PATIENT HEALTH INTAKE AND MEDICAL HISTORY FORM

Patient Name:
Date of Birth:
Date:

Provider:

CONTACT INFORMATION

Phone:

Email:

Preferred communication:

☐ Portal

☐ Phone

☐ Other

PRIMARY HEALTH GOALS

What are you hoping to improve?

☐ Weight management

☐ Metabolic health

☐ Energy/wellness

☐ Body composition

☐ Recovery/performance

☐ Other:

Describe your goals:

CURRENT HEALTH INFORMATION

Height:

Weight:

Recent weight changes:

MEDICAL HISTORY

Have you ever been diagnosed with:

☐ Diabetes

☐ High blood pressure

☐ Heart disease

☐ Thyroid disorder

☐ Hormonal disorder

☐ Kidney disease

☐ Liver disease

☐ Gastrointestinal disease

☐ Autoimmune condition

☐ Cancer history

☐ Mental health condition

☐ Other:

Explain:

SURGICAL HISTORY

Previous surgeries:

MEDICATION HISTORY

Current prescription medications:

Current supplements:

Allergies:

FAMILY HISTORY

Family history of:

☐ Diabetes

☐ Heart disease

☐ Thyroid disorders

☐ Cancer

☐ Other:

LIFESTYLE INFORMATION

Nutrition:

Exercise:

Sleep:

Alcohol/tobacco/other:

PREGNANCY/REPRODUCTIVE HEALTH

Are you:

☐ Pregnant

☐ Trying to become pregnant

☐ Breastfeeding

☐ Not applicable

CURRENT SYMPTOMS OR CONCERNS

PATIENT ACKNOWLEDGMENT

I confirm that the information provided is accurate to the best of my knowledge.

I understand my provider uses this information to assess treatment options and determine appropriate care.

Patient Signature:

Date: