

ENVISTA MEDICAL NECK & BACK CENTER

WELLNESS INTAKE FORM

For Weight Management, Peptide Therapy & Wellness Services

PATIENT INFORMATION

Full Legal Name: _____ Date of Birth: _____

Contact Phone Number: _____ Gender: ☐ Female ☐ Male

Email Address: _____

Address: _____

City: _____ State: _____ ZIP: _____

Occupation: _____

Emergency Contact and Phone Number: _____

YOUR PRIMARY WELLNESS GOALS

Please select ONLY TWO primary goals.

Selecting your two highest priorities helps our clinical team understand what is most important to you and allows us to focus your consultation appropriately.

☐ Anti-aging/Longevity	☐ Injury Healing/Tissue Repair	☐ Immune Support / Gut Health
☐ Fat Loss/Weight Management	☐ Cognitive Function/Clarity	☐ Energy / Mitochondria
☐ Improved Muscle Mass/Recovery	☐ Sleep / Nervous System	☐ Skin / Aesthetic

☐ Other: _____

Of the two goals you selected, which is your #1 priority?

Briefly describe what you would like to improve:

CURRENT HEALTH

How would you describe your overall health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current or previous medical conditions — check all that apply:

☐ High blood pressure	☐ Diabetes / prediabetes	☐ Hormonal condition
☐ Thyroid disorder	☐ Heart disease	☐ Pancreatitis
☐ Kidney disease	☐ Liver disease	☐ Cancer — type/year: _____
☐ Autoimmune disease	☐ Chronic pain	☐ Other: _____

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Past surgeries or hospitalizations (type and year):

MEDICATIONS, SUPPLEMENTS & ALLERGIES

Prescription medications, vitamins, supplements, or over-the-counter medications — include name, dose, and frequency:

Allergies:

- ☐ No known allergies
☐ Yes — please list allergy and reaction:
-

IMPORTANT MEDICAL SAFETY QUESTIONS

*Please answer **YES** or **NO** to each question.*

Currently pregnant, trying to become pregnant, or breastfeeding? ☐ **YES** ☐ **NO**

History of pancreatitis? ☐ **YES** ☐ **NO**

Personal or family history of medullary thyroid cancer or MEN-2? ☐ **YES** ☐ **NO**

Severe kidney disease? ☐ **YES** ☐ **NO**

Severe liver disease? ☐ **YES** ☐ **NO**

Currently receiving treatment for cancer? ☐ **YES** ☐ **NO**

LIFESTYLE INFORMATION

Activity level: ☐ Sedentary ☐ Light ☐ Moderate ☐ High

Days per week you exercise: _____ Average hours of sleep per night: _____

Tobacco use: ☐ Never ☐ Former ☐ Current

Alcohol use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

How would you describe your current nutrition?

☐ Mostly healthy / balanced ☐ Somewhat healthy ☐ Needs improvement ☐ Unsure

Typical daily water intake: _____

ADDITIONAL INFORMATION

Is there anything else you would like our clinical team to know before your consultation?

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WEIGHT MANAGEMENT HISTORY

IF YOU ARE HERE FOR WEIGHT MANAGEMENT, PLEASE COMPLETE THIS SECTION.
IF NOT, PLEASE SKIP TO THE SIGNATURE SECTION.

Desired weight: _____ How long has it been since you were at or near your desired weight? _____

Have you previously used any weight-loss programs or prescription weight-loss medications?

☐ No ☐ Yes

If yes, please list the program(s) and/or medication(s), how long you used them, and your results:

What has been your biggest challenge with weight management? *Check all that apply:*

☐ Hunger / appetite	☐ Emotional / stress eating	☐ Maintaining weight loss
☐ Cravings	☐ Nutrition / food choices	☐ Metabolic or medical concerns
☐ Portion control	☐ Exercise / activity	☐ Other: _____

List up to 3 ways your life or health would improve if you reached your weight-management goal:

1. _____

2. _____

3. _____

Rate your current commitment to making changes toward your weight-management goal:

1 2 3 4 5 6 7 8 9 10
Lowest Highest

Are there any barriers that could make it difficult for you to start or follow a weight-management program?

PATIENT CERTIFICATION & SIGNATURE

I certify that the information provided on this form is true, accurate, and complete to the best of my knowledge. I understand that I am responsible for informing Envista Medical of any changes to my medical history, medications, or health status.

Patient Name (Print): _____ Date: _____

Patient Signature: _____