Intake Form

Please tell us what your main concerns are: _____

Last Name: _____ **M.I:** _____ **First:** _____ **DOB:** _____

Gender: _____**Race:** _____ **SSN:** _____-_____-_____

Height: _____ **Weight:** _____ Email (for appt reminders):_____

Street: _____City: _____State: _____Zip code: _____

Home: _____ Mobile: _____ Work: _____ Occupation: _____

Tobacco use: **Y** or **N** How often: _____Alcohol use: **Y** or **N** How often: _____Illicit Drugs use: **Y** or **N** How often_____

Emergency contact: Name: _____ Phone: _____ Relationship: _____

Please list any medications/supplements you are currently taking (ex: motrin, hydrochlorothiazide) _____

_____

Specify any known allergies & reactions to medications (ex: penicillin-hives) _____

_____

Past medical history (ex: diabetes, hypertension) _____

_____

Past surgical history (ex: tonsillectomy)

_____

May we leave a confidential message on your home/cell answer machine if you are not available? **Y** or **N**

*****Body Procedures Only*****

Have you maintained your current weight? If no, Please explain. _____

_____

Family history of medical conditions (high blood pressure, diabetes, heart problems, bleeding disorders):

_____

How much down time is realistic for your schedule? _____

Please read the following statements and sign below:

I certify that all of the above information is correct to the best of my knowledge and that I have indicated any and all known physical and material conditions and medications. I will keep responsible parties updated on any changes in my medical profile. I also understand that any illicit or suggestive sexual remarks or advances made by me, will result in immediate termination of my session,and I will be reliable for payments of the scheduled appointment.

Signature: _____ **Date:** _____