Initial Appointment
History and Nutrition
Intake Form

Name: ______________________________________ Birth Date: ________________ Age: ___________

Referred by: _________________________ Your Occupation _________________ Date: _____________

Height:__________ Weight: __________ Goal Weight: __________Marital Status: __________________

Who do you live with? ________________ Ages of children: ___________________________________

Primary Physician/NP/PA (& other pertinent care providers): __________________________________

Allergies: ____

List Names (**and Bring**) Current Prescription Medications and Supplements:_____________________

____

____

(Please record the details regarding the amount and when you take each on the Medication and Supplement Record found at the end of this document).

What was the date of your last menstrual cycle? ____

What symptom is bothering you the most today? ____

What is your expected outcome from your visit today? ____

Past Medical History - Have you ever been diagnosed with:

Please check	**No**	**Yes – When?**		**No**	**Yes – When?**
Breast Cancer			Food Allergies/Intolerances		
Other Type of Cancer			Depression /Anxiety		
Diabetes			Alcoholism/ Drug Abuse		
High Cholesterol			Autoimmune Disease		
High Blood Pressure			Arthritis/Joint Pain		
Glaucoma			Kidney or Bladder Disease		
Stroke			Ulcer/IBS/Heartburn/GERD		
Heart Disease/Murmur			Liver/Gallbladder Disease		
Sleep Apnea			Sinus Problems		
Osteoporosis/Osteopenia			Lung Disease/Asthma		
Blood Clot/Bleeding Disorder			Chronic Pain - Fibromyalgia		
Thyroid Problems			Toxic or Chemical Exposure		
Migraines/Headaches			Skin Problems		
Epilepsy/Seizures/Neurologic			Eating Disorder		
Breast Lump			Other:		

Please list hospitalizations and surgeries (excluding vaginal deliveries) with approximate dates:

____

____

Symptom Severity History

Please note the severity of any symptoms you may have experienced over the past 4 weeks:

All bolded symptoms below may be related to hormone imbalances.	None	Mild	Moderate	Severe	Comments
Fatigue/tired and/or exhausted					
Hot Flashes # per day _______					
Night Sweats # per night ______					
Trouble w/ urination/leaking/freq.					
Depression					
Headaches or migraines					
Rapid changes in mood/mood swings					
Lack of sex drive/libido/sexual desire					
Bloating/water retention					
Difficulty falling and staying asleep					
Memory problems/forgetfulness					
Acne/oily skin					
Increased anxiety/nervousness					
Increased irritability and/or anger					
Hair is thinning/hair loss					
Increased growth of facial hair					
Breasts tender/sore and/or swollen					
Vaginal dryness, pain or itching					
Food cravings – carbs/salty/sweets					
Foggy thinking					
Decreased motivation					
Decreased sexual arousal & pleasure					
Muscle weakness or loss of strength					
Decreased focus or attention span					
Feeling fearful/afraid for no reason					
Loss of skin tone and/or wrinkles					
Breasts less full and/or sagging					
Weight loss					
Weight gain					
Low back and/or joint pain					
Increased hostility/aggression					
Dry skin					
Brittle nails					
Unable to tolerate cold					
Heavy and/or irregular periods					
Rashes/hives					
Excess sweating					
Rapid, pounding or irreg. heartbeat					
Dry /itchy/watery eyes					
Hay fever/allergies/stuffy/runny nose					
Frequent infections/persistent cough					
Frequent constipation/diarrhea/vomiting					
Hemorrhoids					
Unusual color of bowel movement					
Breast Lump or nipple discharge					

