INTAKE FORM

Patient Information:

Name: ____ Date:___________________

Address: ____

City: ________________________________ State: __________ Zip code:__________________

Phone: _______________________ Date of Birth:_________________ Age:________________

Occupation:_________________________ Email address:______________________________

How did you hear about us? ☐Website ☐Facebook ☐Instagram ☐Friend _____________________
☐Other

Primary Concern(s):

☐Cold & Flu Symptoms	☐Diarrhea/Nausea/Vomiting	☐Fitness Dehydration
☐Recent Illness	☐Severe Dehydration	☐Immune Support
☐Stress	☐Migraine	☐Hangover
☐Inflammation	☐Pain	☐Insomnia
☐ Fatigue/Low energy	☐Acute & Chronic Pain	☐Depression

Past Medical History- Have you ever been diagnosed with:

☐ Hypertension	☐Edema	☐Kidney Disease
☐Bleeding Disorder	☐Congestive Heart Failure	☐Heart Attack
☐Pulmonary Edema	☐Atrial Fib	☐Asthma
☐Anxiety	☐Sudden Weight Loss	☐Stroke/TIA
☐Currently Pregnant	☐G6PD Deficiency	☐High Parathyroid

Allergies to:

☐Medications ☐Latex ☐Shellfish ☐Iodine ☐None

List Allergy and reactions, if applicable: ___________________________________

Please list all medications you are taking:

____

Sublime Body
MEDICAL SPA