



Personalized Medicine for Better Health

COMPREHENSIVE WELLNESS INTAKE FORM

Please complete this form as thoroughly as possible before your consultation.

Important: This consultation does not replace diagnosis or treatment by your physician or other licensed healthcare provider. Do not stop or change prescription medication without consulting the prescriber.

Patient Name: _____

Date of Birth: _____

Date Completed: _____

SECTION 1: PATIENT INFORMATION

Address / City / State / ZIP: _____

Phone: _____

Email: _____

Primary Care Provider: _____

Other Key Providers: _____

Sex assigned at birth: ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to answer

Relationship status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Widowed ☐ Other

SECTION 2: REASON FOR CONSULTATION & GOALS

Primary reason for consultation: _____

Top 3 health concerns (1, 2, 3): _____

When did you last feel completely well? _____

What was happening when symptoms began? _____

What have you already tried, and what happened? _____

What would make this consultation feel successful to you? _____

SECTION 3: SYMPTOM REVIEW (past 3 months)

Symptom (past 3 months)	None	Mild	Mod	Severe
Energy & Metabolism				
Fatigue / low stamina	☐	☐	☐	☐
Unexplained weight change	☐	☐	☐	☐
Feeling unusually cold or hot	☐	☐	☐	☐
Brain & Nervous System				
Brain fog / poor concentration	☐	☐	☐	☐
Headaches or migraines	☐	☐	☐	☐
Dizziness or numbness/tingling	☐	☐	☐	☐
Mood & Emotional Health				
Anxiety or excessive worry	☐	☐	☐	☐
Low mood / depression	☐	☐	☐	☐
Irritability / overwhelmed	☐	☐	☐	☐
Sleep				
Difficulty falling or staying asleep	☐	☐	☐	☐
Unrefreshing sleep	☐	☐	☐	☐
Snoring, gasping, or restless legs	☐	☐	☐	☐
Digestive				
Bloating / gas	☐	☐	☐	☐
Constipation or diarrhea	☐	☐	☐	☐

Symptom (past 3 months)	None	Mild	Mod	Severe
Reflux / abdominal pain	☐	☐	☐	☐
Pain & Inflammation				
Joint pain or swelling	☐	☐	☐	☐
Muscle aches / morning stiffness	☐	☐	☐	☐
Back or neck pain	☐	☐	☐	☐
Skin, Immune & Allergy				
Dry skin, rash, or hair loss	☐	☐	☐	☐
Seasonal allergies / sinus symptoms	☐	☐	☐	☐
Frequent infections	☐	☐	☐	☐
Hormonal & Sexual Health				
Low libido / hot flashes / night sweats	☐	☐	☐	☐
Menstrual changes or erectile difficulty	☐	☐	☐	☐

Which symptoms interfere most with daily life?

SECTION 4: MEDICAL, SURGICAL & FAMILY HISTORY

Current & past diagnoses (year, status): _____

Surgeries, hospitalizations, or major injuries: _____

Family History	Mother	Father	Sibling	Details / Age
Heart disease / stroke / high BP	☐	☐	☐	
Diabetes / obesity	☐	☐	☐	
Cancer	☐	☐	☐	
Autoimmune / thyroid disorder	☐	☐	☐	
Depression / anxiety / dementia	☐	☐	☐	

SECTION 5: MEDICATIONS, SUPPLEMENTS & ALLERGIES

Prescription & nonprescription medications

Medication	Dose	Frequency	Reason	Helpful / Side effects?

Vitamins, minerals, herbs, supplements

Product	Dose	Frequency	Reason	Benefit / Concern

Medication allergies & reactions: _____

Food allergies / intolerances & reactions: _____

Medication you hope to reduce or stop with prescriber guidance: _____

SECTION 6: NUTRITION, DIGESTION, SLEEP & LIFESTYLE

Current eating pattern: ☐ No special diet ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Mediterranean ☐ Other

Daily vegetable servings: _____ Daily water intake: _____

Foods you avoid / crave, and why: _____

Bowel movements: ☐ More than 3/day ☐ 1-3/day ☐ Every other day ☐ Fewer than 3/week

Digestive red flags (blood/black stool, unexplained change): ☐ No ☐ Yes

History of reflux, IBS, IBD, celiac, gallbladder, or liver disease: _____

Average sleep hours: _____ Energy on waking: _____

Sleep symptoms: ☐ Snoring ☐ Gasping ☐ Dry mouth ☐ Morning headache ☐ Restless legs ☐ Teeth grinding

Current stress level (0-10): _____ Exercise frequency: _____

Biggest current stressors / how you cope: _____

Tobacco / nicotine use: _____ Alcohol use: _____

Occupation & major workplace exposures: _____ Mold, chemical, or water-damage exposure: _____

Who lives with you, and what support do you have? _____

SECTION 7: HORMONAL & REPRODUCTIVE HEALTH

For patients with menstrual cycles / ovaries

LMP / cycle length: _____ Pregnancies / births / miscarriages: _____

Contraception; PCOS, endometriosis, fibroids, or abnormal bleeding history: _____

Menopause status / hormone therapy; last Pap or mammogram: _____

For patients with testes / prostate

Libido, sexual function, urinary symptoms; testosterone therapy: _____

History of infertility / testicular concerns; last PSA & result: _____

SECTION 8: LABORATORY TESTING (past 3 years)

Completed: ☐ CBC/CMP ☐ A1c/glucose ☐ Lipid panel ☐ Thyroid panel ☐ Vitamin D ☐ B12/Ferritin
☐ Sex hormones ☐ Cortisol ☐ DEXA scan ☐ Cardiac testing ☐ GI/stool testing ☐ Genetic test ☐ None/unsure

Recent abnormal findings you want reviewed (attach reports if available): _____

SECTION 9: READINESS & PREFERENCES

Rate your willingness to make each change (0 = not ready, 5 = very ready)

Change	0	1	2	3	4	5
Modify nutrition	☐	☐	☐	☐	☐	☐
Improve sleep routine	☐	☐	☐	☐	☐	☐
Exercise regularly	☐	☐	☐	☐	☐	☐
Take supplements consistently	☐	☐	☐	☐	☐	☐
Complete recommended labs	☐	☐	☐	☐	☐	☐
Reduce alcohol or nicotine	☐	☐	☐	☐	☐	☐
Practice stress-management strategies	☐	☐	☐	☐	☐	☐

Biggest obstacle to improving your health: _____

Support that helps most: ☐ Written plan ☐ Simple first steps ☐ Detailed education ☐ Accountability/follow-up ☐ Coordination with providers

Anything important that was not covered? _____

SECTION 10: PATIENT CERTIFICATION & COMMUNICATION

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that this consultation is educational and collaborative and does not replace medical diagnosis, emergency care, or the services of my prescribing healthcare professionals. I agree to inform The Medicine Chest Pharmacy of significant changes in my medications, allergies, symptoms, or medical history.

Preferred follow-up method: ☐ Phone ☐ Text ☐ Email ☐ Patient portal

May we leave a detailed voicemail? ☐ Yes ☐ No

May we communicate with your providers about recommendations, when authorized? ☐ Yes ☐ No

Patient Signature: _____

Date: _____

Printed Name: _____

Parent/Guardian (if applicable): _____

FOR OFFICE USE: PHARMACIST REVIEW & CONSULTATION PLAN

Consultation date: _____

Pharmacist: _____

Primary priorities identified: _____

Medication-related concerns: _____

Nutrition / supplement opportunities: _____

Recommended provider follow-up / labs / monitoring: _____

Initial action plan: _____

Follow-up date: _____

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