

Hormone Health Intake Form

Personal Information



Occupation	
Hours per week	

Adrenal Health Picture

Check all that apply*

Please be honest! This form is private.

I am a single parent
I have struggled with infertility
I am in an unhappy marriage
I have people close in my life who are suffering from alcohol or drug abuse
I work shift work
I love my job but have too much work to do
My boss is too demanding
My co-workers cause extra stress in my life
Chemicals surround me in my workspace
I don't eat regularly, often skipping meals and going 5+ hours without eating
I smoke; drink alcohol or more than 500ml of coffee daily



My family and friends are not supportive of the things I do or believe
I am constantly the doer in every relationship in my life and feel like no one is there for me
I am worried about my finances
I look at myself in the mirror and think negative thoughts
I feel lonely often
I have feeling feelings of guilt or anger
I am afraid of failing
I feel anxious often
I feel trapped and sometimes like I can't cope
I am exhausted but I keep pushing, I keep going
My stomach is the first place I feel stress
I crave sugar
I am sick more than 3x annually
I have no sex drive
I am always tired

Breast and Reproductive Health



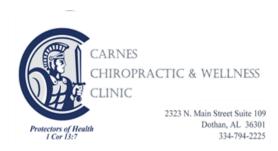
Check all boxes that apply

Please be honest! This form is private.

I have not had children and I am between 25-35
I have not had children and I am 35+
I have no plans to have children
I have suffered one or more miscarriages
I took birth control pills during my teens and 20's
I took birth control pills after the age of 35
I have taken or am taking HRT (hormone replacement therapy Premarin, Provera, Prempo)
I have regular mammograms of Thermo screening
I don't exercise
I exercise 1-3 times weekly
I exercise 3-6 times weekly
I have suffered from depression where medication was needed and/or used
I have had a breast reduction, breast implants or implants removed
I have had more than 2 chest xrays in my life



I am exposed to EMF due to excess computer work, phone use, living near hydro lines or hydro plants, I work in a space where we do xrays or
I use regular bleached sanitary products such as Always and Tampax
I eat non-organic non-gmo free animal products and dairy
I use non-organic make up and body care products
I do not eat organic produce
My period started before the age of 12
I had late menopause, started after the age of 50
I have had a cervical ablasion
I have had a partial or full hysterectomy
I have heavy, painful periods
I have clotting
I feel like my whole period comes in 1-2 days and then almost nothing
I eat a high fat, high animal protein diet and consume dairy daily ex: yogurt, cheese, whey protein, cottage cheese, ricotta cheese, casein,



I don't eat cruciferous veggies ex: broccoli, cauliflower, arugula, bok choy, brussel sprouts, kale, cabbage, radish, turnip and watercress	
I take cholesterol-lowering medications	
I take blood pressure medication	
I use ulcer medication	
I use anti-yeast medication	
A first-degree relative (mother, sister, daughter) has had breast cancer or ovarian cancer or uterine cancer or cervical cancer	

Yes or No

Do you consume soda, diet or regular 1-5 times weekly?*

Yes

No

Do you have a history of 1 or more cycle of antibiotics per year?*

Yes

No

Have you take prednisone or puffers or corticosteroid creams?*

Yes



No Does the smell of perfume, smoke and chemicals affect you?* Yes No Do you crave sugars and bread?* Yes No Do you suffer from headaches or migraines Yes No How often? **Describe them**



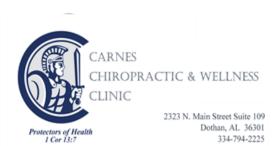
Bloods Sugar and Insulin Regulation

Check which applies*

Enter a 0 for symptoms you never experience Enter a 1 for those that are mild Enter a 2 for those that are moderate

Enter a 3 for those that are frequent or all the time

	0	1	2	3
Afternoon Exhaustion				
Allergies				
Anxiety				
Awaken after a few hours of sleep				
Breathing heavily				
Blurred vision				
Butterflies in stomach				
Can't concentrate				
Can't decide easily				
Can't wake up or get started in the morning without coffee				
Can't work under pressure				
Chronic indigestion				
Cold hands and feet				



