



Carefree Health Path & Medical Spa

Medical History

Last Name: _____ First Name: _____ Date: ____/____/____
Address: _____ City: _____ State: _____ Zip Code: _____
Social Security# _____ - _____ - _____ Date of Birth: _____ Age: _____ Gender: Female Male
Email Address: _____ would you like to subscribe to our online special? Y N
Height _____ Weight _____ Are you: Married Separated Divorced Widowed Single
Home Phone: _____ Work: _____ Cell: _____
Emergency Contact: _____ Phone: _____ Relationship _____
May we communicate with them re: appt's, RX's, and lab results? Y N
Preferred phone number to contact you: Home Work Cell May we leave a message: Y N
Have you ever seen a Naturopathic Physician before? Y N Reason: _____
How did you hear about us? Friend Physician Relative Internet Magazine Other
Referring person's name: _____
Primary Care Physician: _____ Phone: _____
Address: _____ City: _____ State: _____
Do you have Any current or chronic medical illnesses we should know about? Y N Please list: _____
Do you have Any allergies to medications, foods, latex or other substances? Y / N Please list: _____
Do you take/use Any medications, both prescription and non-prescription, herbal or Natural supplements or topical on a regular daily basic? Y/N Please List: _____

Medical History:

Do you have a history of herpes I or II in the area to be treated? Y N
Do you have a history of diabetes? Y N
Do you have any sensitivity to heat, i.e. Heat rash? Y N
Do you have any history of seizures? Y N
Do you have a history of migraine headaches? Y N
Do you have a history of keloid or hypertrophic scarring? Y N
Do you have any active infections or compromised ability to healing? Y N
Do you take Saint John's Wort or any anticoagulants? Y N
Have you taken Accutane in the last 6 months? Y N
Have you had or are you undergoing any treatments for Cancer? Y N
Do you have any permanent make-up, implants or tattoos? Y N
Have you used any exfoliating creams or products (Retin A, Differin, Glycolic acid, alpa-hydroxy acid products) in the last 2 weeks? Y N
Do you have any open lesions in area to be treated? Y N
Have you had mechanical epililation less than 6 weeks ago, this including: Plucking, tweezing, electrolysis, or sugaring? Y N Please specify: _____
For Women: Are you, could you be pregnant or lactating (nursing)? Y N
Are your menstrual periods regular? Y N
Have you had any unprotected sun exposure, used self-tanning creams or tanning beds in the last 4-6 weeks? Y N
Are you sensitive to sunscreens or anti-aging creams? Y N
Which body areas or condition would you like treated? _____
List Previous Hospitalizations/Operations _____

Circle any of the following illnesses you have or have had in the past:

Myasthenia Gravis	Hepatitis	Eye Disease	Autoimmune Disease
Vision Problems	Numbness	Muscle Weakness	Multiple Sclerosis
Amyotrophic Lateral Sclerosis (ALS)		Parkinson's Disease	Neurological Disorders
Lambert-Eaton Syndrome			

Please list and/or explain other Medical Conditions not Listed Above: _____

Have you had plastic surgery or other surgery to your face/neck areas? If so, when? _____

Had Botox® injections before? Y N Last treatment? ___/___/___ what area(s)? _____

Happy with previous Botox® treatments? Explain _____

Ever had eyelid/eyebrow drooping after Botox®? Explain _____

Have you ever been told you have sleep eyes? Explain _____

Do you show a lot of upper eye lid when eyes are open? Explain _____

Do your eyelids feel extra heavy when you do not get enough sleep? Explain _____

Do your eyelids droop without sleep? Explain _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to Carefree Health Path and Med Spa as soon as possible. I have read and understand this questionnaire and health history. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member responsible for any errors or omissions I may have made in completing this form.

Patient / Legal Guardian Signature: _____ **Date:** ___/___/___

Patient Consent

If you have any questions, please ask:

- I acknowledge that no guaranties, either expressed or implied have been made to me regarding the outcome of any treatments or procedures.
- I agree to accept responsibility for payment of all charges relating to the services provided to me. The amounts due for services rendered and that payments must be made directly to Carefree Health Path and that no special arrangements have been made for payment. I understand that all treatments, therapies, medicines and nutritional supplements are non-refundable, and there are no refunds. The services offered are not included in the Medicare program and that if I inadvertently file a Medicare claim it will be denied. Most insurance companies do not pay for these services and any claims I make may be denied.
- I accept t the risks and complications. I agree to follow-up as recommended and to follow any and all of the pre-procedure and/or post-treatment instructions that have been provided to me. I understand that failure to do so can affect my results.
- I have been advised whether, on the days surrounding the treatment or procedure, I should take any and/or all of the medications I informed the doctor I have been taking.
- I understand that some of these therapies are not recognized or approved by the Food and Drug Administration as a standard therapy. I therefore, hereby release Carefree Health Path, and their designates, physician(s), staff, employees, and relatives of such from any liability arriving out of the status of the approval or lack of approval of this therapeutic process.
- As with any therapy, some patients may experience side effects from the therapy(s) chosen and/or agreed to. If they occur, most are likely to be minor or temporary. However, some may be serious or life threatening and need medical attention.

By signing below, you, the patient of Carefree Health Path (or the legal representative or parent of the patients), are requesting and authorizing Carefree Health Path to perform services and to provide you with recommendations on optimizing your present and long-term health goals.

Patient / Legal Guardian Signature: _____ **Date:** ___/___/___

Consent for use and disclosure of health information

Privacy Terms: We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records we keep. Moreover, if you believe that information in your record is inaccurate, you may request that we make corrections or amend that record. These requests must be made in writing. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Carefree Health Path is required to provide you, at your request, with a copy of its Notice of Privacy

