

WELLNESS AND AESTHETICS, LLC

Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Male: \_\_\_ Female: \_\_\_ Other: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_ DOB: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ 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

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

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



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

Menstrual problems	Yes	No
Breast issues (lumps, pain, etc)	Yes	No
<b>Hematologic/Lymphatic</b>		
Anemia	Yes	No
Easy to bruise	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No
<b>Digestive Issues</b>		
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 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 \_\_\_\_\_

# 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 warranted 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 is 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**





# FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems (difficulty falling asleep or sleeping through the night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decline in drive or interest (loss of "zest for life," feeling down or sad)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory (concentration, finding the right word, or retaining information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness or difficulty with sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (night sweats or increased episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes (burst that starts in chest and lasts for short duration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss, thinning or change in texture of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling cold all the time, having cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or migraines (increase in frequency or intensity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight (difficulty losing weight despite diet/exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other symptoms or unique health circumstances to take into consideration:

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