INTAKE FORM

Name: _____ Date of birth: _____

Reason for today's visit: _____

_____

Gender: _____ Blood type**:** _____ Weight: _____Height:_____

Religious/spiritual beliefs (optional):_____Ethnicity/Cultural Heritage:_____

For minors, include: Name of parent/guardian_____

Address(street/city/state/zip code) _____

_____

Home phone number: (___) _____ **Cell phone number**: (___) _____

Is it okay to leave messages with detailed information regarding your visit on your voicemail? : □**Y** □**N**

Emergency Contact Name: _____ Phone Number:(___)_____

Occupation:_____ Can you accept calls at work: □**Y** □**N** if yes, **work phone number:**(___)_____

Living situation: (please check what applies) □ Alone/ With □ Partner/□ Spouse/□ Children/□ Parents/□ Roommate

Do you have a primary care physician? □Yes □ No if yes,who?_____

Do we have your permission to be contacted via email regarding lab results or follow up questions? □Yes□ No

Where did you hear about us?_____

Would you like to receive Dr. Wells' Wellness Letter via Email □ Yes □ No

Signature:_____ Email address:_____

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Medical History (Please check what applies):

□Allergies	□Self	□Family, specify family member:
□Anemia	□Self	□Family, specify family member:
□Anxiety	□Self	□Family, specify family member:
□Arthritis/Joint pain	□Self	□Family, specify family member:
□Asthma/COPD	□Self	□Family, specify family member:
□Autoimmune Disease:	□Self	□Family, specify family member:
□Bleeding problems	□Self	□Family, Specify family member:
□Breast condition	□Self	□Family, Specify family member:
□Cancer:	□Self	□Family, Specify family member:
□Constipation	□Self	□Family, Specify family member:
□Loose stools	□Self	□Family, Specify family member:
□Depression	□Self	□Family, Specify family member:
□Diabetes	□Self	□Family, Specify family member:
□Eating Disorder	□Self	□Family, Specify family member:
□Erectile dysfunction	□Self	□Family, Specify family member:
□Eye Condition	□Self	□Family, Specify family member:
□Gallbladder disease	□Self	□Family, Specify family member:
□GERD/Reflux	□Self	□Family, Specify family member:
□Gynecological Conditions	□Self	□Family, Specify family member:
□Heart arrhythmia	□Self	□Family, Specify family member:
□Heart Condition	□Self	□Family, Specify Family member:
□Hemorrhoid	□Self	□Family, Specify Family member:
□Hepatitis	□Self	□Family, Specify Family member:
□Herpes	□Self	□Family, Specify Family member:
□High blood pressure	□Self	□Family, Specify Family member:
□Learning difficulties	□Self	□Family, Specify Family member:
□Leg cramps	□Self	□Family, Specify Family member:
□Memory changes	□Self	□Family, Specify Family member:
□Migraines	□Self	□Family, Specify Family member:
□Neuropathy	□Self	□Family, Specify Family member:
□Overuse of Alcohol/Drugs	□Self	□Family, Specify Family member:
□Osteoporosis/Osteopenia	□Self	□Family, Specify Family member:
□Prostate problems	□Self	□Family, Specify Family member:
□Seizures/Epilepsy	□Self	□Family, Specify Family member:
□Shingles	□Self	□Family, Specify Family member:
□Sinus infections	□Self	□Family, Specify Family member:
□Skin Condition	□Self	□Family, Specify Family member:
□Sleep problems	□Self	□Family, Specify Family member:
□Thyroid problems	□Self	□Family, Specify Family member:

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Allergies to medications/foods/environmental factors: _____

_____

Are any of these allergies life threatening? □Y □N if yes, which ones? _____

Any other significant health problems:_____

_____

Please list dates and reasons for hospitalizations, surgeries and accidents:

Accident: _____Date:_____Accident:_____Date:_____

Hospitalization: _____Date:_____Hospitalization:_____Date:_____

Procedure:_____Date:_____Procedure:_____Date:_____

Procedure:_____Date:_____Procedure:_____Date:_____

Screening Exams/Procedures

Screening Exams/Procedures:	**Date:**
□ Gyn exam/PAP	
□ Mammogram or other breast screening:	
□ Bone density	
□ Colonoscopy	
□ Prostate Exam	
□ Blood tests:	
□ Other:	

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Please list current medications and nutritional supplements/ □ See attached list:

Prescription & Dosage	**Supplement & Dosage**

Do you exercise □Yes □No if yes, how often and what activity:_____

_____

How much caffeine (coffee/tea/sodas) do you drink daily?_____

Do you smoke cigarettes or use tobacco products? □Yes □No if yes, how much?_____

Do you drink alcohol? □Yes □No if yes, how many drinks **Daily: _____ Weekly:**_____ Does it ever interfere with your daily routine? _____

Do you use marijuana products? □Yes □No
If yes, In what forms? (smoke, edibles, vape, etc.) _____

How often do you use marijuana products **Daily: _____ Weekly:_____**

If you use marijuana products regularly, at what age did regular use begin?_____

How much sleep to you get per night? _____ Do you wake feeling rested? □**Y** □**N**

Any other information you would like me to know about you: _____

_____

_____

Signature:_____ Date:_____

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