Enhanced Medical Care
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WELLNESS INTAKE FORM 1

Full Legal Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Age: _____ Date of Birth: _____ (MM / DD/ YYYY) Gender (circle): Female / Male

Over the counter medications, herbs, and/or supplements taken in past month (include dosages):

_____ _____ _____

_____ _____ _____

Have you taken dietary supplements within the past 4 days? If so, what?

_____

Current Diet

- How many servings of vegetables do you consume daily? _____
- How many servings of fruits do you consume daily? _____
- How many serving of protein do you consume daily? _____
- How many servings of fish do you consume weekly? _____

Do you follow any certain dietary restrictions (I.E. vegetarian, gluten free, low carbohydrate, low fat, etc.)?

_____

Overall Wellness

Rate each category on a scale from 1 (poor) to 5 (excellent)

- Diet 1 2 3 4 5 Comments _____
- Exercise 1 2 3 4 5 Comments _____
- Sleep 1 2 3 4 5 Comments _____
- Energy 1 2 3 4 5 Comments _____
- Stress Level 1 2 3 4 5 Comments _____

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WELLNESS INTAKE FORM 2

Full Legal Name: _____ _____ _____
Last Name *First Name* *Middle Initial*

Age: _____ Date of Birth: _____ Gender (circle): Female / Male
MM / DD/ YYYY

If you could magically eliminate 5 health or wellness concerns what would they be?

1. _____

Comments: _____

_____

2. _____

Comments: _____

_____

3. _____

Comments: _____

_____

4. _____

Comments: _____

_____

5. _____

Comments: _____

_____