Patient Intake Form

Patient Name : _____Date :_____

Street :_____City :_____State :_____Zip : _____

Cell Phone : _____Email :_____

Age : _____ Date of Birth:_____

Occupation :_____

Marital Status: **Single** **Married** **Divorced** **Widowed**

Spouse Name: _____

Ages of Children:_____

Referred by :_____

Family Physician :_____

Concurrent Health Therapies or Regimens: _____

Height : _____Weight :_____Ideal :_____

Previous Weight Programs :_____

Results:_____

Do you consider your health an **investment** or an **expense**? _____

Most recent car accident?_____

Do you have tattoos? **Yes** **No** If yes, How many?____ Any on your stomach or back? **Yes** **No**

Are you pregnant? **Yes** **No** Are you nursing? **Yes** **No**

HSA(Health Savings) and FSA(Flex Spending) cover our services, do you have one? **Yes** **No**

Medical History

(check all that apply)

- ▢ Cancer
- ▢ HIV
- ▢ Hepatitis
- ▢ High cholesterol
- ▢ Significant Trauma
- ▢ High Blood Pressure
- ▢ Heart Disease
- ▢ Diabetes
- ▢ Epilepsy/Seizures
- ▢ Thyroid Disease
- ▢ Kidney Disease
- ▢ Cardiovascular
- ▢ Varicose veins
- ▢ Autoimmune Disorder
- ▢ Insulin Dependent
- ▢ Skin disease/disorder
- ▢ Liver Disease
- ▢ Leukemia
- ▢ Hemophilia
- ▢ Endocrine System condition
- ▢ Surgically implanted Electro-stimulation devices
- ▢ Medications that cause photosensitivity (in the 12 months)

List medications/prescriptions: _____

_____

RIVERCREST HEALTH

Pain Indicators

▢ Headaches	▢ Shoulder pain	▢ Upper back pain	▢ Wrist pain
▢ Mid back pain	▢ Knee pain	▢ Low back pain	▢ Ankle pain
▢ Neck pain	▢ Hip pain	▢ Radiating leg pain	▢ Radiating arm pain

Body Composition

Problem areas you would like addressed:

▢ Love Handles	▢ Wrinkles/ Age Spots	▢ Flabby arms	▢ Mommy tummy
▢ Turkey Neck	▢ Thighs	▢ Back fat	
▢ Cellulite	▢ Stretch Marks	▢ Other: _____	

Lifestyle

▢ Stress ▢ Caffeine ▢ Under / Overeat ▢ Pain ▢ Skipping meals ▢ Sugar / Bad Carbs

▢ No exercise ▢ Poor Sleep ▢ Nerves ▢ Alcohol ▢ Poor liver ▢ Get Hungry ▢ Poor Snacks

List vitamins/minerals/supplements: _____

Would you like to learn which supplements can improve your health? **Yes** **No**

How committed are you to living a healthy life on a scale from 1-10, with 10 being the healthiest? _____

How would your life change if you didn't have the problems listed on this form? _____

_____

_____

How are these problems affecting your family life? Work life? Recreational activities? Mindset?

_____

_____

_____