WELLNESS AND AESTHETICS, LLC

Social Security: _____-___-_____

First Name: _____ Last Name: _____
M.I.: ____ Sex: ____ Date of Birth: _____ Marital Status: _____ Race: _____

Ethnicity: _____ Preferred Language: ENG __ SPA __ Cell Phone: _____

Physical Address: _____ City:_____
State:____ Zip Code: _____ Employer/School: _____ Email: _____

IF YOU ARE COVERED BY HEALTH INSURANCE/MEDICAID PLEASE LIST COMPANY AND ID

PRIMARY:

Company Name: _____

Member ID: _____Group #: _____

Insured DOB: _____ Insured SS#: _____-___-_____ Insured Employer: _____

Address if different from Patient: _____

Patient Relationship to Insured: _____

SECONDARY

Company Name: _____

Member ID: _____Group #: _____

Insured DOB: _____ Insured SS#: _____-___-_____ Insured Employer: _____

Address if different from Patient: _____

Patient Relationship to Insured: _____

IN CASE OF EMERGENCY

First Name: _____ Last Name: _____

Phone Number: _____ Relationship: _____

PLEASE LET US KNOW HOW YOU PREFER TO BE CONTACTED:

Home: ___ Cell Phone: ___ Email: ___ Okay to leave message with information: ___

Okay to leave information with spouse or family member: ___

Leave message with call-back number only: ___

Preferred Pharmacy: _____ **Address**: _____

Adult Patient Information

WELLNESS AND AESTHETICS

MEDICAL HISTORY

Are you currently seeing a chiropractor, acupuncturist, counselor, or any other health care professional? If so, please list: _____

_____

_____

Allergies:

History of allergies or reactions? ☐ No ☐ Yes (please list and include your reaction)

Medications: _____

Environmental: _____

Foods: _____

Screenings and Dates: Colonoscopy _____ Bone Density _____

Mammogram_____ Pap Smear_____

Current Health Concerns in order of importance

1. _____ 2. _____

3. _____

List the prescribed medications, non-prescription medications currently taking with dosage:

_____

_____

_____

List the herbals, vitamins, and minerals you are currently taking currently taking with dosage:

_____

_____

_____

Please list any medications you have been prescribed, but are not taking:

_____

Please list any major illnesses, hospitalizations, surgeries, procedures (date and brief description):

_____

_____

_____

PERSONAL AND FAMILY HISTORY

Please indicate if you or a family member (**specify relationship**) has experienced the following health complaints.

__ Unknown/Adopted

Dementia:	High Blood Pressure:
Addictions:	High Cholesterol:
Allergies:	Migraines:
Anxiety/Depression:	Obesity:
Anemia:	Sexual Abuse:
Arthritis:	Seizures:
Asthma:	Skin Disorders:
Cancer:	Thyroid Disorder:
Heart Disease:	Diabetes:

Review of Symptoms

Circle Yes if experienced within the last 2 months

Constitutional		
Recent Weight Change	Yes	No
Fatigue	Yes	No
Night sweats	Yes	No
Ears/Nose/Throat/Mouth		
Hearing loss/Ringing	Yes	No
Sinus congestion/pain	Yes	No
Sore throat/Voice change	Yes	No
Post-nasal drip	Yes	No
Eyes		
Wears Contacts/Glasses	Yes	No
Blurred/Double vision	Yes	No
Eye disease/injury	Yes	No
Eye Pain	Yes	No
Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Dizziness/Lightheadness	Yes	No
Heart Problems	Yes	No
Respiratory		
Shortness of breath	Yes	No
Cough	Yes	No

Wheezing/Asthma	Yes	No
Sleep Apnea	Yes	No
Musculoskeletal		
Joint pain/Stiffness	Yes	No
Muscle cramps/pain	Yes	No
Joint swelling	Yes	No
Endocrine		
Excessive thirst/hunger	Yes	No
Hair loss/ Unusual growth	Yes	No
Cold hands/feet	Yes	No
Hormone imbalance	Yes	No
Neurological		
Frequent headaches	Yes	No
Tremors/Paralysis	Yes	No
Seizures	Yes	No
Numbness/Tingling	Yes	No
Skin		
Rashes/Itching	Yes	No
Discolored skin	Yes	No
Dry/Peeling skin	Yes	No
Excessive sweating	Yes	No

Urinary		
Blood in urine	Yes	No
Pain/burning with urination	Yes	No
Recurrent bladder infections	Yes	No
Difficulty urinating	Yes	No
Psychiatric		
Depression	Yes	No
Anxiety/Panic attacks	Yes	No
Confusion/Memory loss	Yes	No
Insomnia	Yes	No
Suicidal ideation	Yes	No
Female/Male Issues		
Sexual problems	Yes	No
Infertility	Yes	No
Testicular/Ovarian pain	Yes	No

