Medical Intake Form

Wendy Roberts, CANP

Date:_____

Name:_____DOB:_____

Address:_____City:_____State:_____Zip:_____

Email:_____Home/Cell:_____

Employer:_____Work:_____

Emergency Contact:_____Relation:_____Phone:_____

How did you hear about us?_____

Please describe your main concerns: _____

_____

_____

_____

Medications - Please list any/add medications or supplements you are currently taking:_____

_____

_____

_____

Allergies - medication/food/environmental allergies:_____

_____

Smoking – Do you smoke tobacco?___Yes___No

Women

Are you pregnant or planning on becoming pregnant?___Yes___No Are you currently breastfeeding? ___Yes ___No

Last Menstrual Period_____ Last Pap Test_____ Last mammogram_____ Last DEXA_____

Medical History - Please check all that apply:

____Alcoholism ____Anemia ____Anorexia ____Asthma ____Autoimmune Disease ____Fibromyalgia ____Hepatitis

____Herpes/Cold Sores ____HIV/Aids ____Hypertension____History of Keyloid Scarring ____Bleeding Disorder

____Breast Lump____Cancer ____Connective Tissue Disorder ____Chemical Dependency ____Migraines

____Multiple Sclerosis____Neuromuscular Disease ____Pacemaker/Defibrilltor ____Ploycystic Ovaries

____Urinary Tract Infections____Joint Pains_____Lyme Disease ____High Cholesterol____Headaches

____Chronic Fatigue____Diabetes____Eating Disorders ____Epilepsy ____Pigmentation Disorder ____Seizures

____Skin Lesion____Other (please explain)_____

Past Surgeries (include dates)_____

_____

_____

_____

Past Hospitalizations (include dates)_____

_____

_____

_____

Authorization and Release – I herby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request and agree to activlty participate in such services as routine assessment diagnostic tests, care, and treamment as self-referred or orded by my physician/provider.

Client Signature:_____ Date:_____

Review by:_____ Date:_____