PHARMA 1
PHARMACY & WELLNESS CENTER

Personal Information

Date:	Date of Birth:
Name:	Blood Type:
Address:	Sex:
City/State/Zip Code:	Circle: Right Handed • Left Handed
Home Phone:	Height:
Cell Phone:	Weight: Ideal Weight:
Email:	Occupation:
Do you have a FlexCard or HSA? Y/N	Marital Status: # of Children: Ages:
What are the 5 primary concerns/goals/reasons you are seeking advice? (Please be specific)	
1.	4.
2 .	5.
3.	Other:
List all the current prescription medications (indicate strength and frequency) you are taking:	
1.	5.
2.	6.
3.	7.
4.	8.
List all over-the-counter supplements, herbs and/or homeopathies you currently take: **(Note: Please bring ALL supplements to your appointment or you will be rescheduled. NO EXCEPTIONS)**	
1.	5.
2.	6.
3.	7.
4.	8.

Medical Information

Physician(s)	
1.	2.
Allergies:	
Family Health History (Especially Cancer)	
Mother	Father
Sibling	Sibling
Sibling	Sibling
Date of Last Lab Work: If less than 1 year, please bring to appointment	
Medical Conditions Current:	
Medical Conditions Past:	
Surgeries (List) Type/Year	
1.	4.
2.	5.
3.	6.
Hysterectomy: Yes/No	Date of last menstrual period:
Do you exercise regularly: Yes/No	If so, what type and how often:
Do you have any special dietary preferences (i.e. No Pork, Gluten-Free) we should take into consideration?	
Whom may we thank for your referral:	
How did you find out about our services?	

Lifestyle Choices

How often do you cook at home?	Typical foods cooked?
How much water do you drink daily?	Water type:
How often do you eat out/fast food?	Restaurants:
Do you consume artificial sweeteners?	Type/Frequency:
Do you drink alcoholic beverages?	Type/Frequency:
Do you use tobacco or tobacco products more than casually? Yes/No Type/Frequency:	
Do you have pets? (Indicate # of each) ___Dog ___Cat ___Fish ___Bird ___Other ____________________	
Do you use organic products? Yes/No	How often:

By signing below, I verify that I understand that the providers at Pharma 1 are not physicians and that the counsel given is restricted to the correction of underlying deficiencies, optimizing hormonal imbalances, dietary guidance, symptom management and nutritional counseling. This counseling is not a substitute for medical care by my primary care physician, nor is it intended to diagnose or treat any disease.

(Please sign below)

Signature:	**Date:**

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creiter@pharma1rx.com | http://www.pharma1rx.com/

Please give a 24-hour notice for cancellation of appointments

PLEASE CIRCLE ONE

Initial Hormone Therapy Consult (60 to 90 mins) - $125

Initial Nutrition Consult (60 to 90 mins) - $115

Follow Up Hormone Therapy Consult - $60/30 minutes

Follow Up Nutrition Consult - $50/30 minutes

Medication Therapy Management Consult (60 to 90 mins) - $135

Body Composition Testing - $25

Blood Typing - $25

Glucose and A1c Testing - $45

Cholesterol and Lipid Panel Testing - $45

Flu or Strep Testing - $45

Vaccinations - Depends on type of immunization requested