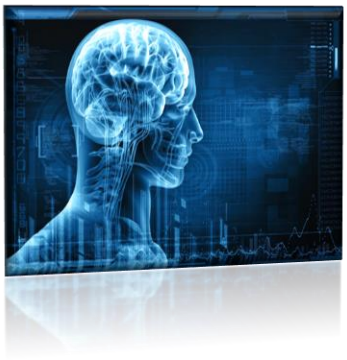
Traumatic Brain Injury (TBI)



New Patient Information Packet (NPIP)

REPLENISH
WELLNESS CENTER

185 CHATEAU DR., SUITE 302-B
HUNTSVILLE, AL 35801
Office: (256) 885-2499
Fax: (256) 885-1905

For your security, please do not email forms.
Please Fax, Mail, or bring to office

Welcome

You have identified yourself as an individual seeking enrollment in our Traumatic Brain Injury (TBI) programs. This packet contains the most important documents needed to start your evaluation. Please download, print, and fill out the information. Once completed, please return the forms by Fax, mail, or bring them to the office.

Any Message to our staff? _____

_____

_____

Please read each page clearly for Instructions. Failure to do so may delay acceptance of your case

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Instructions

1. Please download, print, and fill out the following forms to the best of your ability. Once complete, return to us by fax, mail, or bring to the office.

   For your security, please DO NOT email forms.

2. Once received, your forms will be reviewed for completeness.

3. If accepted, you will be called to start the process of ordering labs. At that time, please ask any questions you may have.

   When accepted and called, you can authorize the office to charge your credit card and your laboratory testing will be ordered.

   At that moment, you are in the hands of:
   Access Medical Laboratories, Julia Gonzales – Office: (866) 720-8386 (x 138)

4. **Access Medical Laboratories** will send you a Blood Draw Kit with instructions on where to go to have your blood drawn.

   Replenish Wellness Center Instructions are:
   a. **DO NOT STOP** or **ALTER ANY** of the medication you are taking.
   b. Fast for 8-12 hours but drink water.
   c. Have blood drawn in the morning on a Monday – Thursday.
   d. Please do **NOT CALL** or **EMAIL** the office that you had your blood drawn. They send us a report every day.

5. Once we receive the laboratory results and Dr. Thacker has reviewed your results and written a report, you will be sent a preliminary report with Instructions on how to arrange for your virtual or In-Office consultation and review.
   a. DO NOT buy any of the products stated until you have reviewed the report and Treatment Protocol with Dr. Thacker.

6. Once you have a consultation date and time, we will be waiting to start your program.

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Request to Share/Release Medical Records

I_____, hereby authorize the office of Dr. James Thacker, his employees, representative or designated representative, to provide all the necessary medical records with the HealthCare Provider (HCP) indicated below. I may at anytime revoke this permission to release my records by sending a request by email or mail.

Patient's Signature Date

Enter the full information on the doctor that you will be seeing. Fax and Email.

HCP Name	
Address	
State	
City/Zip	
Phone	
Email	

Comments or additional directions.

For office use only

Received		Sent		

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Instructions for the New Patient Information Packet (NPIP)

The NPIP consists of those documents that we need initally to establish a knowledge base of your medical history which will also be used in the interpretation of your laboratory results and for providing a customized Treatment Protocol and a Report. We many provide you with additional documents in the future.

Please make sure that you put your name on each space that asks for it and fill out the NPIP to the best of your ability.

Another page is the **Credit Card Authorization** form which needs to be completed for us to open your case and to arrange for your blood draw. We are a cash only facility and do not have an Insurnace Department nor do we, at this time, accept cases on contingency.

At the end of the packet is an "**Informed Consent for Telemedicine"**. This will allow us to communicate virtually in order to provide a Physician-Patient interaction that is LIVE but virtual. Otherwise, you will be required to come into the office.

