263 Vietnam Veterans Memorial Hwy
Mangilao, Guam 96913
Tel: 671.735.8000
Fax: 671.735.8003

HEALTH & WELLNESS INTAKE FORM

General Information

Name: _____ **Date of birth:** _____ **Age**: _____ **Gender**: _____

Address: _____

Home phone: _____ **Cell phone:** _____ **Work phone:** _____

Email address: _____

Preferred contact method (check one): _____ **phone** _____ **email**

Marital status: _____ **Members of Household:** _____

Occupation: _____ **Work hours:** _____

Insurance Information

Primary insurance: _____ **Membership ID:** _____

Insured's name: _____ **DOB:** _____ **Relationship:** _____

Primary care physician name: _____

Other important healthcare providers: _____

Other Information

How did you hear of us? _____

Family History

Do you have a family history of the following? Please select all that apply.

Cancer	High blood cholesterol	Liver Disease
Diabetes	High blood pressure	Thyroid
Heart Disease	Kidney disease	Obesity

Other family medical history: _____

Gastrointestinal Symptoms

Please select if you experience any of the following

Abdominal bloating	Diarrhea	Heart burn
Abdominal cramping	Early satiety	Liquid stools
Abdominal distension	Excessive appetite	Nausea/ vomiting
Abdominal pain	Excessive belching	Poor appetite
Constipation	Excessive wind	Retching

Thyroid Health

Please select if you experience any of the following

Brittle nails	Dry skin	Foggy thinking	Palpitations
Constipation	Fatigue	Memory loss	Memory loss

Hormonal Health

Please select if you have any of the following

Anxiety	Erectile dysfunction	Increased urinary urge	Vaginal dryness
Decreased libido	Hot flashes	Infertility	Weight gain in hips
Depression	Increased facial hair		

Medical History

Please select if you have been diagnosed with or currently have any of the following medical conditions:

Arthritis / Joint pain / Back Pain Details:	Heart disease Details:	PMS
Anemia	Hepatitis	Polycystic ovary syndrome
Arthritis	High cholesterol levels	Pre-diabetes
Autoimmune condition	Hypertension (high blood pressure)	Prostate problems
Cancer (Type:)	HIV/AIDS	Psychiatric conditions Details:
Diabetes (Type:)	IBD (Crohn's or ulcerative colitis)	Sinusitis
Eating disorder Details:	Irritable bowel syndrome (IBS)	Sleep apnea
Epilepsy, convulsions, seizures	Kidney disease Details:	Stroke
Falls	Kidney stones	Thyroid disease Details:
Gallbladder disease / gallstones	Lung Disease Details:	Vitamin D deficiency
Gout	Liver Disease Details:	Rashes, Dry itchy skin, Dermatitis
Heart Attack/ Myocardial infarction	Osteoporosis / osteopenia	Other:

Other medical conditions: _____

Other allergies: _____

Past surgeries/ Hospitalizations: _____

Medication & Supplements

Please list all prescription and over-the-counter medications, vitamin, mineral and nutritional supplements, herbs/botanicals and diet aids you are currently taking.

Name of Medication / Supplement	Reason	Dose & Frequency

Weight History

Your current weight and height as well as information about what your weight was like the past.

Estimated weight: _____ **Height/length:** _____ ft _____ in

Lowest adult weight: _____ **Age:** _____

Highest adult weight: _____ **Age:** _____

Goal Weight: _____

Physical Activity

Approximately, how many days per week do you exercise: _____ **How long is each session:** _____

Type of exercise or physical activity completed (strength training, resistance, yoga, walking, jogging, etc.):

_____

If you do not exercise regularly, what are the barriers to exercising?

_____

Alcohol and Smoking History

Please answer the following questions about your alcohol and smoking history.

Approximately, how many days per week do you consume alcohol: _____

List the type of alcoholic beverages you commonly consume (beer, wine, distilled spirits, sake, etc**):**

_____

On the days that you drink alcohol, how many drinks do you usually have (One drink is equivalent to 12 oz beer, 5 oz glass of wine or 1 1/2 oz of distilled spirits [(vodka, whiskey, gin, etc.)]**:** _____

Do you currently smoke tobacco on a daily basis: yes or no

If yes, how many years: _____

Average number of cigarettes smoked per day: _____

If you smoked in the past, how many years: _____ **Average cigarettes smoked per day:** _____

Stress

On a scale from 1-10 with 10 being the highest, how would you rate your daily level of stress?

Stress rating (0 = no stress & 10 = extreme stress): _____ Details: _____

Sleep

Based on your sleep habits during the past month only.

Average hours slept on week nights: _____ Average hours slept on weekend nights: _____

Diet

Please answer the following questions about your diet and eating habits.

List any food allergies: _____

List any food intolerances and sensitivities: _____

What foods are restricted or limited for any reason (e.g. cultural, religious reason)? Please provide the reason/s for these restrictions: _____

_____

Please list or describe any food cravings that you experience:_____

_____

Approximately, how many days per week do you eat at restaurants, or order takeout? _____

Which meal is often eating away from home? _____

What restaurants do you frequently dine at? _____

What types of things ordered when dining out? _____

Who completes the grocery shopping in your household? _____

Who does the meal preparation and cooking at home? _____

What diets have you tried in the past? _____

How long do your diets usually last? _____

What diets have been successful for managing your health? _____

Are you currently on a diet? _____

What are your health goals? _____

_____

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Client/patient Name: _____ Date: _____

NEWGEN POLICIES

Below you will find information regarding your rights and responsibilities and established policies of this practice. Please read this carefully and sign at the end of each section if you agree. Please feel free to ask any questions for clarification.

Agreement to Use Electronic Signatures and Electronic Documents

You agree that the electronic signatures included in this notice are intended to authenticate this writing and to have the same force and effect as manual signatures.

Electronic signature means any electronic sound, symbol or process attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including (without limitation) typing a name or clicking a check box.

Signature: _____

Appointments & Attendance Policy

Appointments

Office visits are by appointment only. Please arrive on time. Kindly remember to bring any forms, assignments, and labs. Patients who are late for any appointment may be asked to reschedule.

Cancellations

We would like to thank you for being a patient/client in our clinic. We value you and strive to provide the best care possible. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient/client who would like it. Same day cancellation (within 24 hours of appointment date and time) will result in a fee of ***$15.00***. No-show or failure to show up for an appointment without notice will result in a fee of ***$25.00***.

Signature: _____

Financial Policy

Payments will be due at the time of service. If applicable we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

Signature:

Notice of Privacy Practices

Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail, via e-mail or asking for one at the time of your next appointment.

If you would like a copy of our Notice of Privacy Practices, please ask our front desk. By signing this form, you acknowledge that you have been offered a copy for review.

Signature:

Consent to Treat & Authorization to release information, assignment of benefits

By signing this form, you hereby authorize NewGen Physical Therapy aka NEWGEN, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary in the treatment of your condition. You further authorize NEWGEN to furnish the appropriate agencies, for billing, any information acquired during the course of your treatment and to send you notices and reminders of your appointment via email. You agree to assign your insurance benefits to NEWGEN in which you receive and authorize your insurance carrier to make payments to NEWGEN on your behalf. NEWGEN is HIPAA compliant with regard to information sharing policies.

Signature:
