



## Patient Intake Sheet

Patient Information	
Name:	Cell Phone: (    )
Address:	Work Phone: (    )
	Emergency Phone: (    )
Email Address:	Date of Birth:                      Age:
Who referred you?	Weight:                      Height:
Who is your primary care provider?	Employer:
Today's Date:	Your Occupation:

What is the medical reason that brought you to Arcadia Wellness Center?

Medications:	Allergies:

Past Surgeries:	Dates:

General Health Questions
Are you or might you be pregnant? Are you breastfeeding?
Are you trying to become pregnant?
Are there any other health concerns we should be made aware of?

**Medical History:***(Please mark all appropriate boxes)***General:**

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Insomnia                |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Fevers                  |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Alcohol (Quantify_____) |
| <input type="checkbox"/> Tremors  | <input type="checkbox"/> Other: _____  |  |

**Head, Eyes, Ears, Nose and Throat:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Eye problems     | <input type="checkbox"/> Ear aches      | <input type="checkbox"/> Dental problems  |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Head injury      |

**Cardiovascular:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chest pain       | <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Swelling in feet     | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart attack     | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Valve replacement   |
| <input type="checkbox"/> Murmur           | <input type="checkbox"/> High cholesterol     |  |

**Respiratory:**

- |                                       |  |                                    |
|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Valley fever | <input type="checkbox"/> Cough           | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Tuberculosis |  |                                    |

**Gastrointestinal:**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> GI bleeding from meds | <input type="checkbox"/> Constipation |
|--|--|---------------------------------------|

**Musculoskeletal:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Back pain muscle  | <input type="checkbox"/> Tennis elbow           |
| <input type="checkbox"/> Joint pain     | <input type="checkbox"/> Rheumatoid spasms | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Bursitis          |   |

**Renal:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Kidney infections      | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Bladder infections |
| <input type="checkbox"/> Hepatitis (Active?___) |  |   |

**Neuropsychological:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Stress problems | <input type="checkbox"/> Seizure disorder |   |

**Reproductive:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Low Libido           | <input type="checkbox"/> Vaginal Dryness      | <input type="checkbox"/> Pain during sex |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Urinary Incontinence |  |

**Do you take any of the following:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Antibiotics               | <input type="checkbox"/> Anti-coagulants       | <input type="checkbox"/> Anti-depressants        |
| <input type="checkbox"/> Aspirin or Ibuprofen      | <input type="checkbox"/> Cortisone or Steroids | <input type="checkbox"/> Hormones/Contraceptives |
| <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> Insulin               | <input type="checkbox"/> NSAIDS                  |

**Do you take any of the following:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Sedatives                      | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Vitamin D      |
| <input type="checkbox"/> Fish Oils                      | <input type="checkbox"/> Tumeric            | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Accutane in the past 12 months | <input type="checkbox"/> Retin A            | <input type="checkbox"/> Other: _____   |

**Skin Care History:**

Have you had unprotected sun exposure or been in a tanning booth in the last 2 weeks?

Yes \_\_\_\_\_ No \_\_\_\_\_

Are you planning a vacation in the sun in the next 2-4 months?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please list all injectable procedures (Botox, Filler, etc.) and dates performed:

Any history of allergic or other reactions to a skin care product or treatment?

Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please explain:*

Please indicate your current skin care products/regimen:

Do you tan easily? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you burn easily? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you suffer from extreme sensitivity to sunlight?

Yes \_\_\_\_\_ No \_\_\_\_\_

**Ethnicity:**

- |  |   |                                     |
|--|---|-------------------------------------|
| <input type="checkbox"/> Asian           | <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian  |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Mixed Race |
| <input type="checkbox"/> Other _____     |   |                                     |

**Concerns:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dry Skin       | <input type="checkbox"/> Brown Spots        | <input type="checkbox"/> Fine Lines       |
| <input type="checkbox"/> Oily Skin      | <input type="checkbox"/> Redness            | <input type="checkbox"/> Deep Wrinkles    |
| <input type="checkbox"/> Acne/Breakouts | <input type="checkbox"/> Rosacea            | <input type="checkbox"/> Skin Texture     |
| <input type="checkbox"/> Scars          | <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> Facial Veins     |
| <input type="checkbox"/> Thin Lips      | <input type="checkbox"/> Nasolabial Creases | <input type="checkbox"/> Facial/Body Hair |

## Family History:

Disease:    Which family member(s)?

Headaches \_\_\_\_\_

Heart disease \_\_\_\_\_

Stroke \_\_\_\_\_

Diabetes \_\_\_\_\_

High blood pressure \_\_\_\_\_

Increased cholesterol \_\_\_\_\_

Arthritis \_\_\_\_\_

Rheumatoid arthritis \_\_\_\_\_

Kidney problems \_\_\_\_\_

Liver problems \_\_\_\_\_

Seizures \_\_\_\_\_

Osteoporosis \_\_\_\_\_

Cancer \_\_\_\_\_

Other medical problems: \_\_\_\_\_

## Consent for Treatment

**NAME**

**DOB**

I, the undersigned, hereby authorize *Sarah Quinn*, FNP-C and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, and to administer treatment as necessary. I, also certify that no guarantee or assurance has been made to the results that may be obtained and release all liability related to care and that I have provided my complete health history, medications, and health concerns in the Patient Intake Form.

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I

CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

**Patient's Signature**

**Date**

**Witness**



2701 E. Camelback Road, Suite #163  
Phoenix, AZ 85016  
Phone: 480.351.3688  
Fax: 480.351.3689

*We are a boutique Wellness Center located in the heart of the Arcadia/Biltmore district in Phoenix. We specialize in a variety of different services including:*

- Bioidentical Hormone Replacement
- Testosterone Replacement
- Botox
- Dermal Fillers
- Fat Burner & B12 Injections
- Microneedling
- Trigger and Joint Injections
- Migraine Management
- Medical Weight Loss
- Medical Grade Facial Peels
- Food Allergy Testing
- PRP Hair Restoration
- PRP Cosmetic Enhancement
- Laser Hair Removal
- IPL Photo Facials
- Skin Resurfacing
- Skin Tightening
- PDO Threading
- Sclerotherapy
- Medical Grade Skin Products and Latisse