Advance Practice Health Partners

Health Intake Form

Patient information:

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Date of Birth:_____ Age:_____ Sex: M / F

Occupation:_____ Email Address:_____

Emergency Contact-

Name:_____ Phone Number:_____

How did you hear about us? _____ Internet _____ Facebook _____ Walk-In

Friend: _____

What pharmacy do you use?_____

What are your most bothersome symptoms? Check all that apply

_____Fatigue or low energy

_____Stress

_____Poor diet due to busy lifestyle

_____Brain fog or trouble concentrating

_____Low mood or depression

_____Recent illness

_____ Weight gain/Over weight

_____Other

_____Cold or flu symptoms

_____Dehydration

_____Dull or Dry Skin

_____Malabsorption issues

_____Headaches or migraines

_____ Hormone Imbalance

_____ Gentlemen's Health

_____ Ladies Health

Which statements best describe your health goals? Check all that apply

___ I want to have more energy and feel better overall

___I want to do everything I can to nourish my body

___I want to prevent getting sick

___I want to recover quickly from my surgery or illness

___I want to have smoother, brighter and more vibrant and skin, hair and nails

___I want to lose body fat and decrease my BMI

___I want to balance my hormones

___Other_____

Name:_____ Date of Birth:_____

Why are you seeking care today?

_____

_____

_____

Health History

Do you have any known Allergies? Please list all (Medication and Food)

_____
_____
_____

Do you have any medical problems or Diagnosis? If so, Please list them:

_____
_____
_____
_____

Are you Pregnant or breastfeeding? YES / NO

Date of most recent lab testing?_____

Please provide recent labs to Provider or Health care Professional if available

Are you Diabetic? YES / NO

Are you a smoker? YES / NO

How many alcoholic drinks do you consume in a week?_____

Do you use recreational drugs? YES / NO

Do you have a history of any cancers? _____

_____

Please List ALL Medications and Supplements that you are taking and why:

_____
_____
_____
_____
_____

Name:_____ Date of Birth:_____

Do you take Digoxin (Lanoxin) ? YES / NO

Do you take a Diuretic or "water pill"? YES / NO

Do you take Steroids, i.e. Prednisone? YES / NO

Do you have any of the following conditions? (Please check all that apply)

___ High blood pressure

___Heart Problems

___Stroke or "mini-stroke"

___Kidney Problems

___Kidney Stones

___Parathyroid Problems (high levels, cancer)

___Asthma

___Optic Nerve Atrophy or Leber's Disease

___Sickle Cell Anemia

___G6PD Deficiency

___Sarcoidosis

List any Surgical Procedures you have had and approximate date:

_____
_____
_____
_____
_____

Please provide any other information that you would like the Nurse Practitioner to know:

_____
_____

_____

_____

Name:_____ Date of Birth:_____

TeleHealth Medication Management Program:

1. This program is a monthly subscription that you agree to participate in and provide all needed information as requested to participate.
2. If you no longer wish to participate in the program, please provide 30 day written notice to Advance Practice Health Partners.
3. Prescriptions are sent to your pharmacy to be purchased by you at your cost after insurance coverage.
4. A copy of your most recent bloodwork would be informative but not required. It will be recommended that you obtain blood work during this program. It will be your responsibility to obtain this if you choose. An order will be provided for you to take to a lab of your choice. APHP has a partnership with a lab that offers cash prices if you are interested in that please ask your provider.
5. Your signed consent form for the program is needed.
6. Your signed Telehealth form for the program is needed.
7. APHP has a partnership with several pharmacy. If your insurance coverage for medications is too costly let us know and we can price at our affiliated pharmacy's.
8. If you choose to use APHP pharmacy's the cost of the medication is due at the time of order.
9. You agree to pay the monthly subscription fee on the 1st of each month by the agreed upon payment method.
10. This program does not include sick/illness TeleHealth visits. There will be a separate charge for that type of visit.

By signing this for you agree to the participation agreement. We look forward to helping you with your health goals!

Signature:____________________________________ Date:________________________