

# NeuroWellness

## Adult Intake Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Other Phone \_\_\_\_\_ Fax \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

How did you learn about NeuroWellness? \_\_\_\_\_

What is/are the principal health concern(s) for which you are coming to see us?

Migraines       Weight control       High stress level       Arthritis

ADHD       Exhaustion       Focus/mental clarity       PMS

Depression       Fibromyalgia       Chronic fatigue       Anxiety

Low energy       Poor memory       Allergies/Asthma       Sleep

Blood Pressure       Cholesterol       Digestion       Bowel

Do you have other health concerns you would be interested in addressing?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_

Children at home/ages \_\_\_\_\_ Other children/ages \_\_\_\_\_

Occupation \_\_\_\_\_ How many hours per week? \_\_\_\_\_

Existing medical problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many sick days did you take in the past year due to these conditions? \_\_\_\_\_

Past medical problems: \_\_\_\_\_

Please list any surgeries and their dates: \_\_\_\_\_

Current medications (including over-the-counter medications and supplements):

\_\_\_\_\_