Patient name: ___________________________________

Gynecologic & Obstetrics History

Please fill in the blank or circle Yes or No:	
# of Pregnancies__________ # of Live Births ______ Could you be pregnant now? ______________	
Age at first period: _________ Number of menstrual cycles in past year: _______________________	
Have you had your ovaries removed? No Yes If so why: ____________________________________	
Have you had your uterus removed? No Yes If so why: ____________________________________	
How many days do you flow? ________ Average # of days between periods: _____________________	
Any changes in menses? _______________________________	
Do/did you have significant pain with your periods?	No Yes
Do you have any spotting or bleeding between periods?	No Yes
Do you have a history of abnormal pap smears?	No Yes
Have you been exposed to DES (a drug your mom took when pregnant w/ you)?	No Yes
Do/did you have any infertility issues?	No Yes
Have you had any reproductive issues (ovarian cysts, D & C, fibroids, endometriosis)?	No Yes
Did you have any complications with pregnancy or delivery?	No Yes
What is your sexual orientation? (circle) Straight Bisexual Lesbian	
Current number of sexual partners: _________	
List any sexually transmitted diseases you have had: ____	
List current form of birth control: ____	
Have you ever taken birth control pills? No Yes If so when? _________________________________	
Have you suffered from any form (physical, emotional, sexual) of abuse?	No Yes
Are you having any issues with sexual desire, arousal, orgasm or pain?	No Yes
Are you satisfied with your sexual function over the past 3 months?	Yes No
Please list hormone replacement medications and herbal products used to relieve your hormone symptoms:	

Family History (Please note **the approximate age** when the condition was diagnosed)

	None	**Mother**	**Father**	**Siblings**	**Mother's Parents**	**Father's Parents**	**Others**
Osteoporosis							
Alzheimer's							
Breast Cancer							
Other Cancer							
Heart Disease							
Hypertension							
Stroke							
Blood Clots							
Diabetes							
Thyroid Disorder							
Mental Illness							
Alcohol/Drug abuse							
Menopausal Issues							
Digestive Disorders							
Other:							
Current age:							
If Deceased- Age/Cause							

Patient name: ____________________________________

Self Care Assessment

Please check Agree or Disagree	Agree	Disagree	Comments
I take a daily pharmacy or USP grade multi-vitamin and mineral supplement at least two times per day.			
I consume at least 1000 mg. of Calcium, 500 mg. of Magnesium and 2000 I.U. of Vitamin D(3) daily (in both diet and supplements)			
I take at least 2000mg of EPA/DHA in the form of Fish oil daily.			
I use deep breathing exercises or other forms of stress management to help me stay calm when needed.			
I practice at least 2 hours of relaxation per week.			
I exercise at least 4 times weekly for a minimum of 30-40 minutes.			
I drink 64 ounces of water daily.			
I eat 3 regular meals and 3 snacks daily.			
I eat protein with every meal or snack.			
I eat whole grains, beans and legumes daily.			
I eat at least seven (½) cup servings of fruits and vegetables daily.			
I minimize simple carbohydrates (candy, cookies, etc.) daily.			
I consume at least 25 grams of fiber daily.			
I consume no diet sodas or other artificially sweeteners.			
I consume one or less serving of caffeine daily.			
I drink 2 or less servings of alcohol per week.			
I do not smoke now and never have smoked.			
I do not use street drugs.			
My work and personal life are not stressful.			
I do not feel overcommitted or rushed.			
I do not experience much stress in my relationships.			
I have a good support network of family and friends.			
I receive support through my spiritual or religious beliefs.			
I have not experienced any major losses or traumas recently.			
Do you use sleep aids:	No	Yes	
Average # of hours of sleep per night: _________ Feel rested daily:	Yes	No	

Preventative Health Care Screenings

The Date and Location of your last:	**Was your result normal?**	**Comments**
Gynecological Exam:	YES NO	
Pap smear:	YES NO	
Mammogram:	YES NO	
Thyroid tests (TSH, Free T4, Free T3)	YES NO	
Cholesterol test:	YES NO	
Bone density test (DEXA SCAN)	YES NO	
Colorectal cancer test (Colonoscopy):	YES NO	

I have reviewed the above form and the information is correct.