The remaining documents are important medical history and mental health questionnaires. These will act as a record of your baseline, which will be assessed repetitively throughtout your Treatment Protocol. You will also fill out a "**History of Injury**" report. If there have been multiple traumas or injuries in the past, please indicate them in the "**Summary of Injuries**". Please be as concise as possible.

Finally, please use the www.TBIMedLegal.com website to obtain answers and information on the most commonly asked questions or requested information. If you cannot find the answers, please email the office in lieu of calling. Once you have submitted your completed NPIP, we will call you to clarify any issues. We are trying to minimize waiting time so if your NPIP is complete and we can accept you into the program, you will be notified as soon as possible.

For Your Security – Please Fax all forms to: (256) 885-1905, mail, or bring to office

Email questions to: SandraT@ReplenishWellnessCenter.com

I look forward to reviewing your results with you soon.

All the best,
Dr. James D. Thacker, M.D.

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What is included in our programs?

Thank you for learning more about the programs we have that address the many faces of Traumatic Brain Injury (TBI), often mislabeled as Post-Traumatic Stress Disorder (PTSD). Our programs have been used to diagnose and treat individuals with cognitive and physchological conditions that have not responded well to traditional medical interventions. We believe that this is due to the fact that what is assumed to be "physhological" is really a bio-chemical condition that is based upon inflammation. This inflammation appears to alter chemical pathways that allow us to make brain hormones and neurotransmitters that suppot our thinking and emotions. Disruption of these important pathways creates all the negative changes.

What you get with your initial Enrollment into a Program:

1) A phone call from our office to answer your questions before a Program fee is accepted.

2) Once you agree to our Program, the fees are charged so that we can arrange for your blood work to be obtained. Once we place the requisition for your labs, the ball is in the Laboratory's hands and they will contact you, send you a Blood Draw Kit to take to one of their Draw Centers located closest to you. If you would prefer, you may come to our office and we can draw your blood.

3) After the blood is drawn, it is shipped to the lab in Florida for processing. Once the results are completed, they are sent to Dr. Thacker to be entered into a Report Template. At that point, Dr. Thacker reviews your NPIP and writes the Analysis of your labs to suggest a Treatment Protocol.

4) A copy of the Report is sent to you with instructions to call the office to arrange for a 60-minute consultation; in the office, by phone, or virtually (i.e. Zoom or other virtual platforms). If you live outside of Alabama or Colorado, Dr. Thacker will not be able to write any prescriptions. Remember that 80% of the Treatment Programs are based upon Nutraceuticals that do not need a presciption.

5) When you have your consultation with Dr. Thacker, you will review the lab results and learn how these bio-maarkers can influence your well-being. It is the intention of Dr. Thacker to help you understand what is going on so that you can take more control of your health. Near the end of the consultation, Dr. Thacker will review each component of the Treatment Protocol. Please feel free to ask any questions you may have.

6) Upon completion of the consultation, a Final Report will be prepared with a copy of your lab results and over 50 pages of supportive information including much of what was shared with you during the consultation along with medical articles. You will also be offered, from our In-Office Store, the Treatment Protocol that was discussed, but you may get them on your own as well.

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Follow-Up Labs

Laboratory follow-up:

1. Three (3) months post-starting your Protocol.

2. Six (6) months post-starting your Protocol.

3. Twelve (12) months post-starting your Protocol.

Treatment Protocols (Nutraceuticals)

1. Multi-factorial issues will influence the selection of your personalized Treatment Protocol.

Treatment Protocols (Pharmaceuticals) such as:

1. Thyroid
2. Growth Hormone Secretagogue
3. Testosterone
4. Female Hormones

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Credit Card Authorization

Your full name (F M L)	
Street Address1	
Street Address 2	
City	
State and Zip	
Contact Phone #	
Contact Email	
Your Credit Card Type	___ AMEX ___ VISA ___ MasterCard ___ Discover
Credit Card Number	
Expiration Date	
CVV or Code on back	
Credit Card Zip Code	
Dr. James D. Thacker	___$2,500.00
.	

I authorize the Replenish Wellness Center, and/or their representative to charge my Credit Card in the amount indicated above based upon the Program I have selected (marked).

_____ _____

Signature Date

Once your New Patient Information Packet has been submitted to the office, it will be reviewed for enrollment in the Program you have selected. Only after we contact you will the card be charged and the laboratory services be ordered for your initial evaluation.

OFFICE NOTE: DO NOT store patient Credit Card Number(s) on the computer. Delete in all forms.

Contact Email: SandraT@ReplenishWellnessCenter.com

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Traumatic Brain Injury – Neurosteroid Deficiency Syndrome

A developing area in Hormone Replacement Strategies is the relationship between any form of head trauma and hormone deficiencies. Therefore, please answer the following:

Name **Date of exam**

Please check off any of these activities that you participated in or experienced.

√	Activities	YRS	√	Activities	YRS	√	Activities	YRS
	Boxing			Break dancing			Soccer	
	Wrestling /Grappling			Extreme Sports			Rugby	
	Track and Field			Water or Snow Skiing			Basketball	
	Gymnastics			Skate boarding			Football	
	Martial Arts/MMA			Dirt Bikes / Motocross			Baseball	
	Snow Boarding			Stock Car Racing			Roller Coasters	
	Automobile Accident			Motorcycle Accident			Bicycle Accident	
	Slip and Fall			Explosion (IED)			Repetitive gun fire	
	Pneumatic Tools			Parachutist			Artillary	

Injures related to any of the above activities. LOC means Loss Of Consciousness

Type of Injury	Age	Year	LOC	Hom	ER	Hos	Duration/Comment	GCS

Relative to the head injures above have you experience any of the following?

√	Symptoms	Intensity	√	Symptoms	Intensity
☐	Decrease in Recent Memory	1 2 3 4 5	☐	Lack of Interest in life/Bored	1 2 3 4 5
☐	Decrease in Remote Memory	1 2 3 4 5	☐	Lack of sex drive (libido)	1 2 3 4 5
☐	Lack of Concentration (focus)	1 2 3 4 5	☐	Lack of competitiveness	1 2 3 4 5
☐	Periods of Disorientation	1 2 3 4 5	☐	Lack of confidence	1 2 3 4 5
☐	Mood swings	1 2 3 4 5	☐	Sleeping more (hypersomnia)	1 2 3 4 5
☐	Sudden out-bursts of Anger	1 2 3 4 5	☐	On-set of Insomnia.	1 2 3 4 5
☐	Sudden Irritability	1 2 3 4 5	☐	Change in Sense of Smell	1 2 3 4 5
☐	Depression	1 2 3 4 5	☐	Change in Vision	1 2 3 4 5
☐	Self Isolation	1 2 3 4 5	☐	Anxiety (panic attacks)	1 2 3 4 5
☐	Recurrent Headaches/Migraines	1 2 3 4 5	☐	Change in Menses (Periods)	1 2 3 4 5
☐	Decrease in intelligence	1 2 3 4 5	☐	Increase in Tiredness or fatigued	1 2 3 4 5

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Traumatic Brain Injury (TBI) Specific Event Reporting Form - 1

Name Today's Date

Please fill out one of these TBI Reporting Forms *for up to 3 of the most significant traumas that you sustained.*

This event happened in (year)_____, as a ☐Civilian, ☐ Soldier, ☐LawEnforcement, ☐Other_____, when I was_____years old:

☐	Car Accident (MVA)	☐	Blast Trauma	☐	Gun Fire	☐	Slip n Fall	☐	Stroke	☐	Assault
☐	Motorcycle (MCA)	☐	IED	☐	Sports (any)	☐	Cannon Noise	☐	Jet engines	☐	Shot Gun
☐	Bicycle (BCA)	☐	Fall from object	☐	Contact Sport	☐	Martial Arts	☐	Parachute	☐	Surgery
☐	Football	☐	Rugby	☐	Soccer	☐	Lacrosse	☐	Jujitsu	☐	MMA
☐	Wrestling	☐	Grappling								

