rashes
___ Gallbladder Disease
___ Other: ___________________

Tobacco (smoking/chewing/vaping) ☐ None ☐ ____ packs/day
Alcohol ☐ None ☐_____________________
Drugs (including marijuana/THC/CBD): ☐ None ☐_____________________
Sleep How many hours per night do you sleep on average? _______hours
Do you find it hard to stay awake during the day while completing tasks? Yes No

Weight-Related History

1. What was your most recent weight you can recall? _________lbs.
2. When did you begin to experience changes in weight? _______________
3. What's the highest weight you have ever reached in your life? (not including pregnancy weight) ___________lbs.
   - How long ago did you experience this weight? _______________
4. Have you ever lost 10 lbs or more while on a weight loss regiment of any kind? Yes No
   - If yes, when did this occur? ____________
   - Have you regained the weight? Yes No
5. How much do you think you should weigh? __________lbs.
6. How long do you think it should take to reach your goal weight? _______
7. Are you willing to change your eating habits/activity level to achieve your goal? Yes No
8. Please circle any **diets** you have followed and indicate if it was successful:

Weight Watchers
Mediterranean
NutriSystem/Meal Replacement
Jenny Craig
Keto/Atkins
Other ________________________
Low-Fat
Calorie Counting
Noom
Optifast
Medifast

9. Please circle any **weight loss medications** you have used and indicate if it was successful:

GLP-1 (Wegovy, Saxenda, Ozempic)
Metformin
Adipex/Phentermine
Wellbutrin/Bupropion
Alli/Orlistat
Plenity
Topamax/Topiramate
Contrave

10. Have you ever been referred to or met with a Registered Dietitian (not a nutritionist)? Yes No
    - If yes, was it helpful? Yes No

Nutrition-Related History

1. How many meals do you eat per day? ______________________________________
2. Do you have any specific dietary requirements (gluten-free, vegan, etc.)? Yes No
   If yes, please list: ____
3. How often do you go out to eat? ____
4. What food cravings do you experience? _____________________________________
5. Do you tend to snack? Yes No
   If yes, when do you snack most frequently? ____________________________
6. Do you tend to eat more when you are under stress? Yes No
7. Are you experiencing any stressful situations or emotional stress? Yes No
   If yes, please explain: ____

Exercise-Related History

1. Do you have a heart condition and should only do physical activity recommended by a doctor? Yes No
2. Do you feel chest pain at rest or when you do physical activity? Yes No
3. Do you experience dizziness or lose consciousness? Yes No
4. Do you have any bone or joint problems that could be made worse by exercise? Yes No
5. Is there any reason you should NOT participate in physical activity? Yes No
6. Which of the following best describes your current activity level: **(Circle one below)**

Inactive: No regular physical activity, usually sitting or sedentary most of the day

Light Activity: No organized physical activity during leisure time, may walk frequently at work

Moderate Activity: Occasionally involved in going to gym/physical activities 1-2 times a week

Heavy Activity: Consistent exercise involving cardio or weight-lifting 3-4 times a week

Vigorous Activity: Consistent exercise involving cardio or weight-lifting 5 or more times a week

Gynecologic History (Please skip if not applicable)

1. Have you ever been pregnant? Yes No
2. Are you currently pregnant or breastfeeding? Yes No
3. Are you on Hormone Replacement Therapy? Yes No
4. Are you on birth control? Yes No
5. Do you have a history of irregular menstrual cycles? Yes No
6. When was your last menstrual period? ____/_____/_____