



# Optimum Body Composition Intake Form:

Today's Date: \_\_\_\_\_

<b>Last Name:</b>		<b>Middle:</b>	<b>First Name:</b>
<b>Home Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Date Birth:</b>	<b>Age:</b>	<b>Height:</b>	<b>Weight:</b>
How did you hear about Optimum Function ?:		Marital Status (Circle): Single, Married, Divorced, Widowed	
Occupation:		Family/primary physician:	
Employer's Name:		Phone number and/or address of physician:	
Hobbies:			

**YES**,  **NO** I authorize the following telephone numbers  
 **YES**,  **NO** I authorize the use of my address for mailing  
 **YES**,  **NO** I authorize the use of my email address for announcements and newsletters  
 **YES**,  **NO** I authorize Optimum Function to contact the necessary health care providers to obtain pertinent health information.

**Email and Phone Numbers:**

Email: \_\_\_\_\_ Home Ph: \_\_\_\_\_

Cell: \_\_\_\_\_ Work \_\_\_\_\_

Indicate if you have a preferred mailing address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

My office needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State Health Insurance Portability and Accountability Act (HIPAA) patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call.

Your agreement will allow me to use your name, email address and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements or questions, status of your account, and other office related matters.

I will use your email address home address, noted to the left, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising me (Dr. Irving) of this revocation in writing or email.



**ARE YOU TAKING ANY MEDICATIONS?**

**I am not taking any medications currently.** Check any of the following that you are taking currently.

<input type="checkbox"/> NSAIDS (Ibuprofen etc.)	<input type="checkbox"/> Blood pressure/Stroke prevention medications	<input type="checkbox"/> Acid reducers
<input type="checkbox"/> Diuretics	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Blood Thinners (coumadin/warfarin)
<input type="checkbox"/> Birth control	<input type="checkbox"/> Hormone replacement	<input type="checkbox"/> Other:

**Height** (barefoot): \_\_\_\_\_ **Weight** (clothed): \_\_\_\_\_

**Activity Level** (check only one)

- Sedentary** (little or no exercise, desk job or bed ridden)
- Light Activity** (light exercise – sports 1 to 3 days per week)
- Moderate Activity** (moderate exercise – sports 3 to 5 days per week)
- Very Active** (hard exercise – sports 6 to 7 days per week)
- Extra Active** (hard daily exercise – sports and physical job)

**Are you pregnant?**

- Yes
- No

**Do you have an implanted electric device?**

- Yes
- No

**Have you been diagnosed with a heart problem?**

- Yes
- No

**Trauma** (very recent only)

- Yes
- No

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What is your main goal with respect to body composition?:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other health factors you would like to address eventually:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_