Patient Signature/date: ______________________________

Provider Signature/date: ______________________________

NUTRITIONAL ASSESSMENT Patient Name:______________________________

What percentage of your food is home cooked? _____ %

Where do you get the rest of your food from? _______________________________________

List below your typical food intake in a week:

Breakfast	Lunch	Dinner	Snacks	Liquids

List below the foods that are your biggest cravings/challenges/issues:

Breakfast	Lunch	Dinner	Snacks	Liquids

List below the foods you think you should be eating:

Breakfast	Lunch	Dinner	Snacks	Liquids

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PLEASE CROSS OFF FOODS YOU DO NOT EAT Patient Name:

Apple	Chicken	Green Pea	Soybean	Almond	Coconut	Hops	Psyllium
Baker's Yeast	Cinnamon	Iceberg Lettuce	Strawberry	Asparagus	Codfish	Lime	Rye
Banana	Cocoa	Lamb	String Bean	Avocado	Coffee	Lobster	Salmon
Barley	Corn	Lemon	Sweet Potato	Basil	Crab	Millet	Scallop
Beef	Cottonseed	Mustard	Tomato	Blueberry	Cranberry	Mushroom	Sesame
Black Pepper	Cow's Milk	Oat	Tuna	Brewer's Yeast	Cucumber	Olive	Snapper
Broccoli	Egg White	Onion	Turkey	Brussels Sprout	Eggplant	Oregano	Sole
Cabbage	Egg Yolk	Orange	Vanilla	Carob	Ginger	Parsley	Spinach
Cane Sugar	Fructose	Peanut	Wheat	Cashew	Goat's Milk	Peach	Tea
Cantaloupe	Garlic	Pear	White Potato	Celery	Grapefruit	Pecan	Watermelon
Carrot	Gliadin	Pork	Yellow Squash	Cherry	Green Pepper	Pineapple	Whey
Casein	Gluten	Rice		Clam	Halibut	Pinto Bean	
Cauliflower	Grape	Shrimp			Honey	Plum	

Apricot	Date	Lima Bean	Red Beet	Acorn Squash	Curry Powder	Mung Bean	Saffron
Artichoke	Dill	Malt	Safflower	Anchovy	Endive	Mussel	Sheep's Milk
Bass	Duck	Mango	Sage	Anise Seed	Fava Bean	Nectarine	Spelt
Bay Leaf	Fig	Navy Bean	Sardine	Beef Liver	Fennel	Okra	Squid
Beet Sugar	Flaxseed	Nutmeg	Sunflower	Black Currant	Flounder	Parsnip	Swiss Chard
Blackberry	Haddock	Oyster	Tapioca	Bok Choy	Jalapeno Pepper	Pheasant	Swordfish
Black-Eyed Pea	Hazelnut	Papaya	Thyme	Brazil Nut	Kale	Pine Nut	Tarragon
Buckwheat	Herring	Paprika	Tilapia	Cardamom	Kelp	Pomegranate	Turmeric
Caraway	Honeydew	Peppermint	Trout	Catfish	Leek	Quail	Venison
Cayenne Pepper	Melon	Pistachio	Turnip	Chamomile	Licorice	Quinoa	Watercress
Chickpea	Kidney Bean	Pumpkin	Veal	Chili Pepper	Macadamia Nut	Rhubarb	Zucchini
Clove	Kiwi	Radish	Walnut	Coriander	Mackerel	Romaine Lettuce	
Cumin	Lentil Bean	Raspberry		Crayfish	Maple Sugar	Rosemary	

ANY FAVORITE FOODS/BEVERAGES TO ADD?

