

Your Wellness Visit; *Profile Update*

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (cell) _____

Fax # _____ E-mail address*: _____

Age: _____ Birthdate _____ Parents name if under 18 _____

Sex: M F Marital Status: Married Single Divorced Widowed

Occupation: _____

May we email you with test results or other confidential medical information? _____ (yes/no)**

May we leave confidential medical information on the home/cell phone number given above? _____ (yes/no)

PLEASE LIST FOODS YOU USUALLY EAT FOR:

Breakfast

Lunch

Dinner

Snacks

Are you ALLERGIC to, or intolerant of, any HERBS, SPICES, FOODS or DRUGS? Please list below:

Would you like a receipt to submit to your insurance company for your visit today?

(Please note: insurance companies do not generally cover telephone consultations.)

What are your goals for your wellness consultation today?

Please list all prescription medications, birth control pills, hormone replacement therapy, vitamins or other supplements that you are taking:

*Please Note: We strictly maintain the privacy of your email address.

** If no, results will be mailed.