SONORAN
NATUROPATHIC
CENTER

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ANTI – AGING CONSULT
INITIAL INTAKE - FEMALE

Today's Date:_____

Name:_____ ☐**NEW** or ☐ **EXISITING PATIENT**

Date of Birth:_____ **Age**: _____ **Gender**:_____

Street Address: _____

City:_____ **State**:_____ **Zip Code**:_____

Phone: (Home):_____ **(Cell)**:_____

Please list your main anti- aging concerns in their order of importance to you. Give a brief history of when it started, other treatments or doctors/providers you have seen, etc.)

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____

Check off all those that are of interest to you or concern for you that you would like to further discuss with your provider.

- Anti- Aging Skin Rejuvenation
- Skin Care Product Advice
- Sunscreen Advice
- Facial Treatments Advice
- Aesthetic Procedures (including PRP, Ozone Therapy, etc.)
- Anti- Aging Acupuncture
- Gut Health and Anti- Aging
- Supplementation Review and Advice
- Environmental Toxin Review
- Lifestyle Management
- Acne
- Redness
- Fine lines & Wrinkles:
  - Frown lines
  - Crow's feet
  - Dark Circles
  - Forehead
  - Enlarged blood vessels
  - Scarring
  - Vertical lip lines
  - Marionette lines
- Pigmentations/brown spots
- Spider Veins
- Skin drooping/ loss of skin fullness
- Eczema
- Psoriasis
- Other, please specify:
  - _____

With respect to signs of aging, highlight the areas of the face that are most bothersome to you.

Have you undergone any previous cosmetic procedures, including surgically or injectable?

☐ NO

☐ YES, if so please list which procedures and the approximate date they were completed:

- _____
  _____
  _____
  _____
  _____

Is your skin: ☐ DRY ☐ Oily ☐ Combination ☐ Sensitive

List all beauty products you currently use (please include brand name):

_____
_____
_____

Current Medical History:

Medications/Supplementations: (Please include dosage and brand name, if known)

- Medications: (Please include prescriptions as well as Over- the – Counter)
  - _____
    _____
    _____
- Supplements:
  - _____
    _____
    _____
- Allergies: (include Food and/or Drug allergies – please also describe the type of reaction you have had):

  _____
  - ☐ I have no known allergies to medications or foods.
- Any previous complications or side effects to local or general anesthetics? (Please list anesthetic used and describe the reaction you have had):_____
  - ☐ I have had no known complications or side effects to the use of local or general anesthetics.

PAST MEDICAL HISTORY:

- Previous/current diagnosis or illness: (please include date of diagnosis):

  _____
  _____
  _____
- Are you pregnant or plan on becoming pregnant in the next year?
  - ☐ Pregnant
  - ☐ Planning on becoming pregnant
  - ☐ NO
- Are you lactating? ☐ YES ☐ NO