



Creating Healthier Lives

INTAKE FORM

NAME: DATE: ADDRESS: CITY: POSTAL CODE: TELEPHONE: HOME: WORK: E-MAIL: DATE OF BIRTH: AGE: SEX: OCCUPATION: EMERGENCY CONTACT NAME & RELATION: PH: HOW DID YOU HEAR ABOUT OUR THE NARDELLA CLINIC?

MEDICAL HISTORY

PRIMARY FAMILY PHYSICIAN: PH:

MAY WE HAVE PERMISSION TO CONSULT WITH PRIMARY PROVIDER? YES No

PLEASE LIST: CURRENT MEDICATIONS (TOPICAL & INTERNAL): ALLERGIES: SURGERIES:

PLEASE CHECK ANY & ALL CONDITIONS THAT APPLY TO YOU:

- ALCOHOL ADDICTION, ARTHRITIS, ASTHMA, ATHLETES FOOT, AUTOIMMUNE DISORDER, LUPUS, CREST, SCLERODERMA, HASHIMOTO'S, MS, RHEUMITOID, ARTHRITIS, OTHER, BLEEDING TENDENCY, BLISTERING, SUNBURNS, BLOOD CLOTS, BONE / JOINT TROUBLE, BUNIONS, BURSTITIS, CARPAL TUNNEL SYNDROME, CATARACTS, CHEMOTHERAPY, CLAUSTERPHOBIA, CONSTIPATION, CONTACT LENSES, CONVULSIONS, DIABETES, DEPRESSION, DIZZINESS, DRUG ADDICTION, ECZEMA, EMPHYSEMA, EPILEPSY, FEVER, HAY FEVER, HEADACHES, HEART ATTACK, HEART DISEASE, HEART SURGERY, HEPATITIS (TYPE), HERPES, HERPES SIMPLEX, HIGH BLOOD PRESSURE, HIV/AIDS, HYPERTENSION, GLAUCOMA, KELOID SCARRING, KIDNEY PROBLEMS, LOW BLOOD PRESSURE, LOW BACK PAIN, LYMPHEDEMA, MENOPAUSE, MIGRAINES, MOLES, NUMBNESS, PHLEBITIS, PSORIASIS, SCIATICA, SHINGLES, SINUS PROBLEMS, STROKE, TENDONITIS, THYROID, ULCERS, VARICOSE VEINS, WARTS, OTHER, PLEASE DESCRIBE

HAVE YOU HAD A FAMILY HISTORY OF SKIN DISEASE? YES No TYPE

DO YOU HAVE A PACEMAKER? YES: NO: METAL PLATES OR PINS? YES: NO:

LIFESTYLE

DO YOU HAVE ANY DIFFICULTIES WITH YOUR HANDS OR FEET? HOW MUCH WATER DO YOU DRINK IN A DAY? CAFFEINE? ALCOHOL? PLEASE DESCRIBE YOUR DIET (I.E. VEGAN, LOW CARB, ETC.) DO YOU ENJOY HOT OR SPICY FOODS? YES: DESCRIBE NO: DO YOU SMOKE? If YES, HOW MANY? HOW LONG? YRS HOW WOULD YOU DESCRIBE YOUR DAILY LEVEL OF STRESS? DO YOU EXERCISE REGULARLY? YES: NO: DESCRIBE: PLEASE DESCRIBE YOUR SLEEP PATTERNS: PLEASE LIST ANY OTHER INFORMATION WE MAY NEED TO KNOW ABOUT:



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FOR WOMEN:

ARE YOU PREGNANT: YES: ___ NO: ___ IF YES, STAGE: _____ DUE DATE: _____

ARE YOU TRYING TO BE PREGNANT? _____ ARE YOU ON ORAL CONTRACEPTIVES? YES: ___ NO: ___

MEDICAL & AESTHETIC HISTORY

ARE YOU UNDER THE CARE OF A DERMATOLOGIST? YES: ___ NO: ___

DERMATOLOGISTS NAME: _____ REASON FOR TREATMENT: _____

DO YOU TAKE DIETARY SUPPLEMENTS/VITAMINS? YES: ___ NO: ___

IF YES, PLEASE DESCRIBE: _____

DO YOU TRAVEL; FOR WORK OR PLEASURE? _W / P_____ HOW OFTEN? _____

Form with four quadrants: DO YOU TAKE/USE?, HAVE YOU RECEIVED?, SKIN CONDITIONS, SUN EXPOSURE HISTORY. Includes checkboxes for various skin treatments and conditions.

I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE THE TECHNICIAN OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE: _____

DATE: _____



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INFORMED CONSENT

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment, upon service rendered. I also authorize The Nardella Clinic to release information required by my extended health care provider to process my claims. I acknowledge that I must give 48 hours notice for any cancellation or rescheduling of a booked appointment. If said notice is not given I acknowledge that a cancellation fee will be applied to the Credit Card number that I have provided at the time of initial booking.

Patient/Guardian signature