Sarah Rhodes
WELLNESS

Date: ____________________

PERSONAL INFORMATION

Last Name: _________________________________ First Name: ____________________________________

Whom may I thank for sending you?____

Address: ____ City: ________________________________

State: _______ Zip: ___________

Primary Phone: (_______)________-_________ Secondary Phone: (_______)________-_________

Email (Will not be given to any other businesses):____

Who do you live with? And ages? (ie: spouse, children, parents, etc.) _________________________

____

____

Date of Birth: ______/______/________ Age : _______ Marital Status: _______________

Gender: ▫Male ▫Female

Employer: ____ Occupation:____________________________

HEALTH STATUS

Occupational Stress Level (1-10): (no stress) 1 2 3 4 5 6 7 8 9 10 (very stressful)

Personal Stress Level (1-10): (no stress) 1 2 3 4 5 6 7 8 9 10 (very stressful)

Recreational Activities/Hobbies:

____

Habits: Smoking: ____in past ___never ___current ___Other Tobacco: __________________

<1 pack/day 1 pack/day 2 packs/day 3 packs/day

Alcohol: in past never current

Drink/day 0-1 1-2 2-3 3-4 4-5 5+ **or** _____ per week

Caffeinated Drinks: never 0-1/day 1-2 2-3 3-4 4-5 5+ **or** _____ per week

Diet foods/Drinks: never 0-1/day 1-2 2-3 3-4 4-5 5+ **or** _____ per week

Fast Food Consumption: never 0-1/day 1-2 2-3 3-4 4-5 5+ **or** _____ per week

Vegetable Consumption: never 0-1/day 1-2 2-3 3-4 4-5 5+

Sarah Rhodes 527 Mills Ave, ste. 101B, GVL SC 29605
(864) 448-9777 | patientadvocate@gvwell.com | www.gvwell.com

Exercise type and amount:____
Hours of sleep a night:_______________ Do you wake up rested?_________________
Please rate your overall health status: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
Are you healthier today than you were 5 years ago? _____________________________

Why are you seeing the clinician?

____
____
____
____
____

What are your expectations for your health after coming here?

____
____
____

MEDICAL HISTORY
List any surgeries:

List any past injuries:

ADDITIONAL INFORMATION
Please include important medical information the clinician should be aware of: major family histories, cancer, heart disease, stroke, diabetes, surgeries etc:

FEE STRUCTURE
Please note that the fees for your initial visit total $275.00. This includes a consultation, examination, and recommendations for care.

I understand that nutritional consultations are not covered by insurance companies. I assume full responsibility for payment at the time of service.

Patient's Signature ____

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