1. With this injury I ☐Did NOT ☐DID have loss of consciousness lasting_____seconds/minutes/hours/days/weeks.
2. **With this injury I ☐Was NOT ☐Was** in a Coma for ___ hours/days/Weeks/months.
3. With this injury I ☐Did NOT ☐DID have loss of memory immediately before or after the incident.
4. With this injury I ☐Did NOT ☐DID have altered mental state at the time of the incident.
5. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **LESS**(<) than 24 hours.
6. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **MORE**(>) than 24 hours.
7. I was taken to: ☐Home ☐Medical Clinic ☐ER ☐Hospitalized for ____hours/days/weeks. Glasgow Scale____
8. Radiologic Procedures: ☐CT-Scan ☐MRI ☐fMRI ☐SPECT ☐PET Scan ☐DTI-MRI
9. **These are my present symptoms**: (any adverse changes) :

☐ Angry	☐ Anger bouts	☐ Irritable	☐ Short temper	☐ Intolerant	☐ Aggressive
☐ Impatient	☐ Tense	☐ Excitable	☐ Hostile	☐ Defensive	☐ Demanding
☐ Mood swings	☐ Depression	☐ Sad	Grumpy	☐ Mean/hateful	☐ Withdrawn
☐ Memory loss	☐ Anxiety	☐ Nausea	☐ Insomnia	☐ Lonely	☐ Worrying
☐ Sleepy	☐ Bored	☐ Apathetic	☐ Unloved	☐ Muscle pain	☐ Body pain
☐ Disoriented	☐ Dizziness	☐ I'm spinning	☐ world spinning	☐ Headaches	☐ Stomach pain
☐ Paranoid	☐ Alcohol use	☐ Drug use	☐ Narcotics	☐ Marijuana	☐ Low libido

Physician's Notes:

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Traumatic Brain Injury (TBI) Specific Event Reporting Form - 2

Name Today's Date

Please fill out one of these TBI Reporting Forms *for up to 3 of the most significant traumas that you sustained.*

This event happened in (year)_____, as a ☐Civilian, ☐ Soldier, ☐LawEnforcement, ☐Other_____, when I was_____years old:

☐	Car Accident (MVA)	☐	Blast Trauma	☐	Gun Fire	☐	Slip n Fall	☐	Stroke	☐	Assault
☐	Motorcycle (MCA)	☐	IED	☐	Sports (any)	☐	Cannon Noise	☐	Jet engines	☐	Shot Gun
☐	Bicycle (BCA)	☐	Fall from object	☐	Contact Sport	☐	Martial Arts	☐	Parachute	☐	Surgery
☐	Football	☐	Rugby	☐	Soccer	☐	Lacrosse	☐	Jujitsu	☐	MMA
☐	Wrestling	☐	Grappling	☐		☐		☐		☐	

1. With this injury I ☐Did NOT ☐DID have loss of consciousness lasting_____seconds/minutes/hours/days/weeks.
2. **With this injury I ☐Was NOT ☐Was** in a Coma for ___ hours/days/Weeks/months.
3. With this injury I ☐Did NOT ☐DID have loss of memory immediately before or after the incident.
4. With this injury I ☐Did NOT ☐DID have altered mental state at the time of the incident.
5. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **LESS**(<) than 24 hours.
6. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **MORE**(>) than 24 hours.
7. I was taken to: ☐Home ☐Medical Clinic ☐ER ☐Hospitalized for ____hours/days/weeks. Glasgow Scale____
8. Radiologic Procedures: ☐CT-Scan ☐MRI ☐fMRI ☐SPECT ☐PET Scan ☐DTI-MRI
9. **These are my present symptoms**: (any adverse changes) :