Constantly hungry		
Crave bread		
Crave sweets or coffee in the afternoon		
Cry easily or for no reason		
Depression		
Dizziness		
Eat when nervous or sad		
Fatigue that is relieved by eating		
Forgetfulness		
Frequent urination		
Get shaky if hungry		
Headaches		
Heart palpitations		
Indecisiveness		
Irritable before meals		
Irritability in general		
Joint Pain		
Lack of energy		
Moodiness		
Muscle and back pain		



Muscle twitching and cramping		
Nervousness		
Noise or light sensitivity		
Obesity		
Perspiration has bad odour		
Poor exercise performance		
PMS		
Restlessness		
Sighing and Yawning		
Sleepy after meals		
Sleepy during the day		
Sweating		
Wake at night to pee		

Candida Connections

Click the one that applies*

Enter a 0 for symptoms you never experience Enter a 1 for those that are mild Enter a 2 for those that are moderate

Enter a 3 for those that are frequent or all the time

	0	1	2	3
Vaginal discharge or irritation				



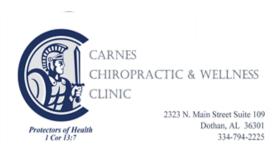
Bladder infections	
Fluid retention	
Difficulty getting pregnant	
Frequent sinus infections	
Have allergies to food and environment	
Feel worse on damp days or in old, moldy, musty spaces	
Experience anxiety	
Have insomnia	
Experience gas and bloating	
Experience constipation	
Diarrhea	
Have bad breath	
Feel spacey often	
Painful joints	
Always congested when you wake up	
Feel pressure or irritation behind your eyes	
Frequent headaches	
Thyroid issues	
Muscle aches and pains	



FULL BODY SKIN SCAN

Privately and on your own you are going to perform a complete head to toe scan of your body and skin. You will need to be fully naked for this and have a full-length mirror accessible. I know this can be very intimidating and feel vulnerable but I can't stress to you all enough just how important knowing more about the skin you are in is. This information is not required for this form, but feel free to share it if you feel comfortable. If you are not comfortable submitting to me this info PLEASE RECORD AND KEEP PRIVATELY FOR YOURSELF SOMEWHERE. You need to know the landscape of your body.

You will begin by scanning the skin on your face and neck and make notes about what you see?
Are you oily, dry, patchy, do you have rosacea patches or melasma?*
Did you ever have a bad sunburn on your face or scalp?*
Make note of acne, pimples, rashes, unevenness, scaly skin etc.*



Excess hair growth, moles, skin tags and birthmarks and/or scars*
to the same thing for your arms; the front, sides and backs of your arms blus your armpit area all the way down to the palm and backside of your
Once you have noted EVERYTHING about your face and neck area you will do the same thing for your arms; the front, sides and backs of your arms
plus your armpit area all the way down to the palm and backside of your hands.*



breasts, your ab	he front of your torso and notice what you see about your domen, navel, side waists, and your back and back of your skin findings as well as curves in the spine, one shoulder higher etc.*



Move your attention to your glutes, hips, pelvis and thigh area; pay attention to any rashes or pimples of bumps on your glutes, between your cheeks, your inner thighs, near your vaginal area etc.*	our



Move down to your lower legs, look all around your knees, the front and back of your thighs and calves.*



Take a look at your feet. Any dry, scaly areas? How about bunions or nammer toe or warts or athlete's foot or fungus?*	



f there is any area you forgot to look at stand back and take one more inal FRONT, SIDE and BACK view (using your phone camera or another nirror)*	



NAIL SCAN
Too often our nails are looked at simply as a pretty base to color and paint but the size, shape, texture, color and growth rate of your nails are like a window into the health of your body.
As you scan both the nails on your hands and your feet look for:
Yellowing
Dry, cracked or brittle
White spots
Deep vertical ridges or lines



Deep horizontal ridges or lines
Visible bumps
Spooning nails (curving upward
Dark Discoloration
You bite your nails



You wear nail polish often	
Nail Polish is organic	
Nail Polish is not organic	
You often have false nails or gels	

TONGUE SCAN

Open your mouth first thing in the morning and stick your tongue out. What do you see? Record everything.

