Patient Intake Form

Wellness BioSciences Rx

Date:

First Name: _____ Last Name: _____ MI: _____ DOB: _____

☐ M ☐ F	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Health Habits & Personal Safety

Exercise	☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy	☐ 1/2 times per week ☐ Several times per week ☐ Daily
Diet	☐ None ☐ Patient Selected ☐ Physician Prescribed	**Diet Plan:**
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Energy Drinks	☐ 1/2 times per week ☐ Several times per week ☐ Daily
Alcohol	☐ None ☐ 1/2 times per week ☐ 3/4 times per week ☐ 1/2 times per day	
Tobacco Use	☐ Cigarettes ☐ Chew/Dip ☐ Pipe ☐ Cigar	
	☐ 1/2 times per week ☐ Several times per week ☐ Daily ☐ Former Use ☐ Never	
Recreational/ Street Drug Use	☐ 1/2 times per week ☐ Several times per week ☐ Daily ☐ Former Use ☐ Never	
Do you need help	☐ Dressing ☐ Eating ☐ Bathing ☐ Medication Management	
Personal Safety	☐ Live Alone ☐ Strong Support System ☐ Hearing Loss ☐ Vision Loss ☐ Frequent Falls	
Socialize	☐ 1/2 times per week ☐ Several times per week ☐ Daily	

Family Health History

Diabetes	☐ Self ☐ Siblings ☐ Father ☐ Mother ☐ Maternal Grandparents ☐ Paternal Grandparents
Alzheimer's	☐ Self ☐ Siblings ☐ Father ☐ Mother ☐ Maternal Grandparents ☐ Paternal Grandparents
Dementia	☐ Self ☐ Siblings ☐ Father ☐ Mother ☐ Maternal Grandparents ☐ Paternal Grandparents
Heart Attack	☐ Self ☐ Siblings ☐ Father ☐ Mother ☐ Maternal Grandparents ☐ Paternal Grandparents
High Blood Pressure	☐ Self ☐ Siblings ☐ Father ☐ Mother ☐ Maternal Grandparents ☐ Paternal Grandparents
Cancer	☐ Self ☐ Siblings ☐ Father ☐ Mother ☐ Maternal Grandparents ☐ Paternal Grandparents

Personal Health

	☐ Concussion **Year(s):** ☐ Stroke **Year(s):**
	Have you ever been prescribed/used medical marijuana? ☐ Yes ☐ No
	Have you ever taken CBD? ☐ Yes ☐ No
	Do you currently use CBD? ☐ Yes ☐ No If so, what are you using and for what ailments?
	Do you want information about the safe & efficacious benefits of CBD from your healthcare provider? ☐ Yes ☐ No
Other Comments	

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	Yes	No
1. I feel depressed.	☐	☐
2. I am feeling discouraged about the future.	☐	☐
3. I am not enjoying things as much as I used to.	☐	☐
4. I often feel irritable for no good reason.	☐	☐
5. I have very little interest in anything.	☐	☐
6. I often have difficulty concentrating.	☐	☐
7. I am easily distracted.	☐	☐
8. I have a very short attention span.	☐	☐
9. I am forgetful and need constant reminders.	☐	☐
10. I feel as though I am scattered and disorganized.	☐	☐
11. It's hard for me to fall asleep.	☐	☐
12. I am restless or get disrupted sleep.	☐	☐
13. I have low energy.	☐	☐
14. I feel fatigued at certain times in the day.	☐	☐
15. I wake up early and can't go back to sleep.	☐	☐
16. I feel anxious.	☐	☐
17. I feel restless and nervous.	☐	☐
18. I worry much more than I used to.	☐	☐
19. I feel tense.	☐	☐
20. I often feel fidgety and can't sit still.	☐	☐
21. Alzheimer's or another form of the dementia disease classification is in on one or both sides of my family.	☐	☐
22. I am unable to remember things like I used to.	☐	☐
23. I am having regular problems with my memory.	☐	☐
24. I sometimes forget where things are kept and look in the wrong places.	☐	☐
25. I seem to not recognize places I have been.	☐	☐
26. I can't remember names of close relatives and friends.	☐	☐