Gard Wellness Center
New Patient Intake Form

Personal Information

First Name _____ Last Name _____ Date of Birth _____

Address _____ City _____ Zip Code _____ Gender: M – F – Other

Phone _____ Social Security number _____ Email _____

Who referred you to our office? _____

Emergency Contact

Name _____ Relationship to patient _____ Phone _____

Who is financially responsible for your care? ☐ Self ☐ Health insurance ☐ Other_____

Health insurance policyholder information:

Policyholder's Name_____ Relationship to patient _____

Policyholder's date of birth _____

*We participate with most major insurance companies. If you have health insurance please provide your card so that we may check your eligible benefits.

Lifestyle History

Please list all current prescription medications _____

Please list all current over the counter medications _____

Please list all supplements _____

Do you use tobacco products? ☐ Yes ☐ No ☐ Occasionally If yes, how many per week? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Occasionally If yes, how many drinks per week? _____

How would you rate your current diet? ☐ **Poor** – Fast food and poor choices often ☐ **Moderate** – fast food and poor choices occasionally ☐ **Good** – fast food and poor choices rarely ☐ **Super clean** – I eat well

Do you need assistance with weight loss or cleaner eating? ☐ Yes ☐ No ☐ Maybe so

Do you exercise? ☐ 5 + times per week ☐ 3-5 times per week ☐ 1-2 times per week ☐ rarely / never

Please list any diagnosed allergies_____

Have you ever been hospitalized for a surgery? ☐ Yes ☐ No If yes, provide procedure and date(s)

_____

Have you or a member of your immediate family ever been diagnosed with cancer? ☐ Yes ☐ No

If yes, please provide type _____

Are you currently pregnant? ☐ Yes ☐ No **If yes, how many weeks of gestation?** _____

Health History

Cardiopulmonary and Circulatory Health – Please place a check next to all that apply to present or past.

☐ Anemia
☐ HIV / Aids
☐ Hemophilia
☐ Hepatitis
☐ Hypertension
☐ Hypotension
☐ Stroke
☐ Heart Attack
☐ Aortic aneurism
☐ Chest pain
☐ Pace maker
☐ Shortness of breath
☐ Lung Disorders
☐ Sinus infections
☐ Emphysema
☐ Asthma

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Endocrine, Gastrointestinal, Neurological Health - Please place a check next to all that apply to present or past.

☐ Chron's	☐ Epilepsy	☐ Post concussive syndrome / head injury
☐ IBS	☐ Seizures	☐ Memory loss
☐ Autoimmune	☐ Headaches	☐ Alzheimer's
☐ Diabetes	☐ Migraines	☐ Other
☐ Candida	☐ Concussion	
☐ Incontinence	☐ Hypothyroid	
☐ Diarrhea	☐ Hyperthyroid	
☐ Bladder disease	☐ Hashimoto's	

Emotional/Behavioral/Mental Health - Please place a check next to all that apply to present or past.

☐ Anxiety disorder	☐ ADHD	☐ Autistic Disorder
☐ Depression	☐ ADD	☐ Spectrum Disorder
☐ Bipolar disorder	☐ Asperger Syndrome	☐ Other

Sensory Health- Please place a check next to all that apply to present or past.

☐ Deafness	☐ Vertigo	☐ Sinusitis
☐ Hearing loss	☐ Tinnitus	☐ Other
☐ Glaucoma	☐ Vision impairment	

Musculoskeletal Health - Please place a check next to all that apply to present or past.

☐ Arthritis	☐ Lyme disease	☐ TMJ syndrome	☐ Joint replacement(s)
☐ Gout	☐ Multiple sclerosis	☐ Fibromyalgia	☐ Failed back surgery syndrome
☐ Herniated disc	☐ Muscular dystrophy	☐ Pinched nerve	☐ Chronic tight muscles
☐ Sciatica	☐ Numbness in hands	☐ General pain	☐ Muscle weakness
☐ Osteoporosis	☐ Numbness in feet	☐ Carpal tunnel	☐ Other

Other - Please place a check next to all that apply to present or past.

☐ Weight loss
☐ Weight gain
☐ Low energy
☐ Sleep problems

ADL Assessment – Please check the appropriate boxes to help us better understand how your current pain is affecting your activities of daily living.

Bending	☐ Painful	☐ Some pain	☐ Not affected
Lifting	☐ Painful	☐ Some pain	☐ Not affected
Stairs	☐ Painful	☐ Some pain	☐ Not affected
Sitting	☐ Painful	☐ Some pain	☐ Not affected
Standing	☐ Painful	☐ Some pain	☐ Not affected
Walking	☐ Painful	☐ Some pain	☐ Not affected
Exercising	☐ Painful	☐ Some pain	☐ Not affected
Housework	☐ Painful	☐ Some pain	☐ Not affected
Kneeling	☐ Painful	☐ Some pain	☐ Not affected

Please list any other areas of your life which are currently affected by your pain/discomfort? _____

_____

Please list any activity(ies) you have been unable to do, as a result of your pain/discomfort? _____

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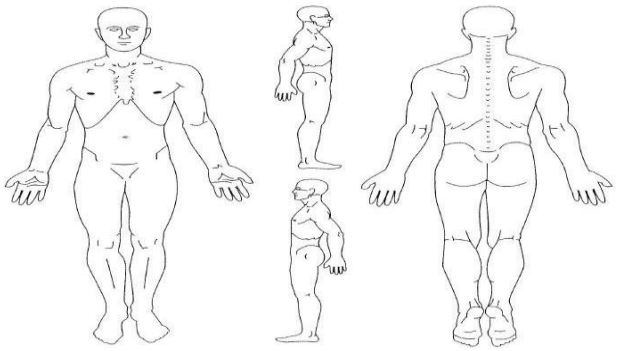
Using the body diagram below, please indicate the area(s) at which you are experiencing pain/discomfort with the following key:



N – Numbness/Tingling
B - Burning
S - Stabbing

Please rate your pain by circling the appropriate #:
(0 = no pain, 10 = bad pain)
1 2 3 4 5 6 7 8 9 10

Please list the date your symptoms began _____

Are your symptoms related to either of the following:
☐ Motor Vehicle Accident ☐ Work related injury or accident

Please indicate how your symptoms are changing:
☐ Getting better ☐ Not changing ☐ Getting worse

Describe your symptoms in order of severity starting with most severe: _____
_____

HIPAA Privacy Practices
I acknowledge I have received and/or have been given the opportunity to review Gard Wellness Center's Notice of HIPAA Privacy Practices for protected health information. This information is available at the Reception Desk and our website. If you would like a copy emailed to you, please ask.

Printed Name _____ Signature _____ Date _____

Consent to treat a minor
Minor's name_____ Name of person authorizing care_____

Signature of person authorizing care_____ Date _____

Thank you for taking the time to fill this out completely. Please turn in this form, along with your insurance and identification card to the Reception Desk and we will be with you shortly.