TRINITY HOLISTIC WELLNESS

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WELLNESS INTAKE FORM

Please Print Clearly

Name: _____ Date: _____

Address: _____ Apt. #: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Date of Birth: _____ Age: _____ Sex: M / F Height: _____Weight:_____

Occupation: _____ Employer: _____

Marital Status: S M D W Name of Spouse: _____

Number of Children: _____ Number of Children Living at Home: _____

Name of Child Age Sex Any physical conditions or concerns?

1._____M/F_____

2._____M/F_____

3._____M/F_____

4._____M/F_____

Overall Health: Excellent Good Fair Poor Other: _____

Do you drink alcohol? Yes No (If yes, please indicate how much): _____

Cigarettes: Yes No # per Day_____ Cigars: Yes No # per Day _____

List any surgery or operations with approx. date: _____

_____

Any Allergies to Medications:

1._____

2. _____

3. _____

List Any Major Illnesses (Diabetes, Hypertension etc.):

1._____

2. _____

3. _____

Current Medications being taken:

Rx Name Purpose How Long? Dose How often? Last dose?

_____

_____)_____

_____

Nutritional Supplements/Vitamins you are taking:

1. _____

2._____

3. _____

4. _____

5. _____

6. _____

Have you ever traveled or lived outside the U.S.? Yes No

Chief Complaint (reason you are here): (use back of page if more room is needed)

_____

_____

Previous Treatments for this Complaint: _____

_____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

1._____

2. _____

3. _____

Any food or environmental allergies (dust pollen grass etc.): _____

_____

Any household pets or other animals you or family members are in close contact with:_____

Did a friend refer you to me? Who may I thank?_____

Please note all services are to be paid in full at the time of your visit. We do not allow any returns on all supplements as we are unable to control the temperature of these products once they leave the office. All sales are final.

Signed: _____Date: _____