INTAKE FORM

NAME:____DATE:___________________
ADDRESS:_________________________________ CITY__________________ POSTAL CODE:____________
TELEPHONE: HOME:______________WORK:______________E-MAIL:____________________________
DATE OF BIRTH:_____________________AGE:_________SEX:_________ OCCUPATION:_______________
EMERGENCY CONTACT NAME & RELATION:________________________________ PH:_________________
HOW DID YOU HEAR ABOUT OUR THE NARDELLA CLINIC?__________________________________

MEDICAL HISTORY

PRIMARY FAMILY PHYSICIAN:_______________________ PH:__________________
MAY WE HAVE PERMISSION TO CONSULT WITH PRIMARY PROVIDER? YES ___ NO ___
PLEASE LIST: CURRENT MEDICATIONS (TOPICAL & INTERNAL):_____________________
ALLERGIES:_______________________________________
SURGERIES:_______________________________________

PLEASE CHECK ANY & ALL CONDITIONS THAT APPLY TO YOU:

___ ALCOHOL ADDICTION
___ ARTHRITIS
___ ASTHMA
___ ATHLETES FOOT
___ AUTOIMMUNE DISORDER
  ___LUPUS
  ___CREST
  ___SCLERODERMA
  ___HASHIMOTO'S
  ___MS
  ___RHEUMITOID ARTHRITIS
  ___OTHER_________
___ BLEEDING TENDENCY
___ BLISTERING SUNBURNS
___ BLOOD CLOTS
___ BONE / JOINT TROUBLE
___ BUNIONS
___ BURSITIS

___ CARPAL TUNNEL SYNDROME
___ CATARACTS
___ CHEMOTHERAPY
___CLAUSTERPHOBIA
___ CONSTIPATION
___ CONTACT LENSES
___ CONVULSIONS
___ DIABETES
___ DEPRESSION
___ DIZZINESS
___ DRUG ADDICTION
___ ECZEMA
___ EMPHYSEMA
___ EPILEPSY
___ FEVER
___ HAY FEVER
___ HEADACHES
___ HEART ATTACK
___ HEART DISEASE

___ HEART SURGERY
___ HEPATITIS (TYPE__)
____ HERPES
___ HERPES SIMPLEX
___ HIGH BLOOD PRESSURE
___ HIV/AIDS
___ HYPERTENSION
___ GLAUCOMA
___ KELOID SCARRING
___ KIDNEY PROBLEMS
___ LOW BLOOD PRESSURE
___ LOW BACK PAIN
___ LYMPHEDEMA
___ MENOPAUSE
___ MIGRAINES
___ MOLES

___ NUMBNESS
___ PHLEBITIS
___ PSORIASIS
___ SCIATICA
___ SHINGLES
___ SINUS PROBLEMS
___ STROKE
___ TENDONITIS
___ THYROID
___ ULCERS
___ VARICOSE VEINS
___ WARTS
___ OTHER, PLEASE DESCRIBE___________
____
____
____

HAVE YOU HAD A FAMILY HISTORY OF SKIN DISEASE? YES______ NO_____ TYPE______________________
DO YOU HAVE A PACEMAKER? YES: __ NO: __METAL PLATES OR PINS? YES: __ NO: __

LIFESTYLE

DO YOU HAVE ANY DIFFICULTIES WITH YOUR HANDS OR FEET?____________________________
HOW MUCH WATER DO YOU DRINK IN A DAY? _____ CAFFEINE? ______ ALCOHOL? __________
PLEASE DESCRIBE YOUR DIET (I.E. VEGAN, LOW CARB, ETC.)_________________________________
DO YOU ENJOY HOT OR SPICY FOODS? YES: __ DESCRIBE __________ NO: _____
DO YOU SMOKE? ____________IF YES, HOW MANY? ____________ HOW LONG? ____YRS
HOW WOULD YOU DESCRIBE YOUR DAILY LEVEL OF STRESS?________________________________
DO YOU EXERCISE REGULARLY? YES: __ NO: __ DESCRIBE:____________________________
PLEASE DESCRIBE YOUR SLEEP PATTERNS:____
PLEASE LIST ANY OTHER INFORMATION WE MAY NEED TO KNOW ABOUT:____________________

