ALIGNED WELLNESS

New Patient Intake Form

Patient Information

Full Name: _____ Date of Birth: _____

Adress: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email

Emergency Contact | Name: _____ Phone: _____

Occupation: _____ Marital Status: _____

Primary Health Concerns

What are your top 3 health concerns?

1. _____
2. _____
3. _____

How long have you been experiencing these issues?

_____

_____

_____

_____

What have you tried so far? (Ex: treatments, diets, medications, etc.)

_____

_____

_____

_____

What are your goals for working with us?

_____

_____

_____

_____

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Women's Health (if applicable)

Are you currently:

- ☐ Pre-menopausal
- ☐ Perimenopausal
- ☐ Menopausal

Cycle Regularity:

☐ Regular ☐ Irregular

Last Menstural Period: _____

Symptoms

☐ Heavy Periods ☐ Painful Periods
☐ PMS ☐ Mood Changes

Pregnant or trying to concieve:

☐ Yes ☐ No

Number of pregnancies: _____

Current Medications

Medications (name/dose): _____

_____

_____

_____

Supplements (name/dose): _____

_____

_____

_____

Allergies & Sensitivies

Any Allergies or Sensitivities? _____

_____

_____

_____

_____

_____

_____

Family History

☐ Heart Disease ☐ Diabetes
☐ Cancer ☐ Thryroid Disease
☐ Autoimmune Disease

Details (relation & condition)

_____

_____

Medical History

Do you have or had any of the following?

☐ Heart Disease ☐ Diabetes
☐ Cancer ☐ Thryroid Disease
☐ Autoimmune Disease ☐ Anxiety/Depression
☐ Gastrointestinal Disease

Other Conditions: _____

_____

_____

_____

Surgeries (include dates): _____

_____

_____

_____

Hospitalizations (include reason/dates): _____

_____

_____

_____

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Lifestyle

Nutrition/Diet

- ☐ Paleo
- ☐ Whole Food
- ☐ Vegetarian
- ☐ Vegan
- ☐ Pescetarian
- ☐ Keto/ Low Carb
- ☐ No Sugar
- ☐ Mediterrian

Other Details:

_____

_____

Do you track macros or calories?

☐ Yes ☐ No

Typical Daily Meals:

_____

_____

_____

Daily Water Intake: _____ /oz

Caffeine Intake: _____ /day

Alcohol Intake: _____ /day

Excercise

- ☐ None (0 days a week)
- ☐ Rarely (1 day a week)
- ☐ Sometimes (2-3 times a week)
- ☐ Often (3-4 times a week)
- ☐ Always (4-5 times a week)

Sleep

Hours per night: _____ hrs

☐ Good Quality ☐ Poor Quality

Do you use sleep aids?

☐ Yes ☐ No

If yes: _____

Stress

Stress Level:

☐ High ☐ Medium ☐ Low

Main Stressors:

_____

_____

Current Symptoms

Energy & Mood

- ☐ Fatigue
- ☐ Brain Fog
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Poor Focus
- ☐ Burnout

Hormonal

- ☐ Low Libido
- ☐ Hair Thinning
- ☐ Weight Gain
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Irregular Periods
- ☐ Menopause Symptoms
- ☐ PMS

Digestive

- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Acid Reflux
- ☐ Food Sensitivities
- ☐ Nausea
- ☐ Gas
- ☐ IBS

Metabolic

- ☐ Difficulty losing weight
- ☐ Sugar Cravings
- ☐ Blood Sugar Swings
- ☐ High Chloestoral
- ☐ High Blood Pressure

Sleep

- ☐ Trouble Falling Asleep
- ☐ Waking up during the night
- ☐ Early waking
- ☐ Non-restoritive sleep

Other

- ☐ Headaches
- ☐ Joint Pain
- ☐ Skin issues (acne, ezcema)
- ☐ Frequent illness
- ☐ Autoimmune condition

Consent Form

I understand that Aligned Wellness provides functional medicine and wellness services focused on root-cause care and does not replace emergency or primary medical care.

I acknowledge that results vary and require active participation.

Name:_____ Date:_____

Signature:_____