Total Wellness Medical Care
208 E. 2nd North St.
Summerville, SC, 29486
Phone: (843) 261-8911 / Fax: (843) 261-8912

Patient Intake Form

Patient Demographics

Name:		DOB:		Date:	
Address:				SS#:	
Email:				Phone #:	
Ok to Leave Voicemail:	☐ Yes ☐ No	Ok to Send Text Message:		☐ Yes	☐ No
Marital Status:		Gender:		Ethnicity:	
Emergency Contact:			Relationship to You:		
Email:			Phone #:		
Referred by:					

Primary Insurance

Insurance Name:	
Member ID:	Group Number:
Insurance Phone #:	Effective Date:
Policy Holder's Employer:	Phone #:
Relationship to Insured:	
Person Responsible for Account:	

Secondary Insurance

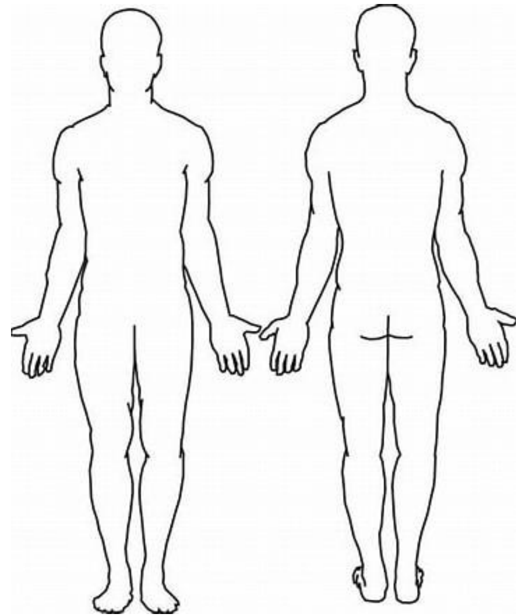
Insurance Name:	
Member ID:	Group Number:
Insurance Phone #:	Effective Date:
Policy Holder's Employer:	Phone #:
Relationship to Insured:	

Medical History

Primary Care Provider:	Phone #:
Please list all health care providers who are currently managing your care.	
Name	**Speciality**
Current Medical Conditions:	

Pain

<table>
<tr><td>Are you experiencing Pain?

Pain level today from 1 (least pain) to 10 (severe pain):</td><td>☐ Yes</td><td>☐ No</td><td>Location of Pain (mark on chart):
</td></tr>
<tr><td>Is this pain due to an accident?</td><td>☐ Yes</td><td>☐ No</td><td>Date of accident:</td></tr>
<tr><td>When did the pain start?</td><td colspan="3">How often do you have this pain? Is it constant or does it come and go?</td></tr>
</table>

Pain level today from 1 (least pain) to 10 (severe pain):	How would you describe the pain? (sharp, aching, burning, throbbing, numbness, shooting, etc)
What makes the pain better or worse? What treatments have you tried?	

Medications

List all prescription and over the counter medications, including herbal and nutritional supplements. *Attach list if more room is needed.*

Medication	Dose	Frequency	Prescribed By

Surgeries/Hospitalizations

Type of Surgery / Hospitalization	Date

Medical Information

List any vaccines you've had in the last year:
Allergies:

Health Maintenance History			
Yearly Physical	Date:	☐ Normal	☐ Abnormal
Lab Work	Date:	☐ Normal	☐ Abnormal
Colonoscopy	Date:	☐ Normal	☐ Abnormal
Pap Smear	Date:	☐ Normal	☐ Abnormal
Bone Density	Date:	☐ Normal	☐ Abnormal
Mammogram	Date:	☐ Normal	☐ Abnormal

Women's Health History			
Are you currently pregnant or breastfeeding?		Yes	No
First Day of Last Menstrual Cycle:		Age of First Menstruation:	
Pregnancy Complications:		☐ Yes	☐ No
Number of Pregnancies:	Number of Live Births:	Age of Menopause:	

Please check any condition you currently have OR have ever had in the past (include childhood illnesses).

