Intake form

Name: _____ **Social security number:**_____

Address: _____**Phone number:** _____

Postal code and place: _____ **Email address:**_____

Do you have any medical diagnoses? _____

Do you use any medications? _____

Have you been in surgery? _____

Have you had a cancer diagnosis?_____

Do you have allergies or sensitivities?_____

Are there diseases that run in your family? _____

Have been in accidents or sustained injuries? _____

Check if you have any of the following:

___ Thyroid dysfunction

___ High blood pressure

___ Chest pain

___ Cardiovascular disease

___ Asthma or other lung condition

___ Osteoporosis

___ Pacemaker or artificial valve

___ Coronary artery disease

___ Diabetes type 1

___ Diabetes type 2

___ Disorder of liver, kidneys or other internal organ _____

___ Rheumatoid arthritis _____

___ Epilepsy or other neurological disease _____

Any other disease, which? _____

May we send you offers and updates? Yes ___ No ___

According to the Personal Data Act (523/99), your personal data will be stored in the register with your consent. Your patient information is kept confidential.

I have read the statement above and confirm the accuracy of the information I have provided.

Time and place: _____ Signature: _____

Guardian / trustee: _____