Patient Registration

Thomas Rohde, M.D., LTD. / Renew Total Body Wellness Center

PATIENT

Full Legal Name ______________________________________ Soc Sec #___________________

Street Address ____ Birth date _____/_____/________

City _____________________________ State _________________ ZIP _________________

Sex: ☐ Male ☐ Female Marital Status _________________

Referring Physician _____________________________ Home Ph (_____) ______________

Work Ph (_____) ______________ Cell Ph (_____) ____________________

E-Mail _____________________________________May we e-mail you at this address? ☐Yes☐No

Work Status: ☐Full-time ☐Part-time ☐Retired ☐Not Employed

Student Status: ☐Full-time ☐Part-time

Employer ________________________ **Is this a work injury? ☐Yes ☐No Accident? ☐Yes ☐No**

Emergency Contact Name ___________________Emergency Contact Phone (_____) ___________

PERSON RESPONSIBLE FOR PAYMENT Please complete if **not** the same as the patient.

Full Legal Name ____________________________Relationship to Patient ___________________

Birth Date _____/_____/_____ Soc Sec # _______________________

Home Phone (_____) ___________ Work Ph (_____) ___________ Cell Ph (_____) ____________

Street Address ____

City ________________________ State ________________ ZIP __________________

E-Mail ____________________________________ May we e-mail you at this address? ☐Yes ☐No

FIRST (PRIMARY) INSURANCE Complete this section with insurance **card holder** data.

No appointment will be scheduled without a front and back copy of your insurance card(s).

Will you be self pay? ☐ Yes ☐ No *(Self pay patients are required to pay in full at time of service.)*

Name of Insurance Company ____

Card holder name **exactly** as shown on card ____

Social Security #_________________ Birth Date _____/_____/_____ Sex: ☐ Male ☐ Female

Member ID # ___________________________ **Policy Group #**____________________________

Remaining Deductible: $_____________________ **Co- Payment: $**________________________

SECOND (SECONDARY) INSURANCE Complete this section with insurance **card holder** data.

Name of Insurance Company ____

Card holder name **exactly** as shown on card____

Soc Sec # ______________ Birth date _____/_____/_______ Sex: ☐ Male ☐ Female

Member ID # ___________________________ **Policy Group #**____________________________

HOW YOU LEARNED ABOUT US What influenced your decision to come to our practice?

☐ Brochure / Flyer ☐ Billboard ☐ Employer ☐ Family / Friend ☐ Facebook ☐ Web Site

Signature Patient/Legal Guardian:________________________________ **Date:** __________

THOMAS ROHDE, MD., LTD
3798 E. FULTON AVENUE…..DECATUR, IL 62521
Phone: (217) 864-2700…..Fax: (217) 422-0004
E-MAIL: HelpRenewMe@gmail.com

AUTHORIZATION TO RELEASE INFORMATION

I, ___________________________________, authorize Thomas Rohde M.D. to release the following medical information to:

____

____

_____ Any and all of medical record (as of the date of this release).

______Any and all of my medical record except the following:

____

This release also specifically allows the release of the following information (this information will not be released unless the appropriate box is initialed):

_______Any record of treatment for Drug and/or Alcohol dependency or abuse

_______Any record of Mental Health Treatment

_______Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only:
____

____ and may not be used for any purpose or released to any other person(s) without my written consent.

This release is effective for six months from the date of execution, however, it may be revoked by me at any time by providing written notice to the above-named party.

___________________________________ ___________________________

Patient/Legal Guardian of Patient Date

____

Witness

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PAYMENT/FINANCIAL POLICY

1. **Insurance**. We participate in some insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** If you have insurance and we are in network, we will assist in processing the claims for services rendered for up to two insurance carriers. It is your responsibility to provide us with current insurance information. Sixty days after this office has filed a claim on your behalf, any outstanding balance is due in full. Once you receive a statement from our office, you have fifteen (15) days to pay in full. It is your responsibility to call your insurance company if the deadline for payment is approaching. If you pay and later the insurance reimburses us, you will receive a refund from us.

2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect payments from patients can be considered fraud. Please help us in upholding the law by paying at each visit.

