Infinite Health Care

INTAKE

Patient Intake Form

Name ______________________ Date ______________

Date of Birth ______________________ Gender ______________

Address ____

City ______________ State ______________ Zip Code ______________

Email Address ______________________ Phone No ______________

Emergency Contact ______________________ Phone No ______________

Martial Status ______________________ Ethnicity ______________

How did you hear about us? ______________________________

MEDICAL HISTORY

Please select any relevant conditions below:

- [ ] Anemia/Blood Disorder
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Condition
- [ ] Blood Clotting Disorder
- [ ] Cancer/History of Cancer
- [ ] COPD
- [ ] Deep Vein Thrombosis
- [ ] Depression/Suicidal Ideation
- [ ] Diabetes/Retinopathy
- [ ] Eating Disorder History
- [ ] Epilepsy/Seizures
- [ ] Heart Disease
- [ ] Headache/Migraine
- [ ] High Blood Pressure
- [ ] HIV/AIDS or Hepatitis
- [ ] Hormone Replacements
- [ ] IBD/IBS
- [ ] Kidney Disorder/Disease
- [ ] Low Blood Pressure
- [ ] Low Libido
- [ ] Mental Health History
- [ ] Neurological Disorder/Stroke
- [ ] Osteoporosis
- [ ] Pancreatitis
- [ ] Renal Failure
- [ ] Sleep Apnea
- [ ] Substance/Alcohol abuse
- [ ] Thyroid Disease

Details or any other condition: ______________________________

____

Are you allergic to any medications? ☐ No ☐ Yes If yes, please explain: ____________

____

Have you had surgery or hospitalizations in the past year? ☐ No ☐ Yes: ____________

____

____

List any vaccines that you've had in the last year:

____

Are you currently taking any blood thinning drugs? (i.e., Aspirin and Warfarin) ☐ No ☐ Yes

If yes, please list them: ____

FEMALE MEDICAL HISTORY

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-menopause

☐ Using contraceptives: ____________ ☐ Other: ____________

Date last menses: ____________ Pregnancies: ____________ Live births: ____________

Please provide a list of all medications or supplements you take:

MEDICATION OR SUPPLEMENTS	DOSE	FREQUENCY	COMMENTS

HEALTH HABITS

Do you smoke? ☐ No ☐ Yes How many per day? ____ How long? ____

Do you drink alcohol on a regular basis? ☐ No ☐ Yes Weekly Use: ____

How is your activity level? ☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active

What methods or interventions have you used to lose weight previously?

☐ Diet ☐ Exercise ☐ Prescription medication ☐ Therapy ☐ Herbal supplements

Date of last physical: ____ Date of last blood work: ____

Relevant results: ____________________

What is your main motivations and concerns for your visit today?

____

____

Have you experienced any of these symptoms recently?

- ☐ Chest Pain
- ☐ Pain with meals
- ☐ Poor balance/falls
- ☐ Unexperienced weight gain/loss
- ☐ Vision changes
- ☐ Shortness of Breath
- ☐ Change in bowel habits
- ☐ Unusual Pain with Menstruation
- ☐ Suicideal Ideation
- ☐ Numbness/Tingling
- ☐ Confusion/Brain Fog
- Other: ____________

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the Medical Practitioner of any changes to my medical history or skincare routine. I agree to waive all liabilities of the Medical Practitioner or employer for any injury or damages incurred due to misrepresentation of my health history.

Client Name (printed)	Client Name (signed)	Date
Provider Name (printed)	Provider Name (signed)	Date