Menstrual problems	Yes	No
Breast issues (lumps, pain, etc)	Yes	No
Hematologic/Lymphatic		
Anemia	Yes	No
Easy to bruise	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No
Digestive Issues		
Indigestion/Belching/Reflux	Yes	No
Constipation/Diarrhea	Yes	No
Abdominal pain	Yes	No
Nausea/Vomiting	Yes	No
Gas/Bloating	Yes	No
Blood in stool	Yes	No
Hemorrhoids	Yes	No

Women:

Start of first period: _____ Last menstrual period: _____

Cycles: ☐ Regular ☐ Irregular. Average Cycle length: _____

Premenstrual complaints? ☐ Yes ☐ No. If yes, list: _____

Are you planning to conceive now or in the near future? ☐ Yes ☐ No

Number of Pregnancies? _____ Number of Children? _____

Vaginal? _____ C-section? _____

Post menopausal? _____

LIFESTYLE HISTORY

Stressors: Rate level of stress, (10 = high stress, 1 = low stress): _____

Top stressor currently or in recent past, if any: _____

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

Regimen: _____

Frequency/Duration: _____How long on this program?_____

Diet:

Do you eat breakfast? ☐ Yes ☐ No. Time: _____

Describe typical meal: _____

Do you eat lunch? ☐ Yes ☐ No. Time: _____

Describe typical meal: _____

Do you eat dinner? ☐ Yes ☐ No. Time: _____

Describe typical meal: _____

Do you snack? ☐ Yes ☐ No. Typical snacks: _____

What are your food cravings, or attractions? _____

Coffee: _____cups/day, Caffeinated Tea: _____cups/day, Water: _____glasses/day

Habits:

Do you smoke or chew (tobacco)? ☐ Yes ☐ No ____packs/day or amount/day. Quit Date _____

Do you drink alcoholic beverages? ☐ Yes ☐ No _____drinks per: day week month

Use recreational drugs? ☐ Yes ☐ No. If yes, which:

_____

Sexual habits:

Sexually active: ☐ Yes ☐ No. If yes, number of sexual partners: ☐ 1, ☐ 2, ☐ 3+

Men _____ Women _____ Both _____

Contraception use: ☐ Yes ☐ No. If yes, which: _____

History of Sexually Transmitted Infections? _____

Sleep:

Rate the quality of sleep (10 is great, 1 is poor): _____

Average hours of sleep per week: _____, weekend: _____

Goals/Expectations: _____

_____

_____

Patient signature: _____ Date: _____

PHARMACY:

Name of Pharmacy: _____ Address: _____

Wellness and Aesthetics, LLC

Informed Consent

Nature of Services

Wellness and Aesthetic services include medical care provided by nurse practitioners trained in traditional medical care as well as integrative and functional medicine. Our services may include the prescription of an integrative program which includes conventional health care, nutritional therapies, functional medicine, as well as other elements of integrative medicine. I hereby grant my authorization and consent to treatment and certify that no guarantee of the assurance has been made as to the results which may be obtained.

Financial Responsibility

I, the undersigned, recognize that the provider cannot accept responsibility for collecting any insurance claims or negotiating any settlement on a disputed claim. In the event of default in payment or any amount due, if this account is placed in the hands of an agency or attorney for collection, or legal action, I agree to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by law governing these transactions. We will bill your insurance company for their expected share of benefits for services received in our office. No third party billing will be done by us. We are not a work comp provider and will not bill for work comp injuries. We do not file claims for auto related injuries. Payment of your expected share is expected at the time of each visit, unless prior arrangement have been made. All co-payments are due and expected at the time of service.

Risks, Benefits, and Alternatives of Treatment

In general, integrative, functional and traditional medicine provide benefits that include relief of presenting symptoms and improved function that may lead to prevention, improvement or elimination of the presenting symptoms, though no particular outcome can be warrantied or guaranteed. Like with any health treatment, such treatment is not without risk. Potential risks of treatment include allergic reactions, sensitivities, adverse effects from, or in response to, natural supplements or dietary measures, failure to improve or worsening of the patient's condition and difficult adjustments to making lifestyle modifications. Other side effects and risks may occur. The patient agrees to inform Wellness and Aesthetics clinical staff of all known factors which might affect treatment, including all medications, drugs, drug sensitivities and allergies, history of seizures, fits or fainting, presence of a pacemaker, bleeding disorder, use of anti-coagulants, damaged heart valves or occluded vessels, immune deficiencies or other special risk of infection, as well as any other significant factors. The patient further agrees to inform Wellness and Aesthetics clinical staff of any disorder, or state of mind, that might affect the patient's capacity to make informed health decisions, and should any such impairment exist, patient will provide information regarding a surrogate decision maker.

An explanation of the risks, benefits and alternatives of any specific procedures or treatments, recommended or undertaken, will be provided to the patient at the time of such recommendation.

