Age Defier RN
3636 N Central Ave., Suite 700
Phoenix, AZ 85012
602-284-0021

Client History

Today's date _____

Name _____ Date of birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Cell phone _____ Home phone _____

Email address _____

Emergency contact _____ Phone number _____

How did you hear about us? _____

Male ☐ Female ☐ Occupation _____

ALLERGIES - Please list: _____

Reaction(s) _____

List all medications, including supplements that you take:

_____ _____

_____ _____

_____ _____

GENERAL MEDICAL HISTORY: Check all the following that apply.

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Thyroid abnormalities
- ☐ Taken Accutane in the last 6 months
- ☐ History of Cancer
- ☐ Cold sores/fever blisters/Herpes
- ☐ Asthma
- ☐ Birth control/hormone therapy
- ☐ Heart palpitations
- ☐ Pacemaker/defibrillator
- ☐ Mitral Valve Prolapse/valve implant
- ☐ Polycystic Ovarian Syndrome
- ☐ Metal or implants in treatment area
- ☐ History of Botulinum immunization
- ☐ Seizures

Do you smoke? Yes ☐ No ☐

Are you currently taking blood thinners or anticoagulants such as Coumadin, Aspirin, Ibuprofen, Vitamin E, etc.? Please list:

Do you have an autoimmune or neuromuscular disorder? Please describe:

Do you have Hepatitis or HIV or are you undergoing treatment such as chemotherapy that could affect healing? Please describe:

Current use of controlled substances? Please describe:

Please list any past surgeries:

Are you currently under the care of a physician for any condition? Please describe:

Client Name (Please print) _____

Signature _____Date: _____