

Aesthetics and Wellness New Patient Intake

Complete the applicable fields. Sign on page 4, or print and sign. Bring this form to your appointment or ask our office for an approved secure return method.

Patient and contact information

Legal name

Date of birth

Preferred name

Phone

Email

Street address

City

State and ZIP

Emergency contact and relationship

Emergency contact phone

Primary care clinician or practice

PCP phone

Preferred pharmacy

Pharmacy phone

Services you would like to discuss

☐ Aesthetics consultation / unsure

☐ EMSELLA

☐ EXION Face

☐ EXION Body

☐ Weight management program

☐ Other wellness concern

☐ EMSculpt Neo

☐ EMFACE

☐ EXION RF Microneedling

☐ CELLUTONE

☐ Wellness injections

Please specify:

Patient name

Date of birth

Your goals

Main concerns, treatment areas and goals

Health and safety screening

Select one answer per row. Your clinician will review your answers and the specific device or medication requirements before recommending treatment.

	Yes	No	Unsure
Pregnant, possibly pregnant, trying to conceive or planning pregnancy?	☐	☐	☐
Breastfeeding or planning to breastfeed?	☐	☐	☐
Pacemaker, defibrillator, implanted pump, neurostimulator or other electronic implant?	☐	☐	☐
Metal implant, mesh, prosthesis or other implant in a proposed treatment area?	☐	☐	☐
Heart or circulation condition, previous stroke, or a significant vascular problem?	☐	☐	☐
Seizure, neurologic or neuromuscular condition?	☐	☐	☐
Bleeding/clotting disorder or use of blood-thinning medication?	☐	☐	☐
Diabetes, impaired wound healing or an immune-system condition?	☐	☐	☐
Cancer history, active cancer treatment or prior radiation therapy?	☐	☐	☐
Infection, open wound, active rash or cold sore in a proposed treatment area?	☐	☐	☐
Unusual scarring, keloids or prior pigment changes after a skin procedure?	☐	☐	☐
Hernia, recent/planned surgery or recent procedure in the proposed treatment area?	☐	☐	☐
Current weight-loss medication or injections from another prescriber?	☐	☐	☐

Explain Yes or Unsure answers and any other important health concerns

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Current medications and supplements

☐ No current medications or supplements

List prescriptions, nonprescription products, vitamins, supplements, injections, creams and as-needed medicines. Attach a list if needed.

Medication / supplement

Dose and frequency

Reason / prescriber

Allergies and adverse reactions

☐ No known allergies

Allergen / product

Reaction and severity

Previous procedures and treatments

List surgeries, skin/device treatments, fillers, injectables, dates, areas and any prior reactions

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Care communication preferences

Standard email and text messages may not be fully secure. These choices concern care-related communication and can be changed by contacting the office.

May we send care-related text messages to your listed phone?

- ☐ Yes ☐ No

May we send care-related email to your listed email address?

- ☐ Yes ☐ No

Voicemail permission

- ☐ Appointments only ☐ Care information too ☐ No voicemail

Optional practice service announcements

Optional announcements about this practice's aesthetics and wellness services are separate from care messages. Choosing No does not affect your care. You may opt out at any time.

☐ I would like announcements by email

☐ I would like announcements by text

Privacy notice and patient acknowledgment

☐ I have received or been offered the practice Notice of Privacy Practices.

Sign after reviewing your information. This intake form does not authorize a specific procedure, public use of photographs or disclosure of health information for advertising. Treatment-specific consent is completed separately.

I certify that my answers are complete and accurate to the best of my knowledge. I will tell the practice about changes in my health, medications, allergies or contact details before treatment.

Patient or legal representative signature (type name or print and sign)

Date

Representative name and relationship, if applicable