



Intake Attachment Form Medical Conditions

Patient Name: _____ **D.O.B.** _____

1. Are you allergic to any medications or have you ever experienced adverse reactions to any medications? (Over the Counter or Prescribed)

- Yes; Describe: _____
 No

2. Do you have any other allergies? (example. food, shell fish, pollens, insect bites)

- Yes; Describe: _____
 No

3. Are you currently under the care of a physician for any medical problems, or are you experiencing any medical problems that you are concerned about?

- Yes (Please list below) No

Problem	Onset of Symptoms	Treating Physician

4. Are you on any type of medication? (Over the Counter (otc) or prescribed)

- Yes (Please list below) No

Medication(s)	Dosage	OTC or Prescribing Physician

5. Have you been treated for any significant medical problems in the past?

- Yes; Describe: _____
 No

Practitioner Signature: _____ Date: _____