NEW – Patient Intake Form

Name:_____ DOB:____/____/____

Allergies

Medication	Reaction

Current Medications

Preferred Pharmacy and Pharmacy Location: _____

Medication	Dose	Frequency	Reason for Taking

Surgical History

Date	Procedure/Operation	Complications

Social History

Primary Care Provider: _____

Please circle all that apply

Diet	Well Balanced	Vegetarian	Routine Mealtimes
	Diabetic	Weight Loss Products/Fads	Caffeine
	Excessive Fat/Calories	Vitamin/Herbal Use	Other Diet: _____
Exercise	Sedentary	Stretching/Balance	Early In Day
	Aerobic/Cardio	More than 20 min/day	Late In Day
	Strength/Weight Training	More than 3x weekly	Other Exercise:_____

Marital Status

Single Divorced Married Widowed Other: _____

How many children do you have?