Last Name: _____ First Name:_____

Birthday (day)_____(month)_____(year) _____

Street Address: _____

City: _____ Postal Code: _____

Home Phone # _____ Business Phone # _____

Cell #:_____ Email:_____

PLEASE LIST YOUR AREA(S) OF CONCERN

_____

_____

_____

_____

_____

PLEASE CHECK ANY TREATMENTS YOU ARE INTERESTED IN:

☐ B 12 Injections ☐ Microneedling ☐ Microneedling with PRP

☐ Facial/Cosmetic Acupuncture ☐ Hair Rejuvenation Other: _____

Please check all that apply on how you would like to be contacted to confirm or change appointments:

Home ☐ Business☐ Cell ☐ Email ☐ I prefer not to be contacted ☐

What is the best way of contacting you about new services or specials?:

Email ☐ Phone: ☐ Mail ☐ I prefer not to be contacted ☐

May we contact you following any procedure to ensure your satisfaction?

_____Yes_____No, I will contact you if I have any concerns.

If we need to contact you by phone, may we leave a message?

_____Yes_____No

MEDICAL HISTORY: *Please answer the following (check all that apply)*

	Yes	No		Yes	No
Are you pregnant or trying to become pregnant?			Do you have diabetes?		
Do you have "low blood" or anemia?			Do you have any lung conditions or asthma?		
Do you bleed easily?			Do you smoke?		
Do you take blood thinners such as Coumadin, Plavix, Aspirin, Advil or Red Wine? If yes, when was the last time?			Do you have any inflammatory conditions such as Rheumatoid Arthritis, Lupus, or other autoimmune diseases?		
Have you experienced blood clots in the legs or lungs?			Have you ever had an organ transplant?		
Has a Doctor ever told you that your kidneys do not function normally?			Have you ever had a stroke or mini-stroke?		
Do you have a liver disease or jaundice?			Are you hard of hearing or do you use a hearing aid?		
Have you ever used addictive drugs or suffered from alcohol abuse?			Have you ever had tuberculosis?		
Do you have high cholesterol?			Do you have epilepsy, seizures, or sometimes faint?		
Do you experience chest pain or angina?			Have you ever had cancer?		
Do you get shortness of breath when lying flat?			Do you get confused or suffer from memory loss?		
Do you have a fast or irregular heart beat?			Do you have Hepatitis B or Hepatitis C or HIV?		
Do you have heart problems?			Have you experienced unintentional weight loss in the last year?		
Do you have high blood pressure?			Do you get keloids or abnormal scars?		
Do you have a pacemaker or metal implant?			Do you get cold sores?		
Do you suffer from depression, anxiety or other psychological disorders?			Do you have any eye conditions? Do you have Glaucoma?		
Do you have Multiple Sclerosis, Myasthenia Gravis or other neurological disorders?			List any medical concerns/conditions not mentioned above:		

List all **MEDICATIONS** you are currently taking, including herbals or alternatives:

Please list any **SURGERIES** or **HOSPITAL** stays that you have had:

Do you have **ALLERGIES** to medications, soy, medical products (i.e. adhesives or latex), anesthetics (i.e. dental freezing), or anything else whatsoever:

Have you had any **COSMETIC** procedures in the past? (i.e. Botox, Fillers, Laser, etc). Please list:

Did you have any adverse reactions to the above?

Please tell us any other information, health concerns or conditions for which you currently receive or have had treatment for in the past (includes medical, nature/homeopathic or allied health care):

Signature _____ Date _____