Sun Health WELLNESS

New Client Intake Form

Date

Name _____ Date of Birth _____

Gender _____ Marital Status _____ Occupation _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Email Address _____

Emergency Contact Name _____ Phone # _____

Primary Care Doctor _____ Phone # _____

Referring Doctor, if applicable _____ Phone # _____

1st Insurance Company and Policy # _____ 2nd Insurance Company and Policy # _____

MEDICATIONS

Please list all medications, vitamins, minerals, or herbal supplements that you are taking, including the dose. (if additional space is needed, please include separate sheet.)

MEDICAL HISTORY

Please check all that apply to your current situation.

- Anemia
- Anxiety
- Balance Issues
- Bleeding Disorder
- Cancer
- Chronic Pain
- Constipation
- Depression
- Diabetes
- Diarrhea/Loose Stools
- Gallbladder Disease
- GERD
- Gout
- Heart Disease
- Hiatal Hernia
- High Blood Pressure
- High Cholesterol, High Triglycerides, High LDL / Low HDL (dyslipidemia)
- IBS
- Injury to Bones/Muscle
- Joint Disease
- Liver Disease
- Lung Disease, SOB, Asthma, Emphysema, COPD
- Memory Issues
- Osteoporosis
- Overweight
- Pre-Diabetes
- Recent Surgeries
- Stroke/TIA
- Thyroid Disorder
- Underweight
- Unexplained Mental Decline
- Urinary/Kidney Disease

Name: DOB:

Current Height: _____ Current Weight: _____

List Allergies (medication, environmental, food, etc.)

Updated: May 2015