

DOCTORS ASSISTED WELLNESS

**NEW PATIENT INTAKE FORM**  
NEW & ESTABLISHED INTAKE INFORMATION

NAME: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ SEX: M / F  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: Street: \_\_\_\_\_ Apt# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE/ CELL: \_\_\_\_\_ BEST TIME TO CONTACT? \_\_\_\_\_  
OK TO LEAVE MESSAGE? YES / NO

PHARMACY NAME & PHONE NUMBER \_\_\_\_\_

MARITAL STATUS: S M D Widower Separated

FEMALES- ARE YOU ON BIRTH CONTROL? \_\_\_\_\_ WHICH TYPE? PILL\_\_ INJECTION\_\_ TUBAL\_\_

ANY ALLERGIES? YES / NO IF YES LIST ALLERGIES: \_\_\_\_\_

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP): \_\_\_\_\_ PHYSICIAN OFFICE PHONE# \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_

SURGICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_

FAMILY/ PARENTAL/ SIBLING HEALTH & DRUG USE HISTORY: CANCER HEART DISEASE STROKE DIABETES THYROID  
FATHER, LIVE OR DECEASED & AGE? \_\_\_\_\_ ALCOHOL OR DRUGS? \_\_\_\_\_  
MOTHER, LIVE OR DECEASED & AGE? \_\_\_\_\_ ALCOHOL OR DRUGS? \_\_\_\_\_  
BROTHER & SISTERS, AGES? \_\_\_\_\_ ALCOHOL OR DRUGS? \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

CURRENT SUPPLEMENTS: \_\_\_\_\_

PRIMARY REASON FOR VISIT TODAY? \_\_\_\_\_

DRUG USE HISTORY? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PSYCHIATRIC HISTORY/ PSYCH MEDICATIONS NOW OR IN THE PAST? \_\_\_\_\_  
\_\_\_\_\_

DRUG TREATMENT OR DETOX IN PAST? WHERE & HOW LONG DID YOU STAY? HOW DID IT WORK FOR YOU?  
\_\_\_\_\_  
\_\_\_\_\_