

# SPECTRACELL TESTING – INTAKE FORM

## Patient Demographics:

Patient's Name : \_\_\_\_\_ D.O.B. \_\_\_\_\_

Gender:  Male or  Female

Primary Care Physician: \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Weight: \_\_\_\_\_ -lbs

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_

**Payment Method:**  Check # \_\_\_\_\_  Credit Card

Visa  Mastercard  AMEX  Discover

Credit Card # \_\_\_\_\_ Exp: \_\_\_\_\_ Sec Code: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

**Insurance information: PLEASE ATTACH FRONT AND BACK COPY OF CARD**

**Test To be completed**  Micronutrient \$150 (with insurance price)  Micronutrient \$260 (Cash price)

## Symptoms/complaints :

Fatigue (R51.83)

Depression (F32.9)

unexplained weight gain (R63.5)

unexplained weight loss ( R63.4)

Vitamin Deficiency (E63.9)

Headaches (R51)

ADD (F90.9)

Hypothyroidism (E03.9)

Type 2 Diabetes (E11.9)

Hyperlipidemia (E78.5)

Other: \_\_\_\_\_

Other \_\_\_\_\_