Patient Intake Form

Today's Date: ________________________________

First Name: ________________________________ Last Name: ________________________________

Date of Birth:_______________________________ Age: ________________

Phone: ____________________________________

Email address: ____

Physical Address: ____

Please explain/list your main health concerns or symptoms:

What would you like to change about your health? What are your health goals?

Please describe why/the reasons you would like to work with Dr. Allison Gandre?

Please list other practitioners you have seen or are seeing as well as any treatments or testing done. Also include results of treatments and testing if available.

Please list any drug allergies and describe the reaction:

Please list any other allergies:

Please list any current medications you are taking, the dosage and reason for taking:

Please list any current supplements you are taking, the brand, dosage and reason for taking:

Please describe your past medical history: any surgeries, hospitalizations, illnesses or major injuries or issues, as well as the dates or approximate time frame of surgery, injury, etc.:

Please describe your family medical history:

Please describe you current and historical quality of sleep:

How many hours do you sleep a night? ________

Do you have trouble falling asleep? ___Y /____ N

Do you have trouble staying asleep? ___Y /____ N

Do you wake feeling rested? ___Y /____ N

How is your energy throughout the day? ________

Do you feel that you need caffeine? ___Y /____ N

Do you experience nervousness or anxiety ___Y /____ N

Please describe you current and historical relationship with food.

Please list a detailed 24-hour dietary recall (all food and fluids in past 24 hours):

How much water do you typically drink in a 24-hour period? Please describe water source: filtered, plastic bottles, tap water, etc.:

Is there anything else you would like to share?

Signature: ____Date: _______________________