☐ Angry	☐ Anger bouts	☐ Irritable	☐ Short temper	☐ Intolerant	☐ Aggressive
☐ Impatient	☐ Tense	☐ Excitable	☐ Hostile	☐ Defensive	☐ Demanding
☐ Mood swings	☐ Depression	☐ Sad	Grumpy	☐ Mean/hateful	☐ Withdrawn
☐ Memory loss	☐ Anxiety	☐ Nausea	☐ Insomnia	☐ Lonely	☐ Worrying
☐ Sleepy	☐ Bored	☐ Apathetic	☐ Unloved	☐ Muscle pain	☐ Body pain
☐ Disoriented	☐ Dizziness	☐ I'm spinning	☐ world spinning	☐ Headaches	☐ Stomach pain
☐ Paranoid	☐ Alcohol use	☐ Drug use	☐ Narcotics	☐ Marijuana	☐ Low libido

Physician's Notes:

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Traumatic Brain Injury (TBI) Specific Event Reporting Form - 3

Name Today's Date

Please fill out one of these TBI Reporting Forms *for up to 3 of the most significant traumas that you sustained.*

This event happened in (year)_____, as a ☐Civilian, ☐ Soldier, ☐LawEnforcement, ☐Other_____, when I was_____years old:

☐	Car Accident (MVA)	☐	Blast Trauma	☐	Gun Fire	☐	Slip n Fall	☐	Stroke	☐	Assault
☐	Motorcycle (MCA)	☐	IED	☐	Sports (any)	☐	Cannon Noise	☐	Jet engines	☐	Shot Gun
☐	Bicycle (BCA)	☐	Fall from object	☐	Contact Sport	☐	Martial Arts	☐	Parachute	☐	Surgery
☐	Football	☐	Rugby	☐	Soccer	☐	Lacrosse	☐	Jujitsu	☐	MMA
☐	Wrestling	☐	Grappling	☐		☐		☐		☐	

1. With this injury I ☐Did NOT ☐DID have loss of consciousness lasting_____seconds/minutes/hours/days/weeks.
2. **With this injury I ☐Was NOT ☐Was** in a Coma for ___ hours/days/Weeks/months.
3. With this injury I ☐Did NOT ☐DID have loss of memory immediately before or after the incident.
4. With this injury I ☐Did NOT ☐DID have altered mental state at the time of the incident.
5. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **LESS**(<) than 24 hours.
6. With this injury I ☐Did NOT ☐DID have post-traumatic amnesia lasting **MORE**(>) than 24 hours.
7. I was taken to: ☐Home ☐Medical Clinic ☐ER ☐Hospitalized for ____hours/days/weeks. Glasgow Scale____
8. Radiologic Procedures: ☐CT-Scan ☐MRI ☐fMRI ☐SPECT ☐PET Scan ☐DTI-MRI
9. **These are my present symptoms**: (any adverse changes) :

☐ Angry	☐ Anger bouts	☐ Irritable	☐ Short temper	☐ Intolerant	☐ Aggressive
☐ Impatient	☐ Tense	☐ Excitable	☐ Hostile	☐ Defensive	☐ Demanding
☐ Mood swings	☐ Depression	☐ Sad	Grumpy	☐ Mean/hateful	☐ Withdrawn
☐ Memory loss	☐ Anxiety	☐ Nausea	☐ Insomnia	☐ Lonely	☐ Worrying
☐ Sleepy	☐ Bored	☐ Apathetic	☐ Unloved	☐ Muscle pain	☐ Body pain
☐ Disoriented	☐ Dizziness	☐ I'm spinning	☐ world spinning	☐ Headaches	☐ Stomach pain
☐ Paranoid	☐ Alcohol use	☐ Drug use	☐ Narcotics	☐ Marijuana	☐ Low libido

Physician's Notes:

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Confidential Health Questionnaire

Date: _____

Personal Information

First Name:	Last Name:	Age:	Gender:
Social Security Number: DO NOT ENTER	Date of Birth:	Marital Status:	Refferal Source:
Street Address:	Zip Code:	City:	State:
Best Contact Phone Number:	2nd Best Contact Phone Number:		
E-mail Address:	Preferred Method of Contact:	if Ok to Leave Message: ☐ Phone O Email	

Medical History

Please check any medical condition or health problem that you and your family currently have or have had in the past.

