

# Center for Metabolic Wellness

## New Patient Intake Form

*Please print clearly and bring with you to the office for your first appointment. All records are confidential.*

Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code

M / F    Ht. \_\_\_\_\_    Wt. \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_    Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact (Name & Number) \_\_\_\_\_

Referred by \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Other Health Care Practitioners treating you \_\_\_\_\_

Chief Complaint (reason for visit)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all previous treatments for this condition (including medication) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Medical Problems \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Center for Metabolic Wellness**  
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Name \_\_\_\_\_

Date \_\_\_\_\_

Current Medication \_\_\_\_\_

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If receiving chemotherapy, type and regimen \_\_\_\_\_

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**Past Medical History:** (check all that apply and include medication)

AIDS/HIV \_\_\_\_\_

Diabetes Mellitus \_\_\_\_\_

Herpes (oral, genital) \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Stroke \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Chest pain \_\_\_\_\_

Glaucoma \_\_\_\_\_

Cancer \_\_\_\_\_

Asthma \_\_\_\_\_

Hepatitis (type) \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Pneumonia \_\_\_\_\_

Seizures \_\_\_\_\_

Thyroid disorder (type) \_\_\_\_\_

Ulcers \_\_\_\_\_

Depression \_\_\_\_\_

List any previous surgery / major trauma (include dates) \_\_\_\_\_

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**Family History:** (list major medical conditions)

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings \_\_\_\_\_

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Name \_\_\_\_\_ Date \_\_\_\_\_

**Life Style**

Do you smoke?    Yes    No    Cigarettes \_\_\_\_    Pipe \_\_\_\_    Cigars \_\_\_\_  
# of Years \_\_\_\_\_    How much? \_\_\_\_\_    Year quit \_\_\_\_\_

Do you drink alcohol?    Yes    No    Do you use street drugs?    Yes    No  
What type? \_\_\_\_\_    What type? \_\_\_\_\_  
How much? \_\_\_\_\_    How much? \_\_\_\_\_  
How often? \_\_\_\_\_    How often? \_\_\_\_\_

Do you regularly drink coffee?    Yes    No  
How many cups per day? \_\_\_\_\_

Are you under a lot of pressure at work?    Yes    No    Please describe \_\_\_\_\_  
\_\_\_\_\_

Do you exercise? \_\_\_\_\_    Type \_\_\_\_\_    Frequency \_\_\_\_\_

# hours of sleep \_\_\_\_\_    bed time \_\_\_\_\_    awoken \_\_\_\_\_

**Diet**

**Describe your typical diet:**

Breakfast \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Name \_\_\_\_\_

Date \_\_\_\_\_

Dietary restrictions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Food allergies \_\_\_\_\_

Food cravings \_\_\_\_\_

Water consumption / day \_\_\_\_\_

Supplements \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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*continued...*





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## New Patient Intake Form

Name \_\_\_\_\_

Date \_\_\_\_\_

### GYNECOLOGY (women):

- date of last pap smear \_\_\_\_\_ results \_\_\_\_\_
- date of last menstrual period \_\_\_\_\_
- length of cycle (regular / irregular) \_\_\_\_\_
- duration of flow \_\_\_\_\_
- do you have clots with menstrual flow \_\_\_\_\_
- menstrual pain / cramping \_\_\_\_\_ location \_\_\_\_\_
- PMS
  - breast tenderness \_\_\_\_\_
  - mood changes (type) \_\_\_\_\_
  - bloating \_\_\_\_\_
  - headache \_\_\_\_\_ location \_\_\_\_\_
  - low back pain \_\_\_\_\_
  - food cravings \_\_\_\_\_
- method of contraception \_\_\_\_\_
- uterine fibroids \_\_\_\_\_ type \_\_\_\_\_
- ovarian cysts \_\_\_\_\_
- age of menopause \_\_\_\_\_

### UROLOGY (men):

- date of last prostate exam \_\_\_\_\_ results \_\_\_\_\_
- urinary frequency \_\_\_\_\_
- poor stream flow \_\_\_\_\_
- premature ejaculation \_\_\_\_\_

Additional information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_