Advanced Family Wellness Inc. PS
1115 west Bay Dr. NW, Suite 202
Olympia, WA 98502
Phone: (360)570-8010 / Fax: (360)570-8009

PATIENT INTAKE FORM

Name: ________________________________ DOB: ______________________ Date: _____________

Reason for Visit (List your main health concerns or reason for scheduling appointment.)

Primary Concern:

Is this visit related to pain you are having? ☐ Yes ☐ No

If so, what is causing this pain?

Is the concern related to: Work? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

If so, have you seen another provider for this injury prior to today? ☐ Yes ☐ No

When did these symptoms start? ________________________ How long do they last? ____________

Do your symptoms: persist or come and go? (Please circle your answer) (Explain as needed)

Please write the **pertinent past medical history** – what has happened in your past that is significant about your complaints / concerns today?

What has happened in your **family medical history** that is pertinent to the symptoms that you have today?

***Are there any medications you are taking that need to be reviewed for refills during your appointment today? Please list them.**

What new medications or supplements have you started, changed or stopped since your last visit at Advanced Family Wellness? (Please list the date you started /stopped each medication or supplement.)

Do you have a medication list or medical history list for the medical assistant to copy and add to your chart today?

Yes / No (Please circle your answer)

What medications, food or environmental exposures are you allergic to?

Flip Over →

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Do you have Advance Directive? Yes / No (Please circle your answer)

*An advanced directive is a written statement of person's wishes regarding medical treatment, made to ensure those wishes are carried out should the person be unable to communicate to a doctor.

Date of your last annual exam: __________________ Pap: _________________

Date of your last eye exam: ______________________ Date of last Mammogram: ________________________

Date of last colonoscopy: ________________________

Have you had any recent vaccinations?

VACCINATION		DATE:
HEP A	Y / N	
HEP B	Y / N	
Pneumonia	Y / N	
Tetanus	Y / N	
FLU	Y / N	
Shingles	Y / N	
HPV	Y / N	

Thank you for taking the time to help Dr. Kather and your medical insurer better understand how you wish to focus your medical visit today.