New Heights
Health & Wellness

New Patient Intake Form

📍 Patient Information

- Full Name: _____
- Date of Birth: _____ Age: _____
- Sex: ☐ Male ☐ Female ☐ Other _____
- Address: _____
- City: _____ State: ____ Zip: _____
- Phone: (_____) _____ -_____
- Email: _____
- Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

📍 Emergency Contact

- Name: _____
- Relationship: _____
- Phone: (_____) _____ -_____

📍 Insurance Information

- Primary Insurance: _____
- Policy/ID #: _____
- Group #: _____
- Subscriber Name: _____
- Secondary Insurance (if applicable): _____

📍 Primary Care Provider (PCP)

- Name: _____

- Phone: (_____) _____ -_____
- Last Visit Date: _____

📍 Referral Source

☐ PCP ☐ Specialist ☐ Hospital/SNF ☐ Friend/Family ☐ Online ☐ Other: _____

📍 Medical History

Chronic Conditions (check all that apply):

☐ Diabetes ☐ Hypertension ☐ Heart Disease
☐ COPD/Asthma ☐ Kidney Disease ☐ Stroke
☐ Liver Disease ☐ Cancer ☐ Arthritis
☐ Depression/Anxiety ☐ Other: _____

Surgical History:

_____

_____

_____

Hospitalizations (last 12 months):

_____

_____

_____

Medication List (or attach list)

_____

_____

_____

Allergies
☐ No known drug allergies (NKDA)
☐ Allergies: _____

📍 Social History

- Tobacco Use: ☐ Never ☐ Former ☐ Current (packs/day: ___)
- Alcohol Use: ☐ Never ☐ Occasional ☐ Regular
- Drug Use: ☐ No ☐ Yes – type: _____
- Living Situation: ☐ Alone ☐ With Family ☐ Assisted Living
- Occupation/Retired: _____

📌 Functional Status

- Do you need help with daily activities (bathing, dressing, meals, mobility)?
  ☐ Yes ☐ No – If yes, please describe: _____
- Mobility Aids: ☐ None ☐ Cane ☐ Walker ☐ Wheelchair

📌 Advance Care Planning

- Do you have an Advance Directive or Living Will? ☐ Yes ☐ No
- Healthcare Power of Attorney: _____

📌 Reason for Visit

_____

_____

_____

📌 Consent & Signature

I certify that the information provided above is accurate to the best of my knowledge. I consent to treatment at **New Heights Health and Wellness** and authorize the release of information necessary to process my insurance claims.

Patient Signature: _____ **Date:** _____

Staff/Provider Signature: _____ **Date:** _____