



CLIENT INTAKE FORM

PERSONAL INFORMATION

Name: _____

Date: _____

Nurse Seeing Today: _____

Are you pregnant?

- ☐ Yes, Due Date _____
☐ No ☐ N/A

Are you breastfeeding?

- ☐ Yes ☐ No

Have you had any vaccination in the last 30 days?

- ☐ Yes ☐ No

Have you tested positive for COVID in the last 30 days?

- ☐ Yes ☐ No

Have you had dental work done or visited the oral hygienist in the last 30 days?

- ☐ Yes ☐ No

Do you plan on having dental work done or visiting the oral hygienist in the next 30 days?

- ☐ Yes ☐ No

Are you taking blood thinners such as aspirin, fish oil, ginkgo biloba or consume red wine, dark chocolate, grapefruit in the last 7 days?

- ☐ Yes, _____
☐ No

Do you have any active inflammatory skin conditions such as a cold sore, rosaceas, or dermatitis?

- ☐ Yes, _____
☐ No

Have you had an infection of any kind such as sinus, urinary tract or bladder in the last 30 days?

- ☐ Yes ☐ No

Do you have any allergies?

- ☐ Yes, _____
☐ No

Has anything changed with your health since the last time you were at our clinic?

- ☐ Yes, _____
☐ No
☐ New Client

Signature

Date