Wise Woman Wellness, LLC
Natural Options ~ Healthy Lives

Medication and Supplement Record

Name ______________________________ **Date** ____________________

(Time Supplement/Medication Was Consumed)

Medications & Supplements including dosage	When Arising	Breakfast	Mid Morning	Lunch	Mid Afternoon	Supper	Mid Evening	Before Sleep
1)								
2)								
3)								
4)								
5)								
6)								
7)								
8)								
9)								
10)								
11)								
12)								

Patient Financial Policy

To keep you informed of our current financial policies, we ask that you read and understand the following information. Please keep this document for future reference.

We recognize medical expenses are often large, unplanned and create further stress at a time when your primary concern is health rather than financial issues. It is our goal to help alleviate this issue.

We are **unable to accept** Medicare, Medicaid or other government payment plans.

Insurance Claims

YOUR MEDICAL INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. WISE WOMAN WELLNESS LLC IS NOT A PARTY IN YOUR INSURANCE CONTRACT. As a result, your coverage and responsibilities are determined by your policy and you are responsible for understanding and following the required procedures. It is also your responsibility to provide WISE WOMAN WELLNESS LLC with sufficient and up-to-date insurance information.

WISE WOMAN WELLNESS may, on your behalf as a courtesy, submit to your insurance company all claims for services provided to you. We will be considered an "Out of Network Provider" for you, and your health insurance will generally cover your care at a lesser rate than if you were seeking care from an "In Plan" or "Participating Provider". There may also be a separate deductible to meet when seeking care from an "Out of Network Provider". **It is your responsibility to contact your insurance company with any questions.**

Payment in full is expected at time of service.

If you cannot pay for your visit at the time of your appointment YOUR APPOINTMENT MAY BE RESCHEDULED.

Wise Woman Wellness accepts cash, check, money order, MasterCard and VISA credit and debit cards. A **5% discount** will be offered to you if you choose to pay by **cash or check only** at time of service. We are sorry that we cannot offer this discount if you pay using a Healthy Savings Account (HSA) card, credit card or debit card.

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Natural Options – Healthy Lives

Financial Hardship Policy

Upon request, due to financial hardship, the payment for your visit may be split into two equal payments, **half due at time of service and the other half due 30 days later**. This option is available only if you agree to pay using a credit card and you agree that we may bill the remaining balance to your credit card 30 days after your visit.

Outstanding Balance Policy

You are responsible for all charges including co-insurance, amounts over usual and customary, deductibles or non-covered services. You may receive a statement from our office indicating what your insurance has paid if we receive notice of payment. Since your insurance company will be reimbursing you directly, we may not receive such notice and then would be unable to provide you with such information. Regardless of reimbursement from your insurance company, the balance on your account must be **paid in full within 30 days.**

This financial policy helps the clinic to provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Please sign below to acknowledge that you have read the above information, accept all terms and conditions and have received a copy of this information. Thank you.

____________________________________ _______________________
Patient Name Today's Date

Potential Risks and Side Effects of Estrogen, Progesterone and Testosterone Therapy

Per the FDA and the North American Menopause Society (NAMS), women are advised to consider taking hormones for treatment of moderate to severe menopausal symptoms, at the lowest dose that helps, for the shortest time needed. The FDA advises that all forms of hormone therapy carry the same risks and that there is no evidence that the use of "natural" or "bio-identical" formulations will result in a different risk profile than synthetic products of equivalent dose. However, it is our personal experience that many women report feeling fewer side effects on bio-identical hormones.

The 2007 NAMS Guidelines list the following potential side effects of estrogen alone or estrogen and progesterone therapy: uterine bleeding, breast tenderness or enlargement, nausea, abdominal bloating, fluid retention in extremities, changes in the shape of cornea sometimes leading to contact lens intolerance, headache, migraine, dizziness and mood changes. Side effects may vary by route of administration, type of progestogen and dose. Testosterone risks may include acne, weight gain, excess facial hair and body hair, permanent lowering of the voice, clitoral enlargement, changes in emotion (e.g., increased anger) and adverse changes in lipids and liver function tests. Such effects are unlikely if androgen levels are maintained within normal physiologic ranges. Testosterone is currently not an FDA approved drug for women. However, it is prescribed for women when appropriate for "off label" use by many providers.

