Wellness Intake Form

NAME_____ DATE OF BIRTH_____ AGE_____

ADDRESS_____ HEIGHT _____'_____" SEX: M/F

CITY/STATE_____ZIP_____ STAUS: MARRIED / SINGLE / DIVORCED / OTHER

EMAIL_____ HOME PHONE (____) _____

WORK PHONE (____) _____

EMPLOYER_____ OCCUPATION _____

PRIMARY CARE PHYSICIAN _____

Please list past or current medical conditions, diseases, surgeries, injuries and dates._____

_____

_____

Please list all current medications & supplements you are taking.

_____ Dosage:_____

_____ Dosage:_____

Please list any drug allergies._____

Do you drink alcohol? ___Never ___Rarely ___Moderately ___Daily

Have you been treated for alcohol or substance abuse? ___ Yes ___ No

Do you smoke? ___Yes ___No If yes, how many packs per day? _____

Have you taken prescription diet pills before? ___Yes ___ No

Have you taken "over the counter" diet pills? ___ Yes ___No

Have you ever had any of the following medical or physical conditions (check if yes):

___Anorexia /Bulimia ___Binge Eating ___Chest Pain /Angina ___Anxiety /Panic Attacks

___Depression ___Diabetes ___Constipation ___Shortness of Breath

___Gallstones ___Insomnia ___Severe Headaches ___Swelling of Ankles /Hands

___Feel Cold (usually) ___Hot Flushes /Sweats ___Anemia ___Low Energy /Tired /Fatigue

FAMILY HISTORY:

Please list any major medical conditions or cause of death, if deceased, for your

Father _____

Mother_____

Brothers_____

Sisters_____

Children_____

How did you learn of Glow Anti-Aging Center and Medical Spa? _____

DIETARY /NUTRITIONAL HISTORY:

Do you eat three or more meals a day? ___Always ___Often ___Occasionally ___Never

What time would you typically eat breakfast? _____

What are your hungriest times of the day? _____

What time do you normally get up in the morning? _____ Go to bed? _____

Do you get up during the night to eat /snack? ___Yes ___No ___ Occasionally

Average number of soft drinks you consume daily: Regular:_____ Diet:_____

Besides water, what other beverages do you commonly drink? _____

_____

Please check which items apply to you:

___ Snack on sweets often ___ Snacks on salty items often ___Eat fast food often

___ Eat restaurant meals often ___ Travel away from home for work overnight regularly

Do you exercise? ___Frequently ___Occasionally ___Rarely ___Never