PRINT

ARCADIA WELLNESS CENTER

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:

- ☐Fatigue
- ☐Cancer
- ☐Weakness
- ☐Tremors
- ☐Low Sex Drive
- ☐Bruise easily
- ☐Diabetes
- ☐Other: _____
- ☐Insomnia
- ☐Fevers
- ☐Alcohol (Quantify_____)

Head, Eyes, Ears, Nose and Throat:

- ☐Eye problems
- ☐Ringing in ears
- ☐Hearing problems
- ☐Ear aches
- ☐Sinus problems
- ☐Headaches
- ☐Dental problems
- ☐Thyroid problems
- ☐Head injury

Cardiovascular:

- ☐Chest pain
- ☐Poor circulation
- ☐Heart attack
- ☐Murmur
- ☐Irregular heartbeats
- ☐Swelling in feet
- ☐Pacemaker
- ☐High cholesterol
- ☐Fainting
- ☐High blood pressure
- ☐Valve replacement

Respiratory:

- ☐Asthma
- ☐Valley fever
- ☐Tuberculosis
- ☐Short of breath
- ☐Cough
- ☐Pneumonia
- ☐Emphysema

Gastrointestinal:

- ☐Nausea/vomiting
- ☐GI bleeding from meds
- ☐Constipation

Musculoskeletal:

- ☐Neck pain
- ☐Joint pain
- ☐Osteoarthritis
- ☐Back pain muscle
- ☐Rheumatoid spasms
- ☐Bursitis
- ☐Tennis elbow
- ☐Carpal tunnel syndrome

Renal:

- ☐Kidney infections
- ☐Hepatitis (Active?___)
- ☐Kidney problems
- ☐Bladder infections

Neuropsychological:

- ☐Depression
- ☐Stress problems
- ☐Anxiety
- ☐Seizure disorder
- ☐Substance Use Disorder

Reproductive:

- ☐Low Libido
- ☐Erectile Dysfunction
- ☐Vaginal Dryness
- ☐Urinary Incontinence
- ☐Pain during sex

Do you take any of the following:

- ☐Antiobiotics
- ☐Aspirin or Ibuprofen
- ☐Blood Pressure Medication
- ☐Anti-coagulants
- ☐Coritsone or Steroids
- ☐Insulin
- ☐Anti-depressants
- ☐Hormones/Contraceptives
- ☐NSAIDS

Do you take any of the following:

☐Sedatives	☐Thyroid Medication	☐Vitamin D
☐Fish Oils	☐Tumeric	☐Blood Thinners
☐Accutane in the past 12 months	☐Retin A	☐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:

☐Asian	☐African American	☐Caucasian
☐Hispanic/Latino	☐Pacific Islander	☐Mixed Race
☐Other_____		

Concerns:

☐Dry Skin	☐Brown Spots	☐Fine Lines
☐Oily Skin	☐Redness	☐Deep Wrinkles
☐Acne/Breakouts	☐Rosacea	☐Skin Texture
☐Scars	☐Skin Care Products	☐Facial Veins
☐Thin Lips	☐Nasolabial Creases	☐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

ARCADIA
WELLNESSCENTER

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
Medical Weight Loss
B12 / Fat Burner Shots
Trigger and Joint Injections
Migraine Management
Vitamin Optimization
Botox, Dysport, Jeuveau
Dermal Fillers
Peptide Therapy
Food Allergy Testing

Growth Factors/PRP Hair Restoration
Bellafill
Kybella Lipodissolve
Threading, Facial & Body
Medical Grade Peels
RF Resurfacing and Skin Tightening
CO2 Skin Resurfacing
IPL Photofacial
IPL Hair Removal
Medical Grade Facials
Microneedling

480.351.3688 | WWW.ARCADIAWELLNESSCENTER.COM
2701 E CAMELBACK RD SUITE 163 PHOENIX, AZ 85016