



TIMELESS WISDOM TO SOLVE TODAY'S PROBLEMS

## NEW PATIENT INTAKE FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ Mailing Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Single  Married/Partnership  Divorced  Widowed  Separated

### Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient:  Parent  Legal Guardian  Spouse  Family Member  Other:

### How did you hear about us?

Add me to your e-mail list:  Yes  No

If under 18 years old, parental consent required: I (please print) \_\_\_\_\_ give Arizona Wellness Foundation permission to treat my child.

Parent/Guardian Signature: \_\_\_\_\_

### Responsibility Agreement, Statement of Financial Policy and Fragrance Policy

By signing below you acknowledge, understand and agree to the following:

1. I am responsible for payment for all services rendered- payment is due in full at the time of service.
2. Arizona Wellness Group, INC is out of network with all insurance companies and does not file insurance claims. Arizona Wellness Group, INC will provide a receipt for me to submit to my insurance company.
3. I understand that unless 24 hours advanced notice is given, a canceled, rescheduled or no-show appointment will result in a \$50 charge to my account and that I will be asked for a deposit to be made for my next visit at the time of scheduling.
4. Arizona Wellness Group, INC treats allergies and environmental illnesses; we ask that all those who come to the office respectfully refrain from wearing perfumes, colognes, fragrance lotions, sprays or other scented products. Sensitive patients may experience adverse reactions such as respiratory distress, fainting or balance problems. If this occurs, I understand that I may be asked to reschedule.
5. I understand that I have the ability and it is my right to be able to select/direct which pharmacy my prescriber uses to fill my medication orders

I have read and understand/agree to the information on this form.

Patient Name: (please print)	Date:	Patient/Guardian Signature:
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# Patient Questionnaire

What is the main reason for your appointment?

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Have there been any major changes in your life within the past year?  Yes  No

Do you currently see a medical doctor?  Yes  No

*If you are currently under the care of another medical professional, Dr. Andria Orłowski is happy to work with both you and your physician to create a treatment plan to serve you effectively and efficiently.*

## Lifestyle

Alcohol:  N/A Type: \_\_\_\_\_ Amount: \_\_\_\_\_ day/week/month  
Caffeine:  N/A Type: \_\_\_\_\_ Amount: \_\_\_\_\_ day/week/month  
Exercise:  N/A  Occasionally  Daily  Recreational  Competitive Athlete  
Tobacco:  N/A Type: \_\_\_\_\_ Amount: \_\_\_\_\_ day/week/month  
Comments:

## Family History

<input type="checkbox"/> Asthma/Allergies	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Auto-Immune Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lung Condition	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Unknown
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other _____	

## Patient Medical History

Please list all sensitivities/allergies/reactions:

Drugs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Foods: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Environment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all current prescription medications and nutrient supplements/herbs:

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Please list any past hospitalizations or surgeries:

Please indicate if you have ever experienced any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Heart Attack     | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Auto-Immune Disease | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Neuromuscular Disease | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis          | Other:                                   |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> HIV/AIDS         | <input type="checkbox"/> Pacemaker             |  |

**Review of System:** Please circle **Y** if you regularly experience it or **P** if you have in the past but no longer are.

**General**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> P Always feel cold | <input type="checkbox"/> Y <input type="checkbox"/> P Cold hands/feet | <input type="checkbox"/> Y <input type="checkbox"/> P Fever/Chills |
| <input type="checkbox"/> Y <input type="checkbox"/> P Always feel hot  | <input type="checkbox"/> Y <input type="checkbox"/> P Fatigue         | Other:   |

**Head & Neck**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> P Dandruff  | <input type="checkbox"/> Y <input type="checkbox"/> P Hair Loss   | <input type="checkbox"/> Y <input type="checkbox"/> P Oily Hair      |
| <input type="checkbox"/> Y <input type="checkbox"/> P Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> P Headache    | <input type="checkbox"/> Y <input type="checkbox"/> P Stiffness      |
| <input type="checkbox"/> Y <input type="checkbox"/> P Dry Hair  | <input type="checkbox"/> Y <input type="checkbox"/> P Head Injury | <input type="checkbox"/> Y <input type="checkbox"/> P Swollen Glands |
| <input type="checkbox"/> Y <input type="checkbox"/> P Fainting  | <input type="checkbox"/> Y <input type="checkbox"/> P Migraine    | Other:   |

