

PERSONAL HISTORY INTAKE INFORMATION

Today's Date: 7/1/50
First Name: Diane E Last Name: Gipson Birth Date: 5/19/50 Age: 70
Marital Status: div Level of Education: _____
Occupation: _____ Retired? ☒ Yes ☐ No

Your Primary Care Provider:

Name: Dr B Baker Phone: 253-268-3345
Date of Last Physical: 1 yr

Active Medical Problems:

back & Neck

Prescription & over the counter medications you are currently taking (include doses):

Allergies – Drugs:

Allergies – Foods & Other:

Nutrients/Supplements you are currently taking & current amount:

D-3
Hormon
prob

PATIENT GOAL SHEET

Please rank your top 10 health goals. 1 being the **highest priority** and 10 being the **lowest priority** using each number only once.

_____ Lose Weight/Fat

5 _____ Increase Strength/Muscle

_____ Improve Libido/Sexual Function

_____ Improve Blood Sugar

3 _____ Improve Skin Appearance/Wrinkles

_____ Lower Blood Pressure

_____ Reduce Alopecia/Hair loss

1 _____ Improve Cholesterol Levels

_____ Treat Menopausal Symptoms

_____ Improve Mental Function

_____ Improve Fatigue

_____ Lower Dementia Risk

_____ Lower Cancer Risk

_____ Improve Sleep

_____ Decrease Pain

4 _____ Balance Hormones

_____ Increase Energy/Stamina

_____ Increase Bone Density

_____ Treat Depression

_____ Lower Cardiovascular Risk

2 _____ Reduce Inflammation

Other areas of your health you would like to improve:
