*<Pharmacy Letterhead or Name and Contact Information>*

Intake Form

We collect this information to help us communicate respectfully with you and provide you with the best possible care. We protect your information by following professional and privacy rules and laws. If you have questions, contact the clinic director at (604) 827-0313.

|  |  |  |
| --- | --- | --- |
| Today’s Date  |  Your Legal Name | Your Chosen Name |
|  |  |  |
| Your E-mail (so we can contact you) |  Your Preferred Pronouns (e.g., he, she, them, ze)  |
|  |  |
| Your Usual Drugstore (name, location, phone) |
|  |
| Your preferred way to be contacted by us |
|  By Phone  Email  Other Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How did you hear about us? |
|  Friend/Family member.  Referral from health care provider (e.g. doctor, pharmacist, nurse) Employer/Workplace  Health event or presentation Website/Online  Other; please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| May we invite you to participate in our research studies in the future?  |
| Yes  No  |
| Rate Your Overall Health Today |
| Worst Imaginable  | Best Imaginable |
|  1 |  2 |  3 |  4 |  5 |  6 | 7 |  8 |  9 |  10 |
| Your Health Concerns in the Order of Importance to You |
| 1 |  |
| 2 |  |
| 3 |  |
| Anything Else You Think is Important for Us to Know (Please use the back of the page if you need) |
|  |