# Apex Health Plus – Patient Intake Form

## Personal Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Gender:** ☐ Male ☐ Female ☐ Other
- **Phone Number:** _____
- **Email Address:** _____
- **Address:** _____

---

## Emergency Contact

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

---

## Medical Information

- **Primary Physician:** _____
- **Current Medications:** _____
- **Allergies:** _____
- **Past Medical Conditions:** _____

---

**Reason for Visit / Admission**

☐ **Alcohol and Other Drugs (AOD)**
☐ **Family Health**
☐ **Psychosocial Recovery Coaching**
☐ **Chronic Condition Support**
☐ **Wellness & Preventive Care**
☐ **Nutrition & Life Support**
**Other:** _____

---

**Consent & Acknowledgment**

**I hereby consent to receive care and support from Apex Health Plus. I declare that the information provided is true and complete to the best of my knowledge.**

**Signature:** _____
**Date:** ____ / ____ / _____