**Skin**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> P Acne               | <input type="checkbox"/> Y <input type="checkbox"/> P Excessive Sweating | <input type="checkbox"/> Y <input type="checkbox"/> P Night Sweats |
| <input type="checkbox"/> Y <input type="checkbox"/> P Bruising           | <input type="checkbox"/> Y <input type="checkbox"/> P Itchiness          | <input type="checkbox"/> Y <input type="checkbox"/> P Psoriasis    |
| <input type="checkbox"/> Y <input type="checkbox"/> P Brittle/Weak Nails | <input type="checkbox"/> Y <input type="checkbox"/> P Hives              | <input type="checkbox"/> Y <input type="checkbox"/> P Rash         |
| <input type="checkbox"/> Y <input type="checkbox"/> P Color change       | <input type="checkbox"/> Y <input type="checkbox"/> P Keloid             | <input type="checkbox"/> Y <input type="checkbox"/> P Warts        |
| <input type="checkbox"/> Y <input type="checkbox"/> P Dryness            | <input type="checkbox"/> Y <input type="checkbox"/> P Lump               | <input type="checkbox"/> Y <input type="checkbox"/> P              |
| <input type="checkbox"/> Y <input type="checkbox"/> P Eczema             | <input type="checkbox"/> Y <input type="checkbox"/> P Mole               | Other:   |

**Eyes & Ears**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> P Blurry vision          | <input type="checkbox"/> Y <input type="checkbox"/> P Double vision  | <input type="checkbox"/> Y <input type="checkbox"/> P Itchiness           |
| <input type="checkbox"/> Y <input type="checkbox"/> P Burning eyes           | <input type="checkbox"/> Y <input type="checkbox"/> P Dry eyes       | <input type="checkbox"/> Y <input type="checkbox"/> P Poor night vision   |
| <input type="checkbox"/> Y <input type="checkbox"/> P Cataracts              | <input type="checkbox"/> Y <input type="checkbox"/> P Earache        | <input type="checkbox"/> Y <input type="checkbox"/> P Ringing in the ears |
| <input type="checkbox"/> Y <input type="checkbox"/> P Chronic ear infection  | <input type="checkbox"/> Y <input type="checkbox"/> P Eye pain       | <input type="checkbox"/> Y <input type="checkbox"/> P Sties               |
| <input type="checkbox"/> Y <input type="checkbox"/> P Darkness under eyelids | <input type="checkbox"/> Y <input type="checkbox"/> P Eye strain     | <input type="checkbox"/> Y <input type="checkbox"/> P Vertigo             |
| <input type="checkbox"/> Y <input type="checkbox"/> P Decreased hearing      | <input type="checkbox"/> Y <input type="checkbox"/> P Floaters/Spots | <input type="checkbox"/> Y <input type="checkbox"/> P Visual changes      |
| <input type="checkbox"/> Y <input type="checkbox"/> P Discharge of the eyes  | <input type="checkbox"/> Y <input type="checkbox"/> P Glaucoma       | Other:  |

**Respiratory/Nose**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> P Allergies/Hay fever | <input type="checkbox"/> Y <input type="checkbox"/> P Chronic cough           | <input type="checkbox"/> Y <input type="checkbox"/> P Coughing up blood    |
| <input type="checkbox"/> Y <input type="checkbox"/> P Asthma              | <input type="checkbox"/> Y <input type="checkbox"/> P Chronic sinus infection | <input type="checkbox"/> Y <input type="checkbox"/> P Cough with phlegm    |
| <input type="checkbox"/> Y <input type="checkbox"/> P Bronchitis          | <input type="checkbox"/> Y <input type="checkbox"/> P Congestion              | <input type="checkbox"/> Y <input type="checkbox"/> P Difficulty breathing |
| <input type="checkbox"/> Y <input type="checkbox"/> P Frequent colds      | <input type="checkbox"/> Y <input type="checkbox"/> P Pneumonia               | <input type="checkbox"/> Y <input type="checkbox"/> P Shortness of breath  |
| <input type="checkbox"/> Y <input type="checkbox"/> P Nosebleeds          | <input type="checkbox"/> Y <input type="checkbox"/> P Polyps                  | <input type="checkbox"/> Y <input type="checkbox"/> P Wheezing             |
| <input type="checkbox"/> Y <input type="checkbox"/> P Painful breathing   | <input type="checkbox"/> Y <input type="checkbox"/> P Post nasal drip         | Other:   |

