**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**

What is the primary reason for your visit?

\_\_ I have an illness: \_\_ Fatigue \_\_Anemia \_\_ Overweight

\_\_ I have an injury or other concern: \_\_Acute Pain \_\_Chronic Pain \_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this start? \_\_\_\_\_\_\_\_\_\_\_\_ Where does it hurt the MOST? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this the result of an accident? \_\_Yes \_\_No If an accident: \_\_ Motor Vehicle \_\_ Work \_\_\_ Lifting \_\_ Fall

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your level of pain now? 1---5----10 Does the pain keep you from doing what you want or need to do? \_\_Y \_\_N

What is the HIGHEST level of pain you have had since it began? 1---5----10

Please identify your primary provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Contact Information

Do you need us to coordinate care with your PCP? \_\_Y \_\_N

Do you have any medical conditions which we need to consider? \_\_ Y \_\_N

**Current Supplements**:

**Current Medications**:

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Supplement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Supplement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Supplement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

**Known Drug Allergies:**

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Taken: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Taken: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Taken: \_\_\_\_\_\_\_\_\_\_

**For Dermal Filler and Neurotoxin Patients Only:**

Please identify any current or past conditions by circling those that apply:

History of adverse reaction to botulinum toxin History of Anaphylaxis Multiple Severe Allergies Facial Acne Hives Herpes

Immunosuppressive Therapy Autoimmune Disease Facial Rashes

Active Inflammatory process Infection (at proposed injection site) Myasthenia Gravis Lambert-Eaton Syndrome

**Signature of Patient**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date