PWH Wellness

INTAKE FORM

Stress Level: 1 2 3 4 5 6 7 8 9 10

Why?

_____

_____

What hours do you typically work:

_____

_____

What kind of support do you have at home:

_____

_____

# of Children / Age:

_____

_____

Hours of Sleep/ Night: _____

Do you feel rested: _____

Activity Level: 1 2 3 4 5 6 7 8 9 10

Activity/Exercise times/week and duration?

_____

_____

How often do you eat out? What do you typically pick up to eat?

_____

_____

Are there any foods/drinks that you cannot live without?

_____

_____

What is your relationship with food?

_____

_____

Do you have a history of any eating disorders? Type? Last incident?

_____

_____

_____

_____

PATIENT INFORMATION

DOB | AGE

NAME

EMAIL

PHONE

RACE | ☐M ☐F

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

OCCUPATION

HOW DID YOU HEAR ABOUT US?

WHAT ARE YOUR GOALS?

WHERE DO YOU GROCERY SHOP?

(CONTINUED)

NAME | DOB

Please list any plastic or elective surgeries and dates:

Have you had any botox/fillers and last date of treatment:

Please list skin care routine:

What have been your biggest hurdles to your goals in the past?

When do you feel the most energized, empowered and/or happy?

What gives you confidence?

When do you feel the most comfortable?

NAME DATE

PWH Wellness

PWH WELLNESS DISCLAIMER

I am aware that pregnancy and nursing is contraindicated for participation in the PWH Wellness Program. I understand that treatment may involve risk of complications or injury from both known and unknown causes and I freely assume these risks. I understand the results may vary from person to person and that an exact result cannot be predicted. Completing the full Wellness Program is recommended to maximize treatment efficacy. It is very unlikely, but it is possible that you will not see any recognizable results after completion of the program. I acknowledge the results may not meet my expectations.

I acknowledge that successful treatment outcome can be affected by smoking or excessive alcohol consumption, eating disorders, on-going medication use or insufficient hydration. While no special diet is required, you are encouraged to eat healthy to help promote and maintain results.

Any recipes or nutritional advice given may contain ingredients that could cause an allergic reaction in some individuals. If you are unsure about potential allergic reactions, please let us know. The creators, producers, participants and distributors of this program do not assume liability for injury or loss in connection with this program and instructions herein.

I agree to before and after treatment photographs, as well as serial weight and body composition measurements for documenting the process and results of the program. Information will also be acquired for medical records and/or marketing purposes.

I have read the above information and I give my consent to be treated by the practitioners of Premier Womwen's Health and their designated staff.

I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered to my satisfaction.

My signature below indicates that the above information is accurate and current.

Signature: _____ Date: _____

Provider Signature:_____ Date: _____