**Genital/Urinary**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> P Bed wetting         | <input type="checkbox"/> Y <input type="checkbox"/> P Genital lesions  | <input type="checkbox"/> Y <input type="checkbox"/> P Nighttime urination |
| <input type="checkbox"/> Y <input type="checkbox"/> P Blood in urine      | <input type="checkbox"/> Y <input type="checkbox"/> P Genital pain     | <input type="checkbox"/> Y <input type="checkbox"/> P Pain with urination |
| <input type="checkbox"/> Y <input type="checkbox"/> P Decreased libido    | <input type="checkbox"/> Y <input type="checkbox"/> P Hernia           | <input type="checkbox"/> Y <input type="checkbox"/> P Prostate disease    |
| <input type="checkbox"/> Y <input type="checkbox"/> P Frequent infections | <input type="checkbox"/> Y <input type="checkbox"/> P Impotency        | <input type="checkbox"/> Y <input type="checkbox"/> P STD/STI             |
| <input type="checkbox"/> Y <input type="checkbox"/> P Frequent urination  | <input type="checkbox"/> Y <input type="checkbox"/> P Incontinence     | <input type="checkbox"/> Y <input type="checkbox"/> P Testicular swelling |
| <input type="checkbox"/> Y <input type="checkbox"/> P Genital discharge   | <input type="checkbox"/> Y <input type="checkbox"/> P Increased libido | <input type="checkbox"/> Y <input type="checkbox"/> P Urgency             |
| <input type="checkbox"/> Y <input type="checkbox"/> P Genital itching     | <input type="checkbox"/> Y <input type="checkbox"/> P Kidney stone     | Other:  |



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**Cardiovascular**

- |   |                      |   |                     |   |                     |
|---|----------------------|---|---------------------|---|---------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> P | Chest pain/tightness | <input type="checkbox"/> Y <input type="checkbox"/> P | Irregular heartbeat | <input type="checkbox"/> Y <input type="checkbox"/> P | Rheumatic fever     |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Edema                | <input type="checkbox"/> Y <input type="checkbox"/> P | Murmurs             | <input type="checkbox"/> Y <input type="checkbox"/> P | Swollen feet/ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Heart palpitations   | <input type="checkbox"/> Y <input type="checkbox"/> P | Poor circulation    | <input type="checkbox"/> Y <input type="checkbox"/> P | Varicose veins      |
| <input type="checkbox"/> Y <input type="checkbox"/> P | High blood pressure  | <input type="checkbox"/> Y <input type="checkbox"/> P | Low blood pressure  | Other:  |                     |
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**Mouth & Throat**

- |   |                       |   |                       |   |                       |
|---|-----------------------|---|-----------------------|---|-----------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> P | Bitter taste in mouth | <input type="checkbox"/> Y <input type="checkbox"/> P | Dentures              | <input type="checkbox"/> Y <input type="checkbox"/> P | Loss of taste         |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Bleeding gums         | <input type="checkbox"/> Y <input type="checkbox"/> P | Difficulty swallowing | <input type="checkbox"/> Y <input type="checkbox"/> P | Lump in throat        |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Canker sores          | <input type="checkbox"/> Y <input type="checkbox"/> P | Dry mouth             | <input type="checkbox"/> Y <input type="checkbox"/> P | Recurrent sore throat |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Cavities              | <input type="checkbox"/> Y <input type="checkbox"/> P | Gum disease           | <input type="checkbox"/> Y <input type="checkbox"/> P | Ulcers                |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Cold sores            | <input type="checkbox"/> Y <input type="checkbox"/> P | Hoarseness            | Other:  |                       |
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**Muscles & Joints**

- |   |                      |   |                        |   |                   |
|---|----------------------|---|------------------------|---|-------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> P | Arthritis            | <input type="checkbox"/> Y <input type="checkbox"/> P | Heaviness of body/limb | <input type="checkbox"/> Y <input type="checkbox"/> P | Leg cramps        |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Body aches/stiffness | <input type="checkbox"/> Y <input type="checkbox"/> P | Joint discoloration    | <input type="checkbox"/> Y <input type="checkbox"/> P | Numbness/tingling |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Generalized pain     | <input type="checkbox"/> Y <input type="checkbox"/> P | Joint pain             | <input type="checkbox"/> Y <input type="checkbox"/> P | Tremors           |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Generalized weakness | <input type="checkbox"/> Y <input type="checkbox"/> P | Joint swelling         | Other:  |                   |
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**Gastrointestinal**

