Women's Intake Form

Name: ______________________ Date: ______________________

Address: ______________________ City: ____________ State: __________

Zip: __________ Cell #: ______________________ Home #: ______________________

Social Security#: ______________________ Date of Birth: ______________________

Driver's License Number: ______________________ State: __________

Email Address: ____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( )Widowed ( ) Separated ( ) Undisclosed

Patients Employer: ______________________ Work#: ______________________

Business Address: ____

City: ______________________ State: ______________ Zip: __________

Occupation: ____

Primary Insurance:______________________ Subscriber ID: ______________

Policy Holder Name: ____

Policy#: ______________________ Group#: ______________________

Secondary Insurance:______________________ Subscriber ID: ______________

Policy Holder Name: ____

Policy#: ______________________ Group#: ______________________

Emergency Contact: ______________________ Phone: ______________________

Relationship to Patient: ______________________ Date of Birth: ______________________

Address: ____

How did you hear about us? (Radio Station, TV Commercial, Facebook, Twitter, Instagram, Friend, Other)

____

Whom may we thank for referring you? ____

Patient Signature: ______________________ Date: ______________________

Patient Name: ______________________________ DOB: ___________________ Date: _______________

Primary Care Doctor (PCP): _________________________________ Phone#: _______________________

Pharmacy#: ____________________________________ Date of Last Exam: ________________________

Personal Health History:

Please Circle All That Apply:

General	Diabetes	High Cholesterol	Unwanted Weight Loss
Cancer	Personal History of Cancer	Family History of Cancer_______________	Autoimmune Disorder_________________
Cardiovascular	Heart Failure	Heart Attack	Heart Murmur
	Vascular Disease	Blood Clots	Edema
	Hypertension	Irregular Heartbeat	Congestive Heart Failure
Respiratory	Sleep Apnea	Shortness of Breath	Asthma/ COPD
	Bronchitis	Pneumonia	Allergies
Gastrointestinal	Lactose Intolerance	Gall Bladder	Gall Stones
	Chronic Diarrhea	Chronic Constipation	
Genitourinary	Prostate Cancer	Prostate Cancer In Family	Overactive Bladder
	Painful Urination	Decreased Urinary Force	ON/OFF Urine Flow
	Enlarged Prostate	Blood in Urine	Kidney/Bladder History
Infection	Kidney/Bladder	Liver	Any other
Psychiatric	History of Depression	Personality Disorder	Any other

List your prescribed medications and any over-the-counter medications, such as vitamins and inhalers. Please make sure, to include any anti-anxiety or anti-depressant medications.

Medication Name: ___________________________ Dosage: _____________ Frequency: ___________

Taken for: ____

Medication Name: ___________________________ Dosage: _____________ Frequency: ___________

Taken for: ____

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Taken for: ____

Medication Name: ___________________________ Dosage: _____________ Frequency: ___________

Taken for: ____

Allergies: Please circle (Y) (N) (No Known Allergies) If yes, list Allergies and Reactions

____

____

____

Surgeries:

Year: _______________ Surgery/Reason: ____

Year: _______________ Surgery/Reason: ____

Health Habits and Personal Safety:

Exercise: ________ Sedentary (No Exercise): ________ Mild Exercise: ________

Occasional Vigorous Exercise: ________ Regular Vigorous Exercise: ________

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week)

____

____

Pregnancies: _____________

Number of Children: _____________

Hysterectomy: _____________ If yes when: _____________

Last Menstrual Cycle: _____________

Rate your quality of sleep: (1-Worst 10-Best) Please circle one.

1 2 3 4 5 6 7 8 9 10

Lifestyle Questionnaire:

Alcohol: Yes or No If Yes, number of drinks per week: ________________________________

Tobacco: Yes or No If Yes, Cigarettes Cigars Chew How many/much: _______________

Are you interested in quitting tobacco? ____

Illicit drug use: Yes or No If Yes, explain ____

Questionnaire:

Anxiety:	Yes______	No______	Irritability:	Yes______	No______
Arthritis:	Yes______	No______	Bladder Symptoms:	Yes______	No______
Cramps:	Yes______	No______	Breast Tenderness:	Yes______	No______
Depression:	Yes______	No______	Difficulty Climaxing:	Yes______	No______
Dry Skin or Hair:	Yes______	No______	Diminished Sex Drive:	Yes______	No______
Fatigue:	Yes______	No______	Fluid Retention:	Yes______	No______
Hair Loss:	Yes______	No______	Headaches:	Yes______	No______
Hot Flashes:	Yes______	No______	Heavy/Irregular Periods:	Yes______	No______
Memory Loss:	Yes______	No______	Insomnia/Trouble Sleeping:	Yes______	No______
Mood Swings:	Yes______	No______	Night Sweats:	Yes______	No______
Vaginal Dryness:	Yes______	No______	Weight Gain:	Yes______	No______

I have had hormones checked previously Yes______ No______

If Yes, When: ____________________ Type: ____________________ Usage: ___________________

I hereby also declare that I will not be attending or starting any military basic/advanced individual training (AIT) school while I am a patient of Axis Rejuvenation, LLC.

Patient Name (Print): ____ DOB: ____________________

Signature: ____ Date: ____________________