INTAKE FORM

FOR WOMEN:

ARE YOU PREGNANT: YES: __ NO: __ IF YES, STAGE: _______ DUE DATE: __________
ARE YOU TRYING TO BE PREGNANT? _____ ARE YOU ON ORAL CONTRACEPTIVES? YES: __ NO: __

MEDICAL & AESTHETIC HISTORY

ARE YOU UNDER THE CARE OF A DERMATOLOGIST? YES: __ NO: __
DERMATOLOGISTS NAME: _________________ REASON FOR TREATMENT: _____________
DO YOU TAKE DIETARY SUPPLEMENTS/VITAMINS? YES: __ NO: __
IF YES, PLEASE DESCRIBE: ____
DO YOU TRAVEL; FOR WORK OR PLEASURE? _W / P_______ HOW OFTEN? ______________

DO YOU TAKE/USE?

__ ACCUTANE
__ RETIN A ___%
__ RENOVA ___%
__ HYDROCORITSONE ___%
__ HORMONE REPLACEMENT THERAPY
__ ORAL ANTIBIOTICS

HOW LONG HAVE YOU BEEN USING THIS MEDICATION?
____

HAVE YOU RECEIVED?

COSMETIC INJECTIONS? __ YES __ NO
IF YES, TYPE ____________ AREA _____________

COSMETIC SURGERY? __ YES __ NO
IF YES, TYPE ____________ DATE _____________

LASER TREATMENTS? __ YES __ NO
IF YES, AREA ____________ DATE _____________

SKIN CONDITIONS

PLEASE INDICATE CONCERNS:
__ ACNE __ ACNE ROSACEA
__ AGING __ BACK/CHEST ACNE
__ BLACKHEADS __ CONGESTED SKIN
__ BURN __ CYSTIC ACNE
__ DERMATITIS __ DARK UNDER-EYE CIRCLES
__ DRY SKIN __ ELASTISITY LOSS
__ ENLARGED PORES __ FRECKLES
__ LINES/WRINKLES __ WHITEHEADS
__ MOLES __ PRE/POST OPERATIVE CARE
__ RAZOR BUMPS __ ROSACEA
__ SCARRING __ OILINESS
__ DISCOLOURATION __ STRECH MARKS
__ SUNBURNS __ UNEVEN SKIN
__ BROKEN CAPPILLARIES

HAVE YOU PREVIOUSLY UNDERGONE:
__ FACIALS __ MICRODERMABRASION
__ PEELS, CIRCLE TYPE:

LACTIC ACID GLYCOLIC ACID

CHEMICAL SALICYLIC ACID

SUN EXPOSURE HISTORY

DO YOU SUNBURN/TAN EASILY?

__ ALWAYS BURN, NEVER TAN
__ SELDOM BURN, TAN EASILY
__ NEVER BURN, TAN EASILY
__ USUALLY BURN, TAN WITH DIFFICULTY

APPROXIMATE SUN EXPOSURE:

__ MINIMAL
__ OCCASIONAL
__ RECREATIONAL
__ OCCUPATIONAL

DO YOU USE A TANNING BED? __ YES __ NO

IF YES, HOW OFTEN? ___________________

DO YOU USE AN SPF DAILY?

__ YES __ NO IF YES _____%

WHAT IS YOUR NATURAL COLOURING?

EYES_________ HAIR_________ SKIN__________

I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE THE TECHNICIAN OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE: ____________________________________ DATE: ______________

202, 1910- 20th Ave. NW Calgary, AB T2M 1H5
Phone: (403)282-4420 Fax: (403)282-0465
email: info@aquaterraspa.ca Web: www.aquaterraspa.ca

INTAKE FORM

INFORMED CONSENT

Statement of Acknowledgement

I confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.
I understand that, as a patient, I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

________________________ ______________ _________________________ **SIGNATURE**

DATE **Witness**

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