

NALU WELLNESS

Patient History & Physical Assessment Form

Patient Information

- Full Name: _____
 - Date of Birth: _____ Age: _____
 - Gender: Male Female Other: _____
 - Phone Number: _____
 - Email Address: _____
 - Address: _____
 - Emergency Contact Name & Phone: _____
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Primary Reason for Visit

- IV Hydration
- Vitamin Therapy
- Aesthetic Treatment (Botox/Dysport/Fillers)
- GLP-1 Weight Loss Program
- Ketamine Therapy
- Other: _____

Chief Complaint / Goals:

Medical History

Do you have a history of any of the following? (Check all that apply)

- Hypertension
- Diabetes
- Heart Disease
- Kidney Disease
- Liver Disease

- Thyroid Disorder
- Anxiety / Depression
- Substance Use Disorder
- Migraines
- Cancer
- Autoimmune Disease
- Seizure Disorder
- Pregnancy / Trying to Conceive
- Breastfeeding

Other: _____

Surgical History

- None

List Surgeries (type & date):

Current Medications

(List ALL prescriptions, OTC meds, supplements)

Medication Dose Frequency

Allergies

- No Known Allergies

Allergen Reaction

Social History

- Tobacco Use: Yes No

- Alcohol Use: None Social Moderate Heavy
 - Recreational Drug Use: Yes No
 - Occupation: _____
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Lifestyle & Wellness

- Water Intake: Low Moderate High
 - Sleep: Poor Fair Good
 - Exercise: None 1–2x/week 3–5x/week Daily
 - Stress Level: Low Moderate High
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Weight Loss (GLP-1 Patients Only)

- Current Weight: _____
 - Goal Weight: _____
 - Previous Weight Loss Attempts: _____
 - History of Eating Disorders: Yes No
 - Family History of Thyroid Cancer: Yes No
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Mental Health Screening (Ketamine Patients)

- History of Depression: Yes No
 - Anxiety: Yes No
 - PTSD: Yes No
 - Bipolar Disorder: Yes No
 - Schizophrenia/Psychosis: Yes No
 - Current Psychiatric Medications: _____
 - Suicidal Ideation (Current/Past): Yes No
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Aesthetic Treatment History

- Prior Botox/Dysport: Yes No
- Prior Fillers: Yes No
- Last Treatment Date: _____

- Any complications? Yes No

If yes, explain: _____

Review of Systems (ROS)

General: Fatigue Fever Weight changes

Cardiac: Chest pain Palpitations

Respiratory: Shortness of breath Cough

GI: Nausea Vomiting Diarrhea

Neuro: Dizziness Headaches

Skin: Rashes Infections

Other: _____

Vital Signs (Provider Use)

- Blood Pressure: _____
 - Heart Rate: _____
 - Respiratory Rate: _____
 - Temperature: _____
 - Oxygen Saturation: _____
 - Weight: _____
 - Height: _____
 - BMI: _____
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Physical Assessment (Provider Use)

General Appearance:

Well-appearing Ill-appearing Distressed

Cardiovascular:

Normal Abnormal: _____

Respiratory:

Clear Abnormal: _____

Neurological:

Alert & Oriented x3 Abnormal: _____

Skin:

Normal Dehydrated Lesions Infection

Hydration Status:

Adequate Mild Dehydration Moderate Severe

IV Access Assessment:

Good veins Difficult access

Treatment Clearance

Cleared for Treatment

Not Cleared

Provider Notes:

Provider Information

- Provider Name: _____
 - Credentials: _____
 - Signature: _____
 - Date: _____
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Patient Acknowledgment

I certify that the above information is accurate and complete to the best of my knowledge.

- Patient Signature: _____
- Date: _____