



# OKLAHOMA HEALTH & WELLNESS CENTER

## Confidential Member Application

Fill out, Print Form, and Fax to (580) 774-2214 OR Bring to Appointment

What are your health goals & expectations? \_\_\_\_\_

When was the last time you felt your best? (How long ago?) \_\_\_\_\_

On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in loss of health potential. Most times the effects are gradual not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime allowing us to better assess the challenges to your health potential.

- List all operations and their date:  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- List all medications you are currently on and what they are for:  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_  
7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_
- List any significant physical traumas since birth:  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_
- How stressful is your life? Occupation \_\_\_\_\_ Personal \_\_\_\_\_  
(1 = No stress / 10 = Extreme stress)

What do you feel is your primary stress? \_\_\_\_\_

### Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children's Names	Ages
1.	
2.	
3.	
4.	
5.	
6.	
7.	

If you have insurance: (Please fill out the following so we can put it on your "Super-bill" for your insurance)

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ID#: \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Address: \_\_\_\_\_

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctors at the Oklahoma Health & Wellness Center and whomever they may designate as their assistants to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct.

Patient's (Parent or Guardian's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_