Medical Condition	Self		Family	
	Yes	No	Yes	No
Heart Attack				
Angina (Chest Pain)				
Palpitations				
Irregular Heart Rhythm				
Heart Failure (CHF)				
Heart Valve disorder				
Stroke				
Transient Ischemic Attack				
Vascular Disease				
Blood Clotting Problems				
Bleeding Disorder				
High Blood Pressure				
Diabetes Mellitus (DM)				
High Blood Sugar (100-125)				
Abnormal Cholesterol				
Obesity/Overweight				
Thyroid Disorder				
Shortness of Breath				
Asthma				
COPD				
Chronic Bronchitis				
Lung/Breathing Problems				
SleepApnea				
Pulmonary Hypertension				
Seizure Disorder				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Insomnia				
Dementia				
Liver Disease				
Gallbladder disease/stones				
Ulcers				
Colitis				
Chronic Constipation				
Chronic Diarrhea				
Kidney Disease or stones				
Chronic Indigestion				
GERD (Reflux Disease)				
Osteopenia or Osteoporosis				
Osteoarthritis				
Rheumatoid Arthritis				
Gout				
Chronic Muscle/Joint Pain				
Neck Pain				
Shoulder Problems				
Back Pain/Sciatica				
Herniated Disc				
Fibromyalgia				
Chronic Pain				
Tendonitis				
Cancer				
Recurrent sinus infections				

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Medical Condition	Self		Family	
	Yes	No	Yes	No
Migraines or Headaches				
Dizziness				
Loss of Consciousness				
Depression				
Anxiety				
Eating Disorder				
Emotional/Psychiatric Illness				
Alcohol Abuse				
Drug Abuse				

Medical Condition	Self		Family	
	Yes	No	Yes	No
Seasonal Allergies				
Eczema				
Psoriasis				
Skin Problems				
Sexual/Libido Problems				
Prostate Problems				
Reproduction Problems				
Sexually Transmitted Dx				

List any other medical conditions or health problems not listed above that you and your family currently have or have had in the past.

1)	2)	3)
4)	5)	6)

Please give detail of all PERSONAL medical conditions and health problems. write N/A if you do not have any medical problems

Medical Condition	Date of Diagnosis	Description
1)		
2)		
3)		
4)		

Please give detail of all FAMILY medical conditions and health problems. write N/A if there is no family history of medical problems

Medical Condition	Relation	Date of Diagnosis	Description
1)			
2)			
3)			
4)			

Allergies to Medications write N/A if No Known Drug Allergies

Medication Name	Reaction
1)	
2)	

Allergy to food, environmental, latex, etc. Write N/A if you do not have any allergies

Allergy to:	Reaction
1)	
2)	

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Medication & Supplement Lists

Anyone that is taking more than 4 prescription and/or supplements, please fill in the information below. In general, I am not a supporter of an excessive number of medications or supplements. Regarding any prescribed medication, it will be your responsibility to discuss modifications to their use with the healthcare provider that dispensed them to you. As for your existing supplementation, we use a very specific grouping of supplements to obtain our results. This is not to say that what you are presently using, upon entry into the Replenish Wellness Center Traumatic Brain Injury (TBI) Program, is useful or not. It is more to say that less is better. The chance that we will ask you to stop other non-essential supplements is very HIGH.

Finally, do not alter any of your medications or supplements prior to having your blood work drawn, especially pro-hormones and hormones. This can cause a misreading of the results.
***Past Medication:** Those medications you used within 6 months of your blood test but were taken off prior to your blood testing.

