PAIN WEST

WELLNESS INTAKE R2.2026 Patient Number (Office Use):_____

How were you referred to our office? _____Today's Date_____

Patient Name (Last, First, Middle)_____

Birth date:_____Age:_____ Gender: Male / Female

Address:_____City:_____State:_____Zip:_____

Home #:_____Mobile #:_____Work #:_____

Email:_____SS #:_____ Driver's License #:_____

Best way to contact? Home # / Work # / Mobile # / Email / Text

Occupation:_____Employer:_____Address:_____

Emergency Contact:_____Phone:_____Relationship:_____

Marital Status: M / S / D / W Name of Spouse / Partner:_____# of Children:_____

Race:_____Ethnicity:_____Preferred Language:_____

SERVICES OF INTEREST *(Check all that apply)*

☐ Massage Therapy ☐ Ozone Therapy ☐ Botox / Fillers ☐ IV / Injection Therapy

☐ Hormone Replacement ☐ Ultraviolet Light Therapy ☐ Medical Weight Loss ☐ Regenerative Cells ☐ PPR

Hair ☐ Laser Hair Removal ☐ Laser Hair Vein Removal ☐ Laser Facial ☐ Laser Resurfacing ☐ Skin

Tightening ☐ Fat Reduction ☐ RF Microneedling ☐ Other: _____

MEDICAL OVERVIEW *(Please check any that apply)*

☐ High blood pressure ☐ Heart disease ☐ Diabetes / blood sugar issues ☐ Thyroid disorder

☐ Autoimmune or inflammatory condition ☐ Cancer (past or current) ☐ Blood clotting disorder

☐ Neurologic condition ☐ Skin conditions or sensitivities ☐ Pregnancy or breastfeeding

☐ None of the above ☐ Other_____

MEDICATION / SUPPLEMENTS☐ None ☐ Yes *(please list):*

_____

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ALLERGIES ☐ None known ☐ Yes *(medications, topical agents, latex, adhesives, etc.):*

CURRENT SYMPTOMS / CONCERNS *(Briefly describe anything we should know)*

SURGERIES *(List all)*

LIFESTYLE FACTORS

☐ High stress ☐ Poor sleep ☐ Digestive issues ☐ Fatigue / low energy ☐ Hormonal symptoms

☐ Weight concerns ☐ Other_____

CONSENT & ACKNOWLEDGMENT

I understand that Wellness & Longevity services are **not a substitute for primary medical care**, and results may vary. I have disclosed relevant health information to the best of my ability and consent to services as discussed with my provider.

I understand wellness, longevity and aesthetic services are **self-pay and not covered by insurance**.

Patient Signature: _____ **Date:** _____