The patient agrees to bring to the attention of Wellness and Aesthetics clinical staff any lack of understanding of such risks, benefits and alternatives, and inquire of staff or further explanation until patient has a full understanding before giving consent to any procedure or treatment.

The patient agrees to immediately inform Wellness and Aesthetics clinical staff of any adverse effect of treatment noted, including any unanticipated pain or other negative sensation, unpleasant cognitive conditions, anxiety, depression or other negative emotions or any unpleasant taste or smell associated with the consumption of supplements or herbs. The patient will immediately notify the Wellness and Aesthetics clinical staff in the event of pregnancy, as some treatments may be contraindicated in the event of pregnancy.

The undersigned patient agrees that he/she has read and understood the information contained in this Informed Consent, has inquired as to all aspects that were not understood, and consents to the care and treatment as outlined herein. In consideration of the services to be performed and products obtained, the undersigned patient agrees to be bound by the terms of this Informed Consent.

Selling Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids and herbs are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use if chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Wellness and Aesthetics

You are under no obligation to purchase nutritional supplements at our clinic or online dispensary.

At this time nutraceutical supplements are not sold in our office. We are affiliated with online dispensaries. We work with companies and manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that are recommended are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have questions or concerns about this issue, please discuss them with our staff.

Functional Medicine Laboratory Testing

The purpose of functional medicine laboratory testing ordered through our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

I have read and understand the above:

_____ _____

Printed Name of Patient **Signature of Patient**

_____

Date

Health Assessment For Women (Female Symptom Questionnaire)

Name: _____ Date: _____

E-Mail Address: _____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "never".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Hot flashes					
Sweating (night sweats or increased episodes of sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire, in sexual activity and/or orgasm and satisfaction)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches or migraines					
Hair loss, thinning or change in texture of hair					
Feel cold all the time or have cold hands or feet					
Weight gain or difficulty losing weight despite diet and exercise					
Dry or wrinkled skin					
Total:					

Severity	Score
Mild	1 - 20
Moderate	21 - 40
Severe	41 - 60
Very Severe	61 - 80

bioTE

Health Assessment For Men (Male Symptom Questionnaire)

Name: _____ Date: _____

E-Mail Address: _____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "never".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Increased need for sleep or falls asleep easily after a meal					
Depressive mood (feeling down, sad, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire or in sexual performance)					
Bladder problems (difficulty in urinating, increased need to urinate)					
Erectile changes (less strong erections, loss of morning erections)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches/migraines					
Rapid hair loss or thinning					
Feel cold all the time or have cold hands or feet					
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise					
Infrequent or absent ejaculations					
Total:					

Severity	Score
Mild	1 - 20
Moderate	21 - 40
Severe	41 - 60
Very Severe	61 - 80

Wellness and Aesthetics LLC
330 N. Campo,
Las Cruces, NM 88001

PHQ-2

Over the last 2 weeks, how often have you been bothered by the following problems?
Circle the answer

1. Little interest or pleasure in doing things?

Not at all	0
Several days	+1
More than half the days	+2
Nearly every day	+3 *

2. Feeling down, depressed or hopeless?

Not at all	0
Several days	+1
More than half the days	+2
Nearly every day	+3 *

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Depression Score (PHQ-9)

Patient Health Questionnaire-9

(PHQ-9) - Depression Severity Score

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Feeling down, depressed, or hopeless *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Trouble falling or staying asleep, or sleeping too much *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Feeling tired or having little energy *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Poor appetite or overeating *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Feeling bad about yourself — or that you are a failure or have let yourself or your family down *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
Thoughts that you would be better off dead or of hurting yourself in some way *	☐ Not at all ☐ More than half the days	☐ Several days ☐ Nearly every day
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all ☐ Very difficult	☐ Somewhat difficult ☐ Extremely difficult

Wellness and Aesthetics, LLC Notice of Privacy Practices (HIPAA)

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) IS A FEDERAL PROGRAM THAT REQUIRES THAT ALL MEDICAL RECORDS AND OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION USED OR DISCLOSED BY US IN ANY FORM, WHETHER ELECTRONICALLY, ON PAPER OR ORALLY, ARE KEPT CONFIDENTIAL. THIS ACT GIVES YOU, THE PATIENT, RIGHTS TO UNDERSTAND AND CONTROL HOW YOUR HEALTH INFORMATION IS USED. AS REQUIRED BY HIPAA, WE HAVE PREPARED THIS EXPLANATION OF HOW WE ARE REQUIRED TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.

We may use and disclose your medical records only for each of the following purposes:

- Treatment: providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment: obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review.
- Health care operations: this includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.
  We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses of disclosures will be made only with your written authorization.
- You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the practice manager:

- The right to request restriction of certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to request an amendment your protected health information but we may deny the request or amendment.
- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of any revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions in this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Signature _____ Print Name _____
Date _____