- |   |                       |   |                      |   |                  |
|---|-----------------------|---|----------------------|---|------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> P | Abdominal pain        | <input type="checkbox"/> Y <input type="checkbox"/> P | Diarrhea             | <input type="checkbox"/> Y <input type="checkbox"/> P | Loose/soft stool |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Acid reflux/heartburn | <input type="checkbox"/> Y <input type="checkbox"/> P | Gall bladder disease | <input type="checkbox"/> Y <input type="checkbox"/> P | Mucus in stool   |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Bad breath            | <input type="checkbox"/> Y <input type="checkbox"/> P | Hemorrhoids          | <input type="checkbox"/> Y <input type="checkbox"/> P | Nausea           |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Black stool           | <input type="checkbox"/> Y <input type="checkbox"/> P | Hiccups              | <input type="checkbox"/> Y <input type="checkbox"/> P | Pancreatitis     |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Bloating              | <input type="checkbox"/> Y <input type="checkbox"/> P | Indigestion/gas      | <input type="checkbox"/> Y <input type="checkbox"/> P | Vomiting         |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Blood in stool        | <input type="checkbox"/> Y <input type="checkbox"/> P | Intestinal pain      | <input type="checkbox"/> Y <input type="checkbox"/> P | Ulcer            |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Constipation          | <input type="checkbox"/> Y <input type="checkbox"/> P | Liver disease        | Other:  |                  |
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**Appetite/Thirst**

- |   |                    |   |                           |   |                             |
|---|--------------------|---|---------------------------|---|-----------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> P | Change in appetite | <input type="checkbox"/> Y <input type="checkbox"/> P | Hunger w/no desire to eat | <input type="checkbox"/> Y <input type="checkbox"/> P | Thirst w/no desire to drink |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Exceedingly hungry | <input type="checkbox"/> Y <input type="checkbox"/> P | No thirst                 | Other:  |                             |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Excessive thirst   | <input type="checkbox"/> Y <input type="checkbox"/> P | Poor appetite             |   |                             |
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**Sleep**

- |   |   |   |   |   |                       |
|---|---|---|---|---|-----------------------|
| # of hours sleep:                                     | <input type="checkbox"/> Y <input type="checkbox"/> P | Sleep apnea   | <input type="checkbox"/> Y <input type="checkbox"/> P | Vivid dreams  |                       |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Difficulty waking                                     | <input type="checkbox"/> Y <input type="checkbox"/> P | Sleep walk  | <input type="checkbox"/> Y <input type="checkbox"/> P | Wake easily           |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Grind teeth   | <input type="checkbox"/> Y <input type="checkbox"/> P | Snore   | <input type="checkbox"/> Y <input type="checkbox"/> P | Wake refreshed/rested |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Nap during the day                                    | <input type="checkbox"/> Y <input type="checkbox"/> P | Trouble falling asleep                                | Other:  |                       |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Nightmares  | <input type="checkbox"/> Y <input type="checkbox"/> P | Trouble staying asleep                                |   |                       |
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**Mental/Emotional**

- |   |                    |   |                       |   |              |
|---|--------------------|---|-----------------------|---|--------------|
| <input type="checkbox"/> Y <input type="checkbox"/> P | Angry/irritability | <input type="checkbox"/> Y <input type="checkbox"/> P | Forgetful/poor memory | <input type="checkbox"/> Y <input type="checkbox"/> P | Relaxed/calm |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Anxiety            | <input type="checkbox"/> Y <input type="checkbox"/> P | High-strung/tense     | <input type="checkbox"/> Y <input type="checkbox"/> P | Stressed     |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Depression         | <input type="checkbox"/> Y <input type="checkbox"/> P | Impatient             | <input type="checkbox"/> Y <input type="checkbox"/> P | Suicidal     |
| <input type="checkbox"/> Y <input type="checkbox"/> P | Fearful/panic      | <input type="checkbox"/> Y <input type="checkbox"/> P | Manic                 | Other:  |              |
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