- ☐ None
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Blood clot
- ☐ Anemia
- ☐ Depression
- ☐ Osteoporosis
- ☐ Pins or Metal Implants
- ☐ Arthritis
- ☐ Epilepsy
- ☐ COPD
- ☐ Anxiety
- ☐ Gout
- ☐ Seizures
- ☐ Hepatitis
- ☐ Stroke
- ☐ Concussion
- ☐ STD
- ☐ Hernia
- ☐ High cholesterol
- ☐ Neurologic disorder
- ☐ Acid reflux/GERD
- ☐ Irritable bowel
- ☐ Glaucoma
- ☐ Fibromyalgia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Heart disease
- ☐ Heart attack
- ☐ Alcoholism
- ☐ Insomnia
- ☐ Liver disease
- ☐ Migraines/Headaches
- ☐ Autoimmune disease
- ☐ Kidney disease
- ☐ High Blood Pressure

Additional Information:

Have you experienced any of these symptoms recently? (Check all that apply)

- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Nausea/Vomiting/ Diarrhea
- ☐ Poor Balance/Falls
- ☐ Difficulty Swallowing
- ☐ Painful Menstruation
- ☐ Dizziness
- ☐ Vision Changes
- ☐ Memory Problems
- ☐ New Muscle Weakness
- ☐ Shortness of Breath
- ☐ Change in Bowel Habits
- ☐ Change in Bladder Habits/Control
- ☐ Suicidal Ideation
- ☐ Self-Injury
- ☐ Fever/Chills/Sweats
- ☐ Difficulty Speaking
- ☐ Numbness/Tingling
- ☐ Change in Appetite
- ☐ Confusion/Brain Fog
- ☐ Unexplained Weight Gain/Loss
- ☐ Other:

Family History

List health problems and causes of death, if applicable:

Relationship to You	**Status**	**Age**	**Medical Problem** (Cancer, Heart Disease, Diabetes, etc)
Father	☐ Living ☐ Deceased		
Mother	☐ Living ☐ Deceased		
Father's Father	☐ Living ☐ Deceased		
Father's Mother	☐ Living ☐ Deceased		
Mother's Father	☐ Living ☐ Deceased		
Mother's Mother	☐ Living ☐ Deceased		
Brother	☐ Living ☐ Deceased		
Sister	☐ Living ☐ Deceased		
Child	☐ Living ☐ Deceased		
Child	☐ Living ☐ Deceased		

Other family member information:

Social History

Employment:
Currently Employed: ☐ Yes ☐ No Occupation:

☐ Never employed ☐ Student ☐ Retired ☐ Disabled

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Temporary/seasonal

Other:

Tobacco Use: ☐ Yes ☐ No	**Alcohol Use:** ☐ Yes ☐ No
If yes, how many packs a day:	If yes, how many drinks a day/week:
Number of years:	☐ Beer ☐ Wine ☐ Liquor
Have you ever quit smoking? ☐ Yes ☐ No	Have you been told your drinking is a concern?
	☐ Yes ☐ No
Drug Use: ☐ Yes ☐ No	Notes:
If yes, which ones?	

Exercise: Do you exercise regularly? ☐ Yes ☐ No	What kind of exercise? Duration: Frequency:	
Safety: Do you feel safe at home? ☐ Yes ☐ No	If no, please explain:	
Sleep: How many hours, on average do you sleep per night?	Trouble falling asleep? ☐ Yes ☐ No	Trouble staying asleep? ☐ Yes ☐ No

Sexuality: Are you sexually active? ☐ Yes ☐ No

If sexually active, do you practice safe sex? ☐ Yes ☐ No

Current sex partner(s) are: ☐ Male ☐ Female

Birth control method:	
Have you ever had a sexually transmitted disease?	☐ Yes ☐ No
If yes, please explain:	
Are you interested in being screened for sexually transmitted diseases?	☐ Yes ☐ No
Emotions: In the past year, have you had 2 or more weeks when you've felt sad, depressed or lost interest in things you once enjoyed?	☐ Yes ☐ No
Have you felt depressed or sad much of the time in the past year?	☐ Yes ☐ No
Do you find yourself so anxious that you isolate or avoid situations?	☐ Yes ☐ No
Do you ever feel like hurting yourself or others?	☐ Yes ☐ No
Is there any additional information you would like us to know?	

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Signature	Printed Name	Date