Intessa
PAIN RELIEF SPA

PATIENT INTAKE SHEET

NAME: _____

DOB: _____

DATE: _____

Please note: The doctor relies on your honesty to accurately assess your condition. Any breach of this trust has a negative effect on the Patient-Physician relationship.

What is the main reason that you feel you qualify for the MMMP Registration Card? Be specific about the body part that is affected?

What treatment or medications are you currently using for this condition?

When did this condition first occur and under what circumstances:

Describe the frequency and intensity of your pain, nausea, or muscle spasms:

Are you satisfied with your current medication or treatment for your condition?

Do you want to avoid prescription narcotics?

A

List the surgeries that you have had:

Are you an alcoholic?

Do you smoke cigarettes?

Do you have a family history of diabetes or heart disease?

What DAILY medications do you take:

Are you allergic to any medications?

Are you aware of any pending legal action against you?

SIGNATURE:_____