Clinical Services Patient Intake Form

First Name: _____ Last Name: _____

Preferred Name: _____ Phone: _____

Address: _____ Email: _____

Gender: _____ Date of Birth: _____ Marital Status: _____

Emergency Contact Full Name: _____ Phone: _____

Primary Physician: _____ Phone: _____

Address: _____

List Any Medical Conditions: _____

List Current Medications: _____

Do You Have Any Allergies? ☐ Yes ☐ No

Please List: _____

Previous Major Injuries, Surgeries and/or Treatments and Dates: _____

Reason For Today's Visit: _____

FOR WOMEN

Are You Pregnant? ☐ **Yes** ☐ **No**

Notes or comments: _____

LAB WORK

Do you have any recent lab work? ☐ **Yes** ☐ **No**

Your lab work is helpful for Scott Porter to have before your consult.

Please deliver any relevant lab work or test results in person to the Nutrition Center or email to: scott@sandpointsuperdrug.com

Other Comments: _____