Last Name:\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_Allergies:\_\_\_\_

Phone number and Email that is ok to text or leave messages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all Medical Conditions/year diagnosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries/hospitalizations Performed/Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke?\_\_\_\_\_\_\_\_\_\_\_\_\_ How many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note amount/frequency of Alcohol consumed?\_\_\_\_\_\_\_\_\_\_\_\_\_ Illicit Drug use ?\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Medications or Supplements you are taking:? Dose/frequency?

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle if you have had any of the following symptoms or conditions and note next to it when it started:

 If you are female when was your last menstrual cycle? On bcp? Any menstrual problems?

Anxiety Depression Other mental illness Fever Ear/Nose/Throat problems

Cough Shortness of breath Rash Chest pain Anorexia Weight gain

Bulimia Abdominal pain Gallstones/or Gallbladder Numbness

Hormone therapy Vomiting/Nausea Diarrhea Constipation Pain

Seizures Headaches Swallowing problems Weakness Gerd

Dizziness Tremor Thyroid Falls Diabetes/sugar problems

Cancer Heart/blood pressure Murmur Bladder pain or Urination difficulties

Edema passing out Skin problems Blood in stool or urine

Fatigue Insomnia Palpitations Muscle or joint problems

Please list below if you have any of the above, date it started, and list any other symptoms you have:

The above is true and I understand that Joanne Gigi Hardtke, ANRP is not my primary care provider but serves to assist with nutritional goals and it is my responsibility to follow up and see a primary care provider for ongoing medical care.

**PATIENT INFORMATION**

PATIENTS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_\_\_\_\_ BIRTHDATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_ M \_\_\_\_\_F

PRIMARY CARE DOCTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST NUMBER/EMAIL OK TO LEAVE PERSONAL MESSAGES TO TEXT (Yes/no):\_\_\_\_\_\_\_\_\_\_\_ (INITIALS)

EMERGENCY CONTACT:\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_

I understand that the information provided on this form is true and correct to the best of my knowledge. I understand that for services provided by Joanne Gigi Hardtke, ARNP my insurance will not be billed and are not covered by insurance. I also do not have Federal or State insurance such as Medicare or Medicaid or any version of State provided insurance. I hereby give permission to Joanne Gigi Hardtke, ARNP any qualified staff to evaluate, diagnose, discuss care with primary care provider/pharmacy, and treat my condition as may be deemed necessary. I understand that my arm will be used primarily during testing and assume all of the risks associated with the evaluation and treatment. I understand that Joanne Gigi Hardtke, ARNP uses nutritional therapy to primarily to assist in my well-being not to diagnose or treat a condition. I agree to allow my information to be provided to the nutritional company in order to obtain supplements. My information may only be released to me if I sign a release and provide a copy of a valid ID. It is my responsibility to follow up and call if any concerns or new symptoms arise. I also understand that Joanne Gigi Hardtke, ARNP is not my primary care provider and I will contact my primary contact provider for an appointment immediately if any medical conditions/concerns/discomforts or symptoms develop. I release all rights and claims of damages against Joanne Gigi Hardtke, ARNP for injuries or damages that occur as a result of evaluation and treatment.