The 2002 Women's Health Initiative Study found that the use of non-bio-identical estrogen and progestin slightly increased a woman's chances of coronary heart disease, stroke, venous thrombo-embolism and breast cancer. It decreased the chances of colorectal cancer, hip fracture and death for women between the ages of 50 and 59. The risks increased with each additional ten years of a woman's age.

Wise Woman Wellness often uses saliva testing to determine appropriate types and levels of hormone replacement therapy. Saliva hormone testing is considered by some to be controversial. While the saliva test kits used by Wise Woman Wellness have been approved by the FDA, saliva testing of hormones is not acknowledged as standard care by the American College of Obstetricians and Gynecologists (ACOG) or NAMS.

Should you choose to take "bio-identical" hormones from Restore Health, you will receive a Patient Advisory Leaflet that was reviewed by the International Academy of Compounding Pharmacists when you receive your hormone preparations in the mail. It further details the potential side effects and precautions of Estrogen, Progesterone and Testosterone.

I have read and understood the above information on the potential risks, benefits and side effects of estrogen, progesterone and testosterone therapy. I have also had the opportunity to ask questions about its content. I do not expect Wise Woman Wellness to anticipate or explain all possible risks and complications of hormone therapy, such as those which are extremely remote.

I further understand that Wise Woman Wellness practices integrative medicine and does not provide primary care. I understand that I am expected to continue seeing my primary care physician for my primary care needs.

By signing below, I consent to hormone therapy, which may include the use of saliva hormone testing and "natural" / "bio-identical" hormones.

Patient's Signature:______________________________Date:______________________ 19108787v1 904856 71816

Wise Woman Wellness, LLC
Natural Options – Healthy Lives

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Wise Woman Wellness LLC to use and disclose my protected health Information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Wise Woman Wellness LLC describes such uses and disclosures more completely and is continually displayed in the waiting room at Wise Woman Wellness LLC.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wise Woman Wellness LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rene Hoffmann at Wise Woman Wellness LLC.

With this consent, Wise Woman Wellness LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist in the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Wise Woman Wellness LLC may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements.

With this consent, Wise Woman Wellness LLC may e-mail to my home or alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that Wise Woman Wellness LLC restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Wise Woman Wellness LLC to use and disclose my PHI to carry out treatment, payment and health care operations.

I may revoke by consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wise Woman Wellness LLC may decline to provide treatment to me.

Signed ______________________________ ____________ ________________
Signature of Patient or Legal Guardian Date Relationship to Patient

______________________________ ______________________________
Print Patient's Name Print Name of Legal Guardian, if applicable

Parent/guardian must be provided with a signed copy of this authorization form.

Authorization to Release Medical Records

To: ____(Care Provider)

Location: ____

Telephone: ______________________________ Fax: __________________________________

Re: ____(Patient Name)

Date of Birth: ______________________________ SSN: XXX-XX- ________________

I, __________________________, hereby authorize, consent, and direct you to release the following information about me to any representative of Wise Woman Wellness LLC, for their use in providing care and treatment:

__ Documentation from my most recent yearly physical examination;

__ The following pertinent medical history documents:

____

____

__ A copy of my most recent Pap Smear, Mammogram, DEXA Scan and Colonoscopy results.

__ A copy of my most recent Thyroid, Cholesterol (Lipid Panel) and Vitamin D results;

__ Any Pathology results from any gynecologic or breast surgery if abnormalities were found;

I hereby waive any privilege that may exist with respect to the above-described materials. This release and authorization is continuing in nature, shall include all of the above-described materials that may be created after the date hereof, and shall remain in full force and effect until and unless revoked by me in writing.

A faxed copy or photocopy of this document shall be as valid as the original.

Dated this ____________ day of ______________________, 20_______.

____
(Patient Signature)