Desert Holistic Health PLLC
9188 E San Salvador Dr.
Suite 205
Scottsdale, AZ 85258
Phone: 480.336.4195
Fax: 602.914.7412
www.deserthh.com

Desert holistic Health

New Patient Intake/Consent Form Date _____

Name* _____ Age _____ DOB* _____

Address _____ City _____ Zip*_____

E-mail Address _____ Phone # _____

Emergency Contact name* _____ Phone #*_____

Primary Care Provider name _____Phone # _____

Occupation _____ Marital Status _____

Height _____ * Weight _____ * Smoker: Past/Present/Never *

Food/Medication allergies:*_____

Weekly alcohol intake*: 1-3 drinks/4-7 drinks/7-11 drinks/12+

List any prescription medications including dose:*

1.

2.

3.

List any herbal/vitamin supplements:*

1.

2. * = required

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Past medical history*

1. High Blood pressure? Y/ N 2. Heart disease? Y/ N

3. Thyroid disorder? Y/ N 4. Cancer? Y/N

5. Neurological disorder? Y/N 6. Kidney or Liver disease? Y/N

7. Glaucoma? Y/N 8. Diabetes? Y/N

9. Breathing problems? Y/ N 10. Abnormal EKG? Y/ N

11. Any implantable device including cheek or chin implant? Y/N

Other- please list

Women- Are you pregnant?* Y/ N Breastfeeding?* Y/ N

Last Menstrual Period date _____

Family medical history (May skip if only receiving botox/filler)

Mother-

Father-

Siblings-

Aesthetics interest Questionnaire (please fill out if receiving any cosmetic treatment):

What most concerns you about your appearance (please circle):

Wrinkles/Fine lines, Laugh lines, volume loss, dark circles/tired eyes, dark spots, smoker's lines, lip volume, aging hands, hooded eyelids, dry skin, double chin/jawline definition, jowls.

Are you interested in a B12 shot today? Y/N

Other concerns:

I consent to treatment as a new patient performed by Megan Davies NP.

*_____

Patient Signature Date