INTERNAL USE: PCID: _____Health Goal: ____

Wellness Intake Form

Name: _____ Date: _____ Age: _____
Address: _____ City: _____ State: ____ Zip: _____

Email Address: _____ Phone: _____ Date of Birth: ___/____/___

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____
How many servings of vegetables do you consume per day? _____
How many servings of protein do you consume per day? _____
How many servings of bread/crackers/pasta do you consume daily? _____
Do you consume artificial sweeteners? __Yes __ No If yes, what brands? _____
Do you consume fast food? __ Yes __ If yes, what do you typically eat? _____
Do you eat breakfast? __ Yes __ No If no, what time is your first meal of the day? _____
Do you consume alcoholic beverages? __ Yes __ No If yes, how many per week? _____
Do you consume coffee? __ No __ Yes If yes, how many cups per day? _____
Do you consume dietary supplements? __ No __ Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

____ Lose weight ___ More energy ___ Sleep better ___ Improve digestion

____ Improve blood work ___ Prevent problems ___ Anti-aging support ___ Improve general health

If you could improve ONE thing about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

1. What number best describes how you feel about your health today? _____
2. What health goal do you want to achieve?: _____

NOTE: In our commitment to your health, our office provides our patients with access to a free online resource for education, science and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

__ Health Reality Check __ The Meaning of Essential Nutrients __ Creating Optimal Health __ Other _____
__ Customizing Your Health Plan __Healthy Age Management __ Genetics and Health __ Healthy Weight Loss