SUNFLOWER WELLNESS CENTER, LLC

New Patient Intake Form

Name: First_____ Last_____ Today's Date_____

Mailing Address:

Street _____

City_____ State_____ ZIP_____

Home Phone # _____ Work Phone #_____

Mobile Phone # _____ Other Phone # _____

Email Address_____

Emergency Contact & Relationship_____

Occupation_____ Employer _____

SSN_____-_____-_____ DOB ___/___/____ Health Insurance_____ _____

Height_____ Current Weight_____ Ideal Weight_____

How did you hear about Sunflower Wellness Center?

Personal referral from: _____

Provider referral from: _____

Insurance list of doctors: BCBS / UHC / NMHC / Other

Internet search for: _____

Other_____

What are your primary health concerns and/or goals at this time?

What types of treatments have you tried for these issues, and what has helped?

What makes things better? (Heat, cold, rest, movement, morning, evening, certain foods, etc.)

What makes things worse? (Heat, cold, rest, movement, morning, evening, certain foods, etc.)

Other health issues you have now or have had in the past – please check all that apply:

- ☐ Seasonal Allergies / Hayfever
- ☐ Food Sensitivities_____
- ☐ Digestive problems
  - ☐ Bloating, Gas
  - ☐ Constipation
  - ☐ Diarrhea
  - ☐ Heartburn/Indigestion/Acid Reflux/GERD
  - ☐ IBS or other digestive pain
  - ☐ Crohn's Disease, Ulcerative Colitis
  - ☐ Incontinence: Urine Stool
  - ☐ Other _____
- ☐ Stress _____
- ☐ Sleep troubles
  - ☐ Difficulty falling asleep
  - ☐ Waking during the night
  - ☐ Difficulty falling back to sleep
  - ☐ Waking too early in the morning
  - ☐ Frequent nighttime urination
  - ☐ Dream-disturbed sleep
  - ☐ Anxiety / palpitations
  - ☐ Busy mind
  - ☐ Hot flashes
  - ☐ Night sweats
  - ☐ Other _____
- ☐ Pain, Stiffness, Limited Mobility
  - ☐ Where?_____

- ☐ Headaches, Migraines
- ☐ Low Energy / Fatigue: Acute Chronic
- ☐ Low Libido
- ☐ Mood Issues
  - ☐ Weepy, Emotional or Sensitive
  - ☐ Low Mood, Depressed
  - ☐ Anxious, Agitated, Fearful
  - ☐ Irritable
  - ☐ Other _____
- ☐ Menstrual Problems_____
- ☐ Infertility
- ☐ Menopausal Issues (pre, peri or post)
  - ☐ Hormone Imbalances
  - ☐ Hot Flashes
  - ☐ Other _____
- ☐ Vision or Hearing problems_____
- ☐ Blood Sugar issues
  - ☐ Hypoglycemia
  - ☐ Pre-diabetes (A1c 5.7-6.4)
  - ☐ Metabolic Syndrome
  - ☐ Type 2 Diabetes
  - ☐ Alzheimer's / Type 3 Diabetes
- ☐ Your Typical Blood Pressure: High _____ Low_____
- ☐ Brain Fog, Mental Clarity or Memory issues
- ☐ Other_____

Indicate if you have had any blood relatives with any of the following problems:

- ☐ Cancer
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Thyroid Disorders
- ☐ Other

List any food or medication allergies or sensitivities_____

_____

Do you use tobacco in any way? Yes No Recently stopped? Yes No Want to quit? Yes No

What Western medical diagnoses, surgeries and medications have you had/taken in your life?

What supplements, herbs and other non-prescription medicines are you currently taking?

_____

_____

_____

_____

Typical sleep schedule:

What do you do, how often, for exercise?

What do you do for stress relief?

What are your fondest health desires and goals? Please check all that apply:

- ☐ Have more energy
- ☐ Improve mental function
- ☐ Minimize pain and stiffness
- ☐ Improve mood
- ☐ Reduce stress
- ☐ Improve sleep quality
- ☐ Attain ideal weight / body fat %
- ☐ Strengthen immune system
- ☐ Improve vision

- ☐ Other_____

_____

_____

_____

Thank you for taking the time to fill this out! ☺

_____ _____

Patient Signature Date of Signature