MWC INTAKE FORM

MINISTRY WELLNESS CENTER

PERSONAL INFORMATION

Full Name :

Place of Birth : **Date of Birth** : D D M M Y Y

Full Address :

Status : Single Married Divorce Others **Religion** :

E-Mail :

Phone Number : **Gender** : Male Female

MEDICAL INFORMATION

List of Previous Medical Conditions/Medications/Allergies: (Please indicate any conditions you currently have)

- Diabetes
- Hypertension (High Blood Pressure)
- Hyperlipidemia (High Cholesterol)
- Heart Disease
- Asthma
- Allergies
- Other (please specify): _____

HOUSEHOLD INFORMATION

Others in your home :

Smoke detectors available: Yes No **Recent loss:** Yes No

LIST OF CURRENT HEALTHCARE PROVIDERS

Name :

Phone Number : **Fax** :

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Current Medical Equipment in Use:

Living Will and Durable Power of Attorney: Yes No

PHYSICAL ACTIVITY

Number of Days of Physical Activity per Week:

Limitations:

Average Daily Steps (Approx.):

DIETARY HABITS

Number of Meals per Day: **Servings of Fruits/Vegetables per Day:**

Daily Water Consumption (in liters):

Other Drinks Consumed: (Soda, Energy Drinks, Coffee, Alcohol, Wine)

GENERAL HEALTH

Self-rated Health: Poor Fair Good Very Good Excellent

Annual Dental Exams: Yes No **Annual Vision Exams:** Yes No

MENTAL HEALTH

Major Stressors:

Quality of Sleep: Poor Fair Good Very Good Excellent

Church Affiliation: Yes No **Support System:** Yes No

Recent Feelings (Past 2 Weeks):

Anxious: Yes No **Depressed:** Yes No **Suicidal:** Yes No

Safety Habits:

Always Fasten Seatbelt: Yes No **Always Use Helmet for Bike Rides:** Yes No

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Frequency of Stress (Health, Finances, Family, Work, Relationships):

Health :

Finances :

Family :

Work :

Relationships :

SOCIAL HABITS

Smoking Habits :

Cigarettes : Yes No **Pipe** : Yes No **Frequency/Amount:**

Alcohol Consumption:

Liquor: Yes No **Beer:** Yes No **Wine:** Yes No **Frequency/Amount:**

Use of Street Drugs: (Marijuana, Cocaine, Heroin) **Frequency/Amount:**

Vaping/Nicotine Replacement Products: Yes No

Sexual Activity : Yes No **Number of Partners in the Past 3 Months:**

Barrier Use : Yes No

History of STIs :

Type : **Current Contraception:** Yes No

FEMALE-SPECIFIC QUESTIONS

Number of Pregnancies: **Number of Children:**

Menstrual Information:

Still having monthly periods: Yes No **Regularity:** Regular Irregular

Flow: Light Moderate Heavy **Folic Acid Use:** Yes No

Hormonal/OTC Products: Yes No **Urinary Incontinence/Frequency/Urgency:** Yes No

Menopausal Symptoms:

Hot Flashes: Yes No **Vaginal Dryness:** Yes No

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MALE-SPECIFIC QUESTIONS

Libido/Erection Problems: ☐ Yes ☐ No

Use of Viagra/Cialis/OTC Meds for Sex: ☐ Yes ☐ No

ELDERLY-SPECIFIC QUESTIONS

Number of Falls in the Past 12 Months: _____ **Ambulation/Balance Problems:** ☐ Yes ☐ No

Use of Viagra/Cialis/OTC Meds for Sex: ☐ Yes ☐ No

Hearing/Vision Problems: ☐ Yes ☐ No **Memory/Speech Problems:** ☐ Yes ☐ No

Family History:

Memory Problems: ☐ Yes ☐ No

Need Assistance with Activities of Daily Living (ADL): ☐ Yes ☐ No **Specify:** _____

Need Assistance with:

☐ Finances ☐ Cooking ☐ Managing Money ☐ Shopping ☐ Transportation

Family Medical History:

☐ AAA (Abdominal Aortic Aneurysm)

☐ Dementia

☐ Cancers (Breast, Colon, Ovarian, Cervical, etc.) and Age of Onset: _____

☐ Heart Disease and Early Deaths: _____

☐ Men (Age < 55 years old)

☐ Women (Age < 60 years old)

☐ Overweight/Obesity

☐ Hypertension (HTN)

☐ Hyperlipidemia (HLD)

☐ Diabetes Mellitus (DM)

THANK YOU FOR YOUR INFORMATION