3. **Collection fees:** In the event that any unpaid balance, no show/late fees, NSF fees, etc are referred to a collection agency, attorney, or any other service for collection, a collection fee of 43% of the unpaid balance will be added to the unpaid balance due. I agree that I or the responsible party agree to pay any costs incident to collection incurred directly or indirectly by the creditor, collection agency, attorney or other services. These costs may include but are not limited to court costs, attorney fees, sheriff fees, interest, and late fees. I agree that the authorized collection fee (43% of the unpaid balance) and any additional incidental costs incurred to collect the outstanding amounts constitutes the actual total costs incurred to collect any amounts due from me or my responsible party under this agreement in the event of placement or referral for collection.

4. **Non-covered services**. Insurance plans do NOT cover all services. It is your responsibility to determine if a specific service, test, or procedure is covered. You will be expected to sign an Advanced Beneficiary Notice (ABN) for services, tests, and procedures that may be considered "non-covered", "investigational" or cosmetic in nature. By signing the ABN, you agree that by giving your consent to the service, test, or procedure, you are totally responsible for the entire charge listed on the ABN. Depending on the circumstances, you must pay for these services in full at the time of visit. If your insurance pays us we will issue a refund for any amount paid by you.

5. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of both your driver's license to be able to positively verify your identity and your current valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

6. **Claims submission**. Providing we are in network with your insurance carrier, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

PAYMENT/FINANCIAL POLICY

7. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpaymen**t. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. After that 30-day period, no refills will be given.

9. **Missed appointments**. **We have a "No Show" policy.** We cannot provide the quality care you deserve if you miss a scheduled appointment. This is also a time slot that could have been extended to help another patient. **We charge $50.00 for missing a routine appointment** or for not cancelling an appointment 24 hours prior to the appointment. **We charge $300.00 if you miss or fail to cancel a lengthy consultation or procedure appointment**. Insurance will NOT cover these fees and you will be personally responsible for them.

10. **Third Party Insurance.** We understand that work and liability accidents happen, however **we do not file to Workman's Compensation or to other liability insurance** companies such as auto insurance. We will ask you to pay for your visit at the time of service and provide you with a receipt to file with your carrier for your settlement.

11. **Forms.** At times, you may need our help in filling out various forms such as FMLA, disability, auto insurance, and bank forms of all types. There is a $25 fee payable by you prior to filling these forms out unless you are seen by a provider to complete these forms together. You will be responsible for any copay and charges for that visit to complete your forms.

12. **Parents.** By law, the legal guardian must authorize treatment of minor children for whom they have custody. If the parent cannot accompany the child to their appointment for whatever reason, the parent must contact the nurse prior to the visit to discuss treatment and grant permission for treatment. The parent with legal custody of the child is responsible for the bill regardless of whose insurance policy the child is covered under. In the case of joint custody, the parent who brings the child in for care is responsible for the bill.

Thank you for choosing us as your health care provider. Our practice is committed to providing the best treatment to our patients and affordable health care. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines:

________________________________ ______________________

Signature of patient or responsible party Date

 	THOMAS ROHDE, MD., LTD **3798 E. FULTON AVENUE…..DECATUR, IL 62521** **Phone: (217) 864-2700…..Fax: (217) 422-0004** **E-MAIL: HelpRenewMe@gmail.com**

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, ____, hereby give my
(Name of Patient or Authorized Agent)

consent to Thomas Rohde, M.D. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of
___________________________________.

I acknowledge receipt of the physician's Notice of Privacy Practices. The notice of privacy practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that Dr. Rohde has reserved a right to change his privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Dr. Rohde or his staff. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be mailed to Dr. Rohde's office.

You have my permission to release medical/financial information to:

Name	Relationship

Signed: ___________________________________ Date: ______________

If you are not the patient, please specify your relationship to the patient:

______________________.

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Authorization Form for Release of Confidential Health Information

I, ____________________________, hereby authorize _________________________________to release TO:
(Name of Patient or Authorized Agent)

Thomas W. Rohde, M.D., LTD

the following information contained in the patient record of ____
(Patient's Name)

born______________________ , residing at____
(Birthdate) (Street Address, City, State and Zip Code)

- ☐ The Entire Medical Record
- ☐ Mental Health Treatment Records
- ☐ Alcoholism Treatment Records
- ☐ Drug Abuse Treatment Records
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- ☐ Laboratory Reports
- ☐ X-ray Reports
- ☐ Operative Notes
- ☐ Other:____

The above information for the following period of time shall be released:
From: __________ to ___________.
(Date) (Date)

The purpose of the authorization is: ____

____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until expires, unless it is revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _________________.
(Date)

Signed: ____ Date: __________________________

If you are not the patient, please specify your relationship to the patient:_________________________

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Consent For Treatment

Patient's Full Legal Name____

Birthdate (mo/day/year) ____/___/______ Social Security #_______________

Consent for Treatment

I am asking for, and consent to receive, care from Thomas Rohde, M.D. and other health care providers at the Rohde Total Body Wellness Center. I understand this care may include 1) tests and procedures (which may include laboratory tests and X-ray examinations) and 2) medical and surgical treatment. I permit the health care providers, their associates and assistants, and their employees to provide me with services that are considered necessary or advisable.

No guarantees have been made to me about the outcome of this care. I may choose not to have recommended tests, procedures, and healthcare performed. In the event I decide to refuse the recommended treatment, considered necessary or advisable, by the health care providers I relieve Thomas Rohde, M.D. and its health care providers of all responsibility for any ill effects which might result from my action.

I acknowledge that I have read the consent for treatment and conditions listed above and further acknowledge that I am the patient or that I am duly authorized by the patient as a legal representative to execute and accept the terms as set forth herein.

2. Other

I permit a copy of this consent to be used in place of the original. This consent shall remain in effect until rescinded in writing. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to Thomas Rohde, M.D. or any of its health care providers.

If you are not the patient, please specify your relationship to the patient: ____________________

____ __________________
Signature of Patient (or Legal Guardian if Patient is a Minor) Date

____ __________________
Signature of Guarantor (Person Responsible for Payment) Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care generated by Renew

Privacy Contact. If you have any questions about this policy or your rights contact the Privacy Officer, Ann Rohde, 217-864-2700.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Renew. This includes for:

Treatment. With your permission, we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside Renew that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS

You have the following rights under State and federal law:

Copy of Record. You are entitled to inspect the personal health record Renew has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing. Renew is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Program Director who will consult with the staff involved in your care to determine if the request can be granted.
Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the Program Director and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our Privacy Officer in writing at our office for further Information. You also may complain to the Secretary of Health and Human Services if you believe Renew has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. Renew reserves the right to change its Privacy Policy based on the needs of Renew and changes in state and federal law.

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Credit Card Payment Authorization Form

Complete, Sign, and Return this form to authorize Renew Total Body Wellness Center to make a debit of Three Hundred Dollars ($300.00) to your credit card listed below to secure your initial appointment with Dr. Rohde. This payment is required to secure an appointment and will be applied to any money owed at the time of your visit with us. In the event that you are a "No Show" or do not give us a 48-hr cancellation notice for your appointment this fee will be forfeit as your missed appointment could have been used to help another patient. If you call to cancel more than 48 hours prior to your appointment we will refund this reservation fee.

Please complete:

I, ______________________________, authorize Renew Total Body Wellness Center to charge my credit card account indicated below for Three Hundred Dollars ($300.00). I understand no appointment will be scheduled without this information.

Billing Address ______________________________ Phone# __________________________

City, State, Zip ______________________________ Email __________________________

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name ____

Account Number ____

Expiration Date ____

CVV: ____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE ____ DATE ____________________

RENEW TOTAL BODY WELLNESS CENTER

CONFIDENTIAL HORMONE / ANTI-AGING HEALTH HISTORY

Today's Date: _______________

NAME: ____ **Birth date :** ___/___/___ **Age:** _______

Marital Status: ___________________________________ **Level of Education**: ___________________
Current Occupation: _______________________________ **Is your occupation enjoyable?** *Y / N*
Is it stressful? *Y / N* **Is it fulfilling?** *Y / N* **Hazardous Material exposure?** *Y / N*
If retired, what was your main occupation? ____
When did you retire? _________________________ **Are you happy in retirement?** Y / N
YOUR GOALS: *What you hope to achieve in your participation in the RENEW Wellness Program?*
____
____
____

	LIST ACTIVE MEDICAL PROBLEMS	PRESCRIPTION & OTC Meds Now Taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES: - DRUGS: **FOODS:**
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________
_______________________ _______________________

NUTRIENTS / SUPPLEMENTS you are taking:
____
____
____
____
____

	LIST Hormones You ARE Taking:	LIST Hormones You HAVE Taken:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

CONDITIONS: *Check any other conditions you have ever had in the past, & indicate what year?*
___ AIDS / HIV+ ___ Allergies / Asthma ___ Anemia ___ Alcohol / drug problem
___ Anorexia / Bulemia ___ Arthritis ___ Atrial Fibrillation ___ Anxiety / Panic Disorder
___ Back pain ___ Bleeding Disorder ___ Candida / Yeast ___ Cancer – Specify:_______________

___ Chronic Fatigue ___ Crohn's Disease ___ Colitis ___ Diabetes -Type: I II
___ Depression ___ Emphysema ___ Epilepsy / Seizures ___ Fibromyalgia
___ Glaucoma ___ Goiter ___ Gout ___ Hiatal Hernia / Reflux
___ Heart Disease ___ High cholesterol ___ Irritable Bowel ___ Hypertension / High BP
___ Jaundice ___ Kidney Disorder ___ Kidney Stones ___ Liver Disease
___ Hepatitis ___ Migraines ___ Multiple Sclerosis ___ Osteoporosis
___ Pancreatitis ___ Parasites ___ Parkinson's ___ Pelvic Infl Disease
___ Pneumonia ___ Polio ___ Prostate Problem ___ Rheumatic Fever
___ Root canal ___ Sinusitis ___ Stroke / TIA ___ Suicide Attempt
___ Thyroid problem ___ TMJ ___ Tooth Abscess ___ Tuberculosis
___ Ulcers ___ Urinary Infection OTHER: ____________________

CURRENT or RECENT SYMPTOMS: *Check any symptoms that you have noticed recently.*

___ Chest pain ___ Blood in sputum ___ Fainting / collapse ___ Leg pain w walking
___ Nose bleeds ___ Shortness of Breath ___ Swollen ankles ___ Snoring excessively
___ Abdominal Pain ___ Acid reflux ___ Black tarry stools ___ Bright blood in stool
___ Difficulty swallowing ___ Loss of appetite ___ Persistent nausea ___ Mood swings
___ Kidney pain ___ Blood in urine ___ Frequency of urination ___ Urgency of urination
___ Change in headaches ___ Double vision ___ Dizzy / spinning ___ Eye pain
___ Bone pain ___ Unusual bruising ___ Prolonged bleeding ___ Bloated
___ Excessive thirst ___ Rapid heart beat Other Symptoms: ____________________
___ Recent change in bowel habit
___ Weight loss - unexpected

HOSPITALIZATIONS: *Please include surgeries, illnesses, severe accidents, births, miscarriages:*

Year:	Procedure	Reason:	Outcome:

FAMILY HISTORY: *Please complete health Information about your family:*

Relation	Age:	State of health:	Age at Death:	Cause of death	√	Check if your blood relatives had any of the following Disease:	Relation to you:
Father						Arthritis / Gout	
Mother						Asthma / Hay Fever	
Brothers						Cancer: Where: _____	
						Drugs / Alcohol	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressure	
						Osteoporosis	
						Stroke	
						Cholesterol Problem	
						Thyroid	

RECENT TESTS:
If you have had any of these tests, please complete:

TEST:	Date	Reason:	Result:
Chest X Ray			
EKG			
EGD (Stomach)			
Colonoscopy			
Ultrasound			
CAT Scan			
MRI Scan			
Bone Density			
Other			

HEALTH HABITS:
***Which substances do you consume*:**

Substance	How Much?
Caffeine	**cups,cans / day**
Cigarettes	**cigs / day X yrs**
Are you interested in quitting? Y / N	
Alcohol	**Type Amount**
Drugs Y N	**What Amount**
Chew tobacco Y N	**Amount Yrs**
Nutrasweet	Servings per day:
Saccharin	Servings per day:
Splenda	Servings per day:

FOR WOMEN:

Date of 1st day of last period: ______________ Birth control method: _____________ Are you pregnant? Y / N

Have you ever used hormonal contraception? Y / N For How Long? ____________________________

Any Problems ? ____

Date of last PAP test: _____________ *normal / abnormal* Have you ever had an abnormal pap? Y / N

When? ____________ Treatment: ____

Date of last Mammogram: _________ *normal / abnormal* Date of Menopause: _______________

Review this list of symptoms/problems and check any that apply.

___ PMS (mood swings)
___ Acne
___ Uterine Fibroid
___ Fibrocystic Breasts
___ Ovarian Cysts
___ Irregular periods
___ Vaginal dryness/ irritation
___ Weight gain
___ Increased fat around hips / thighs
___ Heart palpitations
___ Painful Periods
___ Hot flashes
___ Depressed Mood
___ Vaginal Dryness / Pain
___ Loss of interest in sex
___ Leak Urine
___ Daytime Fatigue
___ Painful sex
___ Increased Body/Face Hair
___ Endometriosis
___ Thinning Skin
___ Bladder Symptoms
___ Sleep problems
___ Headaches
___ Foggy Thinking
___ Harder / Unable to Climax
___ Unusual vaginal discharge
___ Cramps / clots w periods
___ Spotting after menopause
___ Night Sweats
___ Problems w Infertility
___ Irritability

FOR MEN:

Date of last prostate exam: ____________ *normal / abnormal*

Date of last PSA test: _________________

Review this list of symptoms/problems and check any that apply:

___ Lowered interest in sex ___ Erections less firm ___ Difficulty in initiating urine stream
___ Getting up at night to urinate ___ Enlarged prostate ___ Can't maintain an erection
___ Slowing urinary stream ___ Urine Dribbling ___ Bladder not emptying completely

REVIEW THESE SYMPTOMS OF AGING AND CHECK ANY THAT APPLY.

Thyroid

___ Dry hair
___ Infertility
___ Headaches / Migraines
___ Losing hair
___ Constipation
___ Fluid retention
___ Crave caffeine
___ Dry coarse skin
___ Diets don't work
___ Cold hands & feet
___ Elevated cholesterol
___ Low body temperature
___ Fatigue / Exhaustion
___ Decreased memory
___ Brittle unhealthy nails
___ Unable to lose weight
___ Daytime drowsiness
___ Aches and pains
___ Elevated Cholesterol
___ Feel cold / dress more warmly
___ Foggy / spacey mind
___ Depression / Anxiety
___ Low ambition / motivation
___ Decreased concentration
___ Fibromyalgia / Chronic fatigue

Cardio-Respiratory:

___ Decreased ability and desire for exercise
___ Palpitations
___ Decreased stamina
___ Decreased endurance
___ Run out of breath sooner
___ Easily exhausted with exercise

Skin / Integumentary:

___ Dry skin
___ Thin Lips
___ Graying hair
___ Skin blemishes
___ Thin brittle nails
___ Tendency to bruising
___ Thinned skin –hands, face, arms
___ Thinning hair – scalp, armpits, legs
___ Wrinkling skin – face, neck, hands & arms
___ Sagging skin – under eyes, arms, face, breasts

Adrenal:

___ Palpitations
___ Salt craving
___ Sugar craving
___ Panic attacks / ___ Anxiety
___ Depression
___ Easily frustrated
___ Excessive hunger
___ Prone to infection / ___ Chronic illness
___ Low blood pressure
___ Poor stress tolerance
___ Low back pain (SI joints)
___ Light headed on standing up
___ Racing mind prevents sleep
___ Autoimmune illness
___ Aches and Pains
___ Elevated Triglycerides
___ Blood sugar imbalance
___ Evening Fatigue

Metabolism:

___ Can not skip meals
___ High blood pressure
___ Headache w missed meal
___ Cravings for sugar & carbs
___ High cholesterol / triglyceride
___ Increased fat around abdomen
___ Prone to inflammation and bursitis
___ Periods of low energy relieved w food
___ Shaky / weak episodes – Eating helps
___ Jittery / irritable episodes – Eating helps
___ Alternating between high and low moods
___ Alternating between sluggish and high energy

Neuro-cognitive:

___ Loss of esteem
___ Feeling hopeless
___ Feeling defeated
___ Loss of confidence
___ Vision deteriorating
___ Hearing deteriorating
___ Memory deteriorating
___ Sense of powerlessness
___ Decreased sense of well being

Gastrointestinal:
___ Feel full faster
___ Slower digestion
___ Fullness after meals
___ Eat less / smaller meals
___ Indigestion / Hyperacidity
___ Burping or belching after meals
___ Decreased sense of taste / smell

Muscles/Joints:
___ Osteoporosis
___ Aches and Pains
___ Loss of strength
___ Body & joints stiff
___ Balance deteriorating
___ Coordination deteriorating
___ Thinning muscles – buttocks, arms, legs

DIET: Are you on any specific diet? *(Please specify:___________________________________*
Has this been successful? Y / N
List which diet(s) have been effective in the past: _____________________________________
How is your current weight - Happy? Y / N Weight Goal: ______________________________

STRESS:
Rate your current stress level: *Extreme; High; Medium; Low (Please circle)*
How long has it been like this? _________________________
You expect this to last a *short medium long* period of time. *(please circle)*
Is your stress: at Home at Work
Do you have a solution? Y / N
Do you need help? Y / N

EXERCISE: ***Please circle which you do.***
Aerobic Weights Walking Other:__________________________
How long are your workout sessions? ______________ How many days /week? _________

SLEEP: *Please check the symptoms that you notice.*
___ Trouble getting to sleep – racing mind
___ Nightime awakening(s) – How many? __________
___ Sleep not as restful / Wake up not rested
___ Wake up through night feeling like you are choking or having a smothered sensation
___ Your partner has noticed very heavy snoring during sleep
___ Your partner has noticed that you stop breathing through the night with heavy snoring
___ Daytime drowsiness or sleepiness especially with periods of inactivity
___ Toss and turn through night / wake frequently through the night

Take a moment to reflect on your response to the following question:
On a scale of 0 – 5 (5 being the strongest response), circle your response:

How important is it to you, and how committed are you to a wellness program? 0 1 2 3 4 5

Health Assessment

General Information

(Y) = Yes (N) = No (P) = in the Past

Current Height: ______________ Weight: ___________ Weight 1 Year Ago: ______________

Maximum Weight: ____________ When: ___________ Ideal Weight: ____________________

Do you have sufficient energy throughout the day? Y N

Please rate your energy from 1-10 (best)? 1 2 3 4 5 6 7 8 9 10

When is your energy best? ____

When is your energy worst? ____

Habits/Lifestyle

(Y) = Yes (N) = No (P) = in the Past

Main interests and hobbies: ____

Do you exercise? Y N

If yes, what kind/how often ____

Hours of sleep each night	___________	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awake rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	How many hours of TV per day?	___________
Have a history of abuse?	Y N	How much time/day in relaxation?	___________
Been treated for drug dependence?	Y N	Do you eat 3 meals a day?	Y N
Use Alcoholic beverages?	Y N	Do you go on diets often?	Y N
Treated for alcoholism?	Y N P	Do you eat out often?	Y N
Do you use tobacco?	Y N P	Do you drink coffee?	Y N P
How many years and packs/day?	___________	Do you drink soda/pop?	Y N
Have a religious/spiritual practice?	Y N P	If yes, quantity per day or week	___________

REVIEW OF SYSTEMS

(Y) = Yes (N) = No (P) = in the Past

Mental / Emotional

Treated for emotional problems	Y N P	Depression	Y N P
Mood Swings	Y N P	Anxiety or nervousness	Y N P
Considered/Attempted suicide	Y N P	Tension	Y N P
Poor concentration	Y N P	Memory problems	Y N P

Immune

Reactions to immunizations	Y N P	Chronic infections	Y N P
Chronic Fatigue	Y N P	Slow wound healing	Y N P
Chronically swollen glands	Y N P		

Endocrine (Hormone System)

Underactive thyroid	Y N P	Heat or cold intolerance	Y N P
Low blood sugars	Y N P	Excessive hunger	Y N P
Excessive thirst	Y N P	Seasonal depression	Y N P
Fatigue	Y N P		
Night Sweats	Y N P		

Neurologic

Seizures	Y N P	Paralysis	Y N P
Muscle weakness	Y N P	Numbness or tingling	Y N P
Loss of memory	Y N P	Loss of balance	Y N P
Vertigo or dizziness	Y N P	Motion Sickness	Y N P

Skin

Rashes	Y N P	Eczema/Hives	Y N P
Acne	Y N P	Itching	Y N P
Color changes	Y N P	Hair loss	Y N P
Lumps	Y N P	Brittle	Y N P
Dry skin	Y N P		

Head/Neck

Headaches	Y N P	Jaw/TMJ problems	Y N P
Migraines	Y N P	Lumps	Y N P
Head injury	Y N P	Swollen glands	Y N P

Eyes

Spots in Eyes	Y N P	Cataracts	Y N P
Impaired vision	Y N P	Glasses/contacts	Y N P
Blurriness	Y N P	Eye pain/strain	Y N P
Color blindness	Y N P	Tearing or dryness	Y N P
Double vision	Y N P	Glaucoma	Y N P

Ears

Impaired hearing	Y N P	Ringing in the ears	Y N P
Earaches	Y N P	Dizziness	Y N P

Nose and Sinuses

Frequent colds	Y N P	Nose Bleeds	Y N P
Stuffiness	Y N P	Hay fever/Post Nasal Drip	Y N P
Sinus problems		Loss of smell	Y N P

Mouth and Throat

Frequent sore throat	Y N P	Dry Mouth Sore	Y N P
Teeth grinding	Y N P	tongue/lips	Y N P
Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Metal/Silver Fillings	Y N P

Respiratory

Cough	Y N P	Pain on breathing	Y N P
Spitting up blood	Y N P	Shortness of breath	Y N P
Asthma	Y N P	Shortness of breath lying down	Y N P
Pneumonia	Y N P	Bronchitis	Y N P
Emphysema	Y N P		

Cardiovascular

Heart disease	Y N P	Swelling in ankles	Y N P
High Blood pressure	Y N P	Chest pain	Y N P
Blood clots	Y N P	Murmurs	Y N P
Phlebitis	Y N P	Fainting	Y N P
Rheumatic fever	Y N P	Palpitations	Y N P

Gastrointestinal

Trouble swallowing	Y N P	Heartburn/reflux	Y N P
Change in thirst	Y N P	Abdominal pain/cramps	Y N P
Change in appetite	Y N P	Belching or passing gas	Y N P
Nausea/vomiting	Y N P	Constipation	Y N P
Ulcer	Y N P	Diarrhea	Y N P
Yellow skin	Y N P	Bowel Movements per day	
Gall bladder disease	Y N P	Black stools	Y N P
Liver disease	Y N P	Blood in stool	Y N P
Hemorrhoids	Y N P		

Urinary

Pain on urination	Y N P	Increased frequency	Y N P
Frequency at night	Y N P	Inability to hold urine stream	Y N P
Frequent infections	Y N P	Kidney stones	Y N P

Musculoskeletal

Joint pain or stiffness	Y N P	Arthritis	Y N P
Broken bones	Y N P	Weakness	Y N P
Muscle spasms/ cramps/ pain	Y N P	Sciatica	Y N P
Osteoporosis / Osteopenia	Y N P		

Blood Vessels

Easy bleeding or bruising	Y N P	Anemia	Y N P
Deep leg pain	Y N P	Cold hands/feet	Y N P
Varicose veins	Y N P		

Male Reproductive

Hernias	Y N P	Prostate disease	Y N P
Testicular pain	Y N P	Discharge or sores	Y N P
Are you sexually active	Y N P	Sexually transmitted disease	Y N P
Impotence	Y N P	If yes, which one(s): ______________	
Testicular masses	Y N P	______________________________	

Female Reproductive/Breasts

Age of first menses	________	Vaginal Dryness	Y N P
Age of last menses (if menopausal)	______	Number of pregnancies	______________
Length of cycle (days)	________	Number of live births	______________
Duration of menses (days)	________	Number of miscarriages	______________
Are cycles regular	Y N P	Number of abortions	______________
Bleeding between cycles	Y N P		
Painful menses	Y N P	Endometriosis	Y N P
Heavy or excessive flow	Y N P	Ovarian cysts	Y N P
PMS	Y N P	Breast lumps	Y N P
If yes, what are your symptoms _______		Nipple discharge	Y N P
______________________________		Have you had a bone density scan	Y N
______________________________			
Pain during intercourse	Y N P		

Cancer History

Primary Cancer		Secondary Cancer (ie. Metastasis)	
Onset Date		Onset Date	
Location		Location	
Initial Stage		Stage	
Current Stage			

Previous Treatments (ie. Surgery, Chemo, Radiation)			
Type			
Started			
Ended			

Previous Treatments (ie. Surgery, Chemo, Radiation)			
Type			
Started			