Patient Intake Form

Demographics

Name:_____ Preferred Name:_____
Phone:_____ is this a cell or home?
Alternate contact:_____
Gender:_____
Date of Birth: _____
Address:_____ City:_____ State:____ Zip:_____
Email:_____
SSN:_____
Okay to send correspondence via email, phone, and mail (circle) YES or NO

Insurance:

Name of insurance:_____
ID:_____Group #:_____

Employer Company Name:_____
Name of Insured : _____ Relationship_____
Insured DOB:_____

Former PCP:_____
Last seen by HealthCare Provider:_____
Preferred Pharmacy Name:_____ number:_____ Location:_____

Medical History:
Medications:(please include all supplements and otc meds)

Name of Medication:	Dose:	How do you take? (daily, twice daily, as needed, etc)

Allergies:_____ Reaction if any:_____
Environmental or food Allergies_____

Immunizations: (circle) up to date not sure
Do you take the yearly flu shot?_____ last time received?_____

Medical Diagnoses: (circle for yes)

Asthma High cholesterol Lupus Acne Chronic constipation

Diabetes Anxiety Eczema IBS Ulcerative Colitis Hypothyroid

Hypertension Depression Bipolar Disorder Cancer what type_____

Bleeding disorder Blood clots sickle cell MRSA Heart Murmur

Other:_____

Surgical History:

Type of surgery	Date

Family History:

Relative	Alive or deceased?	Medical hx
Mother		
Father		
Paternal GM		
Paternal GF		
Maternal GM		
Maternal GF		

Social History:

Marital status: Married Single Widowed Divorced
Sexual Orientation(who are you attracted to): Heterosexual Lesbian Gay Bisexual Queer
Gender Identity: (how do you see yourself) Female Male Non-Binary
Employed?_____ FT/PT/seasonal/Retired?_____
Occupation:_____
Exposed to hazardous materials (chemicals, metals, etc). If so which ones?_____
Children? If so ages_____
Ever Smoked cigarettes/cigars_____ How many years_____ At your highest, how many packs per day_____
Alcoholic drinks per week_____
Illicit or illegal drugs (current or past)_____
Personal history of Abuse?_____Do you feel safe at home?_____
Caffeine use:_____ how much a day_____

For females: Date of LMP_____ How many times in your lifetime have you been pregnant?_____ How many living children do you have_____
Abortions_____ Ever been told you have an abnormal pap?_____
Any complications in pregnancy or childbirth?_____

Preventive Healthcare Have you had any of these screening tests? (circle)	Date?
Colonoscopy	
Prostate	
Pap smear	
Mammogram	

I certify that the above information is accurate and correct to the best of my knowledge:
Printed Name:_____
Signature:_____

Date:_____

Cancellations:

Cancellations of membership can be canceled at anytime, with a written notice from the patient emailed to affinitywellnessconsultants@gmail.com. If cancellations are within 30 days of signing up for membership, a $99 cancellation fee will be assessed and automatically charged to the credit card on file.

Care Delivery

I understand that with this membership, I agree to consent to care and treatment and understand that care will not be rendered until payment is made in full PRIOR to care.