



WELLNESS CONCEPTS OF FLORIDA, L.L.C.
CONFIDENTIAL PATIENT INTAKE

Date _____

Name _____ M F Home Phone (____) _____

Other Phone (____) _____

Address _____ City _____ ST _____ Zip _____

Age _____ Birth Date _____ Social Security # _____

Marital Status M S W D No. of Children _____ Email _____

Occupation _____ Employer _____

Address _____

Work Phone(____) _____

Name of Spouse _____ Spouse Social Security # _____

Spouse Employer _____ Work Phone (____) _____

Address _____

Name of Emergency Contact _____ Phone (____) _____

How do you prefer to be verbally addressed? _____

Whom may we thank for referring you? _____

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN _____

May we contact your physician regarding your care at this office? Yes No

What **Non-prescription** meds are you taking? ___ Tylenol ___ Ibuprofen/Advil ___ Aspirin ___ Other _____

GOALS (Please circle all that apply)

Symptom Relief

Nutrition

Exercise

Wellness Plan

QUESTIONS _____

Patient Signature

Date