ANGEL WALK WELLNESS

Evidence-Based Wellness & Telehealth Care
www.aww-center.com | contact@aww-center.com
Healing with Heart, Science, and Purpose

PATIENT / CLIENT INTAKE FORM

Please complete the sections that apply to your scheduled service. This form may contain sensitive personal or health information. Do not send a completed form through ordinary email or the public appointment-request form. Angel Walk Wellness will provide instructions for an appropriate secure submission method when needed.

1. CONTACT INFORMATION

Full Legal Name _____ Preferred Name _____

Date of Birth _____ Phone _____ Email _____

Street Address _____ City _____

State _____ ZIP Code _____ Preferred Contact Method _____

[ ] Phone [ ] Secure portal/message when available [ ] Other

2. SERVICE REQUESTED

[ ] Wellness & Educational Consultation [ ] Medical Telehealth (CA/NY eligible patients only)

Physical State at Time of Visit _____ Preferred Visit Date _____

Medical Telehealth is currently limited to eligible patients physically located in California or New York at the time of the visit.

3. EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____ Alternate Phone (optional) _____

4. PRIMARY GOALS / REASON FOR VISIT

What would you most like help with during this visit?

[ ] Nutrition [ ] Physical activity [ ] Weight [ ] Blood pressure [ ] Blood sugar [ ] Cholesterol [ ] Sleep [ ] Stress [ ] Healthy aging [ ] Other

5. GENERAL HEALTH BACKGROUND

Primary Care Clinician (if applicable) _____ Specialist(s) (if applicable) _____

Current health conditions or major past medical/surgical history you want the clinician to know about:

6. MEDICATIONS, ALLERGIES & SUPPLEMENTS

Current prescription and over-the-counter medications (name, dose if known, and how often):

Medication, food, or other allergies / important reactions:

Vitamins, supplements, or herbal products currently used:

7. RECENT HEALTH INFORMATION

Height _____ Weight (optional) _____ Waist (optional) _____

Recent Blood Pressure (if known) _____ Recent A1c / Glucose (if known) _____

Recent laboratory results, imaging, or other information you believe is relevant:

8. LIFESTYLE OVERVIEW

Typical Sleep (hours/night) _____ Physical Activity (days/week) _____

Nutrition pattern / dietary preferences:

[ ] Tobacco/nicotine: Never [ ] Former [ ] Current [ ] Prefer not to answer
[ ] Alcohol: None [ ] Occasional [ ] Regular [ ] Prefer not to answer

9. QUESTIONS OR CONCERNS FOR THIS VISIT

10. ACKNOWLEDGMENT

I understand that I should provide accurate information to the best of my ability. I understand that Wellness & Educational Consultation is separate from Medical Telehealth, and that medical decisions, prescriptions, testing, or treatment are provided only when legally permitted and clinically appropriate. I understand that this intake form is not for emergencies.

Patient / Client Signature _____ Date _____

Provider: Mei Chen, ACNP-BC, FNP-C
Founder, Angel Walk Wellness