CONFIDENTIAL INTAKE FORM

(as regulated by HIPPA Laws)

First and Last Name_____

Street Address _____

City _____

State _____ Zip_____ Cell Phone_____

Email _____

Age _____ DOB _____

How Did You Learn Of Our Company?

Where online?

_____

Who referred you?

_____

Thank you for your patience in completing the forms. The information is often important in the treatment Planning.

Center for Sexual Health & Education

MEDICAL INTAKE FORM

Are you currently under doctor's supervision and if so, for what ailment?

Do you have diabetes, heart conditions or blood pressure problems?

Are you currently menstruating or have you reached menopause?

What are other medical conditions that we should know?

Have you had any surgeries or injuries?

Which medications are you currently using?

Do you have any allergies to medications?

Do you smoke or consume alcohol?

What is your occupation?

Do you have dietary goals or restrictions?

Do you have fitness goals? What fitness or sports activities do you do? How frequently?

Do you have physical limitations?

How do you currently manage stress?

Please read and sign:

I understand that the information provided is used only by the Center for Sexual Health and Education, LLC. I have to the best of my knowledge, stated all my known medical conditions and take it upon myself to keep the doctors and therapists updated on my physical health. All information is confidential, unless an authorization for release of information is requested by me. I understand that if I cancel an appointment without at least 24-hours advanced notice, I am liable for the $50.00 cancellation fee.

Print _____ **Signature**_____ **Date**_____