Creating Healthier Lives

INTAKE FORM

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

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

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
___ BURSITIS
___ 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:_____

202, 1910- 20th Ave. NW Calgary, AB T2M 1H5
Phone: (403)282-4488 Fax: (403)282-0465
email: drnardella@nardellaclinic.com Web: www.nardellaclinic.com

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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? _____

DO YOU TAKE/USE?

__ ACCUTANE
__ RETIN A ___%
__ RENOVA ___%
__ HYDROCORITSONE ___%
__ HORMONE REPLACEMENT THERAPY
__ ORAL ANTIBIOTICS

HOW LONG HAVE YOU BEEN USING THIS MEDICATION?
_____

HAVE YOU RECEIVED:

COSMETIC INJECTIONS? __ YES __ NO
IF YES, TYPE _____ AREA _____

COSMETIC SURGERY? __ YES __ NO
IF YES, TYPE _____ DATE _____

LASER TREATMENTS? __ YES __ NO
IF YES, AREA _____ DATE _____

SKIN CONDITIONS

PLEASE INDICATE CONCERNS:

__ ACNE
__ AGING
__ BLACKHEADS
__ BURN
__ DERMATITIS
__ DRY SKIN
__ ENLARGED PORES
__ LINES/WRINKLES
__ MOLES
__ RAZOR BUMPS
__ SCARRING
__ DISCOLOURATION
__ SUNBURNS
__ BROKEN CAPPILLARIES
__ ACNE ROSACEA
__ BACK/CHEST ACNE
__ CONGESTED SKIN
__ CYSTIC ACNE
__ DARK UNDER-EYE CIRCLES
__ ELASTISITY LOSS
__ FRECKLES
__ WHITEHEADS
__ PRE/POST OPERATIVE CARE
__ ROSACEA
__ OILINESS
__ STRECH MARKS
__ UNEVEN SKIN

HAVE YOU PREVIOUSLY UNDERGONE:
__ FACIALS
__ MICRODERMABRASION
__ PEELS, CIRCLE TYPE:

LACTIC ACID GLYCOLIC ACID

CHEMICAL SALICYLIC ACID

SUN EXPOSURE HISTORY

DO YOU SUNBURN/TAN EASILY?

__ ALWAYS BURN, NEVER TAN
__ SELDOM BURN, TAN EASILY
__ NEVER BURN, TAN EASILY
__ USUALLY BURN, TAN WITH DIFFICULTY

APPROXIMATE SUN EXPOSURE:

__ MINIMAL
__ OCCASIONAL
__ RECREATIONAL
__ OCCUPATIONAL

DO YOU USE A TANNING BED? __ YES __ NO
IF YES, HOW OFTEN? _____

DO YOU USE AN SPF DAILY?
__ YES __ NO IF YES _____%

WHAT IS YOUR NATURAL COLOURING?
EYES_____ HAIR_____ SKIN_____

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

Statement of Acknowledgement

I confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I understand that, as a patient, I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

_____ _____

SIGNATURE **DATE**

PATIENT IS SUITABLE FOR TREATMENT _____ _____

Date **Dr. Signature**

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