Name: Date:

Present Medication	Dose and Frequency	Present Medication	Dose and Frequency
*Past Medication	Dose and Frequency	*Past Medication	Dose and Frequency
Supplement	Dose and Frequency	Supplement	Dose and Frequency

Thank you,
James D. Thacker, M.D.

Contact for any questions: SandraT@ReplenishWellnessCenter.com

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Please list prescription medications currently being used.

○ Check if you are not using prescription medications

Medication Name	Dosage and Frequency	Date Started	Reason for Use
1)			
2)			
3)			
4)			

Please list prescription medications used in the last year which you are no longer using. Start with the medications which were most recently stopped.

○ Check if you haven't used prescription medications in the past

Medication Name	Dosage and Frequency	Date Started	Date Stopped	Reason Used
1)				
2)				
3)				
4)				

Please list supplements and over-the-counter medications currently being used.

○ Check if you are not using supplements and over-the-counter medications

Medication Name	Dosage and Frequency	Date Started	Reason for Use
1)			
2)			
3)			
4)			

Please list all past SURGERIES.

Check if you have not had surgery in the past ○

Surgery	Date of Surgery	Reason for Surgery
1)		
2)		
3)		
4)		

Personal & Social History.

Occupation:	Employer:	Stress Level at Work (1O=highest)	Describe Work Stressors:
Marital Status:	# Living Children:	Stress Level at Home (1O=highest)	Describe Home Stressors:

Use of Alcohol: ○ Yes ○ No	Type of Alcohol:	Amount:	Start Date:	Stop Date:	Duration:
Tobacco: ○ Yes ○ No	Cigarettes/day :	Other Tobacco:	Start Date:	Stop Date:	Duration:

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Street Drug Use: ○ Yes ○ No	Type of Drug:	Amount:	Start Date:	Stop Date:	Duration:
Sexually Active: ○ Yes ○ No		# of Partners:	Unprotected Sex: ○ Yes ○ No	Contraception:	Duration:
Hobbies/Interests:					

0b/Gyn History (Female patients)			
Last Menstrual Period:	Age During Onset of 1st Period:	PMS Symptoms:	Cycle Duration:
Check if you have any of the following: O Heavy Bleeding O spotting O Painful or Irregularity		Describe:	
Are you pregnant: ○ Yes ○ No	Are you breastfeeding: ○ Yes ○ No	Are you trying for a pregnancy: ○ Yes ○ No	

#of Pregnancies:	Vaginal:	C-section:	Miscarriages :	Abortions:	Other Complications:

Review of Systems

Please check YES to any symptom that you experience. For any YES answer please provide a brief description

Symptoms	YES	NO	If YES List Doctor Seen, Describe Condition and How Long
Fever/Chills			
Execess Fatigue			
Weight Loss/Gain			
Enlarged Lymph Nodes			
Frequent Bruising			
Blurry Vision			
Ringing in Ears			
Hearing Difficulty			
Mouth Sores			
Sinus Problems			
Cardiovascular:			
Chest Pain at Rest or Exercise			
Cold hands/Cold Feet			
Swelling of Legs			
Gastrointestinal:			**# Bowel Movement /Day** | |
Constipation			
Diarrhea			
Bloating			
Exessive Belching			
Gas/Acidity			
Blood in Stool			
Thirst: Lack of /Too Much			**# Glasses of Fluid/Day** | |
Genitourinary:			
Pain on Urination			
Cloudy/Bloody Urination			
Urinating Too Many Times			**# Times per Day** | |
Difficulty Urinating			
Loos of Urine			

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Musculoskeletal:	**If YES. please Rank PAIN Severity**
Do you see a Chiropractor?	
Any Regular Body Treatment Massage?	
Back Pain	
Neck Pain	
Shoulder Pain	
Arm Pain	
Hip Pain	
Knee Pain	