BELLA VIA
Therapeutic wellness spa

Injectable Consult/Treatment Intake Form

Name:________________________ DOB:____________ AGE:________ Gender:____________

Address:________________________ City:____________ State:______ Zip:________

Home Phone: ________________ Cell:________________ Work:________________

Email:________________________________ Occupation:________________________

(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable)

Dr. Colville Dr. Zavell Leslie, NP Website Friend:________________

Other:____

Medications/Supplements/Vitamins (Please list all and reason for taking)

Medication Name	Dose/Strength	Reason/Condition for taking

No Known Allergies ◯ (check circle or complete below)

List any allergies	Reaction

Do you have any facial implants? Yes ◯ No ◯ If yes, where? ________________________

Do you have a history of cold sores/herpes? Yes ◯ No ◯

Have you had Botox/Xeomin/Dysport in the past? Yes ◯ No ◯ If yes, how long ago? ____________

Have you had any dermal filler in the past? Yes ◯ No ◯ If yes, how long ago? ________________

Have you had any dental procedures within the past 2 weeks or do you have any upcoming dental procedures? Yes ◯ No ◯

Social History:

Tobacco/Nicotine/Vaping: Yes ◯ No ◯ If yes, how often/much? ______________________________

Cannabis/Marijuana/CBD: Yes ◯ No ◯ If yes, how often/much? ______________________________

Female Patients: Are you currently pregnant or breastfeeding? Yes ◯ No ◯

Height:__________ Weight:__________

Anything else you would like your provider to know regarding your health or past experiences? Yes ◯ No ◯

If yes, comment here:

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Patient signature: ____ Date:__________