PREMIER WELLNESS CENTER CLIENT INTAKE FORM

PATIENT NAME _____

DATE OF BIRTH_____

ADDRESS_____

CITY _____ **STATE** _____ **ZIP CODE** _____

CELL PHONE_____

HOME PHONE _____

EMAIL _____

Would you like to receive emails that tell you about special events and promotions? ___ Yes ___ No

OCCUPATION _____

EMERGENCY CONTACT NAME / NUMBER

_____

How did you hear about us? Referral source (Website, Facebook, Magazine, etc.): _____

If a client referred you, please list name so we can thank him or her: _____

Which of our services are you interested in?

__ Botox	__ Dermal Fillers	__ Laser Hair Removal
__ Sclerotherapy (spider veins)	__ Facials	__ Microneedling
__ MicroPlaning	__ Vitamin B12 Injections	__ Weight Loss Program
__ Naturopathic Medicine	__ Chemical Peels	__ CoolSculpting
__ Kybella	__ Vaginal Rejuvenation	__ Womens Wellness
__ IPL PhotoFacials	__ Food Allergy Testing	__ IV Therapy
__ Acne Treatments	__ Other Service _____	
__ Skin Care Products	__ Supplements	

ALLERGIES:

Medication or Food Allergies __Yes __No If yes, what are you allergic to? _____

Reaction: _____

Allergy to Laytex? __Yes __No

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What are your skin care concerns (pigmentation, dryness, acne, pore size, texture, fine lines, wrinkles, etc.)? _____

What skin care products are you currently using? _____

_____

What medications or supplements are you currently using? _____

_____

Surgical History (list any operations you've had) _____

Do you smoke? __Yes __No If yes, how much/how often? _____

What is your ethnicity? _____

Do you use sunscreen daily? __Yes __No

Extended sun exposure in last 3 weeks (i.e. hiking, horseback riding, sunbathing)? __Yes __No

Could you be pregnant? __Yes __No Are you currently nursing? __Yes __No

Do you wear contacts? __Yes __No Do you have metal implants? __Yes __No

Any questions/concerns or any medical concerns you think could be relevant to your treatment(s)?

_____

_____

I certify that the above statements are true and all questions have been answered truthfully to the best of my knowledge. I understand that it is also my responsibility to notify the staff at Premier Integrative Wellness, LLC, a.k.a. Premier Wellness Center in the event that any of this information changes, or if I have any medical/health changes.

_____

Patient Name (Print) **Patient Signature** **Date**