Check all that apply.

Do you notice the following?

Brown or yellow fuzz?

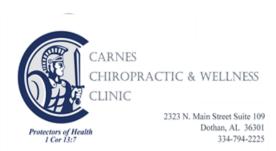


White thick coating?	
White spots?	
Dark red patches?	
Cuts or splits?	
Wrinkles?	
Red bumps or blisters?	
Pimples?	
Extra Notes	
Extra Notes	
Extra Notes	

EYE SCAN

Stand in the mirror with no eye make up on and gaze into and around your eyes. Check all that apply.

What do you see?



Are your eyebrows thinning or disappearing?	
Do you have styes in or around your eye?	
Are they yellow or discolored?	
Patches or dry skin on or around your eyelids?	
Discharge from your eyes or crusty lids in the morning?	
Burning Sensations?	
Dry eyes?	
Any dots or odd-looking markings on the pupil or Iris of your eyes?	
Extra Notes	

HAIR SCAN

With zero products in your hair and when it is clean and dry, take note of what you see. Check all that apply.



What do you notice?

Dry, split ends?	
Frizzy?	
Grey?	
Slow growing?	
Dry scalp?	
Dandruff?	
Yeast or cradle cap on the scalp?	
Moles or clogged pores/pimples/hair follicles?	
Thinning or hair loss?	
-	
Extra Notes	

Weight & Body Measurements

Please take note of the following measurements.

Dr. Robert Carnes & Dr. Ashley Carnes
2323 W. Main St. Suite 109, Dothan, AL 36301
334-794-2225/ www.carneswellness.com



Height* Resting Heart Rate: sit calmly and hold your two peace fingers to your left wrist and count your heart for 15 seconds and x by 4 to achieve your RHR*
What Does Your Day Look Like?
Let me know what your day looks like and be honest.
I'm not judging you, and this isn't a competition to see who has the most on their calendar or can check the most things off their list in a day.
This is for me to get a clear picture of what is going on in your day-to-day life, the demands, stress and tension you may be under and how it connects to the way you are feeling and what is going on in your body.
Can you tell me about your morning routine?



FOOD - What does your average day look like, in regards to food? *
Please write out for me your day from the time you wake until bed in regards to what you drink and eat.



o you enjoy f nore	ood prep or do you find t	his a struggle? Please tell me

HYDRATION - how much water / herbal tea / smoothies do you get in a day?*





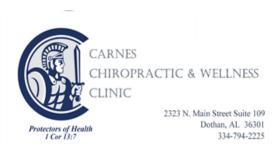
o you use any of the following & if so how much a day? Alco farijuana or CBD*	ohol,
lave you recently been given any medications or had any ne last 6 months)*	w shots?



What is your current stress picture? What in your life causes you stress?
How has your body historically responded to stress?



How old were you when you got your period?	
What was your cycle like for you as a teen?	



What about in you	ur 20's, 30's, 4	40's etc.?		

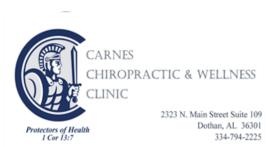


Can you tell me about your cycle now?
ength, your actual bleed week (period) quality, length you bleed for,
ymptoms prior to and during or anything else important for me to know



What do you do for movement or exercise?	

Can you tell me about your evening routine and sleep?



hat are you ho	ping to learn abou	t your body w	orking together?*

Acknowledgement and Assumption of Risk

The Services and Courses provided by us are strictly for informational and educational purposes only. You expressly acknowledge and assume all risk associated with your use of the Services and any subsequent actions you choose to take or not to take, as a result of the information or materials provided to you as part of the Services. Risks include, but are not limited to,



engaging in physical activity and exercise that may lead to serious injury and damages, and/or trying new foods, herbs or supplements, which may lead to adverse or allergic reactions. Breath work and movement practices should not be done if you are pregnant without the consultation of a doctor and/or regulated healthcare provider. You expressly acknowledge that the dangers and risks associated with the Services and Courses listed here are not complete. Your voluntary participation in the Services and Courses illustrates your understanding and assumption of all the risks and potential risks of the Services and Courses.

Signature:	Date:
Signature	Date