Burns Integrative Wellness Center

Personal Information

Date_____

Name_____ Date of Birth_____ Age_____

Height_____ Weight_____ Gender: Male / Female

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____

Would you like to subscribe to our newsletter (no more than 1-2 emails per month)? YES / NO
(Our newsletter includes health-related articles, Medical Marijuana announcements, and healthy recipes.)

How did you hear about us? _____

Medical History

Current medical complaint:

_____

_____

_____

Medications (please include prescription, herb, and over-the-counter):

_____

_____

Allergies (please list all known food/drug allergies):

_____

_____

Please list the surgeries that you have had along with month/year:

_____

_____

_____

Medical History (continued)

Do you have or have you ever had any of the following medical problems?

____Asthma/Lung Disease ____Cancer ____HIV/AIDS ____Diabetes ____Hepatitis

____Epilepsy/Seizures ____Stroke ____Liver Disease ____Kidney Disease

____High Blood Pressure ____Heart Disease ____Sleep Disorders (sleep apnea, insomnia)

____Substance Abuse ____Intestinal Disorders (IBS, ulcers) ____Multiple Sclerosis

____Mental health problems ____ADD/ADHD

Female Patients Only

Are you pregnant? Yes/No Are you currently breastfeeding? Yes/No

Drug and Alcohol History

Do you currently use: Tobacco Yes/No number of cigarettes per day _____

Alcohol: Yes/No number of drinks per week _____

Other substance use history:

_____ Cocaine/Meth

_____ Opiates/Prescription opiates/heroin/methadone

_____ Hallucinogens/ecstasy/LSD/mushrooms

_____ None

Would you like help quitting? Yes / No / NA

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

_____ _____

Patient Signature Date

Hormone Questionnaire

PROGESTERONE							
Signs & Symptoms		**Never**				**Always**	
1.	My breasts are large.	0	1	2	3	4	
2.	My close friends complain I'm nervous & agitated.	0	1	2	3	4	
3.	I feel anxious.	0	1	2	3	4	
4.	I sleep lightly and restlessly.	0	1	2	3	4	
Questions 5-10 are for women who are non-menopausal or on hormone replacement therapy (estrogen and/or progesterone):							
5.	My breasts are swollen and tender or painful before my period.	0	1	2	3	4	
6.	My lower belly is swollen.	0	1	2	3	4	
7.	I'm irritable and aggressive.	0	1	2	3	4	Add up your overall score:
8.	I lose my self-control.	0	1	2	3	4	
9.	I have heavy periods.	0	1	2	3	4	
10.	My periods are painful.	0	1	2	3	4	

TESTOSTERONE							
Signs & Symptoms (Men and Women)		**Never**				**Always**	
1.	My face has gotten slack and more wrinkled.	0	1	2	3	4	
2.	I've lost muscle tone.	0	1	2	3	4	
3.	My belly tends to get fat.	0	1	2	3	4	
4.	I'm constantly tired.	0	1	2	3	4	
5.	I feel like I'm making love less often than I used to.	0	1	2	3	4	
Signs & Symptoms (Men Only)							
6.	My breasts are getting fatty.	0	1	2	3	4	
7.	I feel less self-confident and more hesitant.	0	1	2	3	4	Add up your overall score:
8.	My sexual performance is poorer than it used to be.	0	1	2	3	4	
9.	I have hot flashes and sweats.	0	1	2	3	4	
10.	I tire easily with physical activity.	0	1	2	3	4	

GROWTH HORMONE							
Signs & Symptoms (Men and Women)		**Never**				**Always**	
1.	My hair is thinning.	0	1	2	3	4	
2.	My cheeks sag.	0	1	2	3	4	
3.	My gums are receding.	0	1	2	3	4	
4.	My abdomen is flabby / I've got a "spare tire."	0	1	2	3	4	
5.	My muscles are slack.	0	1	2	3	4	
6.	My skin is think and/or dry.	0	1	2	3	4	Add up your overall score:
7.	It's hard to recover after physical activity.	0	1	2	3	4	
8.	I feel exhausted.	0	1	2	3	4	
9.	I don't like the world. I tend to isolate myself.	0	1	2	3	4	
10.	I feel continuously anxious and worried.	0	1	2	3	4	

THYROID

Signs & Symptoms (Men and Women)	Never				Always
1. I'm sensitive to cold.	0	1	2	3	4
2. My hands and feet are always cold.	0	1	2	3	4
3. In the morning my face is puffy and my eyelids are swollen.	0	1	2	3	4
4. I put on weight easily.	0	1	2	3	4
5. I have dry skin.	0	1	2	3	4
6. I have trouble getting up in the morning.	0	1	2	3	4
7. I feel more tired at rest than when I am active.	0	1	2	3	4
8. I am constipated.	0	1	2	3	4
9. My joints are stiff in the morning.	0	1	2	3	4
10. I feel like I'm living in slow motion.	0	1	2	3	4

Add up your overall score:

ESTROGEN

Signs & Symptoms (Men and Women)	Never				Always
1. I am losing hair on top of my head.	0	1	2	3	4
2. I am getting thin, vertical wrinkles above my lips.	0	1	2	3	4
3. I have hot flashes.	0	1	2	3	4
4. I feel tired constantly.	0	1	2	3	4
5. I am depressed.	0	1	2	3	4
Signs & Symptoms (Women Only)					
6. My breasts are droopy.	0	1	2	3	4
7. My face is too hairy.	0	1	2	3	4
8. My menstrual flow is heavy. (0 = moderate, 1-3 = low, 4 = none)	0	1	2	3	4
9. Women with periods: My cycles are irregular, too short (< 27 days), or too long (> 31 days).	0	1	2	3	4
10. Women without periods: I do not feel like making love anymore.	0	1	2	3	4

Add up your overall score:

ENERGY

1. Do you have a hard time getting up in the morning?	YES	NO
2. Do you always feel tired or tired in the afternoon?	YES	NO

SEX

1. Do you lack sexual desire?	YES	NO
2. Does your penis or clitoris seem less sensitive?	YES	NO
3. Are your erections not firm enough?	YES	NO
4. Have you lost your attraction toward your partner?	YES	NO
5. Do you lack vaginal lubrication?	YES	NO

SLEEP

1.	Do you sleep poorly?	YES	NO
2.	Do you rarely dream?	YES	NO

MEMORY

1.	Do you suffer from short- or long-term memory loss?	YES	NO
2.	Do you have trouble concentrating?	YES	NO

SKIN & HAIR

1.	Do you have wrinkles on your face along the nose, smile lines, or forehead creases?	YES	NO
2.	Do you have wrinkles or crows feet around the eyes?	YES	NO
3.	Do you have age spots?	YES	NO
4.	Do you have dry, thin skin?	YES	NO
5.	Are you losing your hair or is it turning gray?	YES	NO

WEIGHT CONTROL

1.	Is your abdomen too plump? Is it distended?	YES	NO
2.	Women: Are your breasts too large? Do they get larger before your period?	YES	NO
3.	Are your buttocks and thighs too well padded?	YES	NO
4.	Are you pear-shaped?	YES	NO

STRESS & MOOD

1.	Do you suffer from constant fatigue?	YES	NO
2.	Do you have high blood pressure?	YES	NO
3.	Are you anxious, nervous or irritable?	YES	NO
4.	Do small things set you off?	YES	NO
5.	Are you depressed?	YES	NO

JOINTS & BONES

1.	Do you have arthritis	YES	NO
2.	Do you have osteoarthritis in the hip?	YES	NO
3.	Do you have fibromyalgia (sharp shoulder pain)?	YES	NO
4.	Have you lost muscle mass, tone and strength?	YES	NO
5.	Do you have bone loss of the spine, hips, hands, wrists and feet?	YES	NO

Burns Integrative Wellness Center
Consent for Use or Disclosure of Health Information

We here at Burns Integrative Wellness Center are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

- We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Burns Integrative Wellness Center, its staff or employees, may from time to time schedule appointments for other healthcare providers, when requested. These providers are not partners or contractors of Burns Integrative Wellness Center. All health and patient information disclosed to Burns Integrative Wellness Center, its employees or staff, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA, are complied with.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By signing below, I hereby acknowledge that I have read and understood how my health information may be used and/or disclosed. This Acknowledgement will be filed with my records.

Patient Name (print): _____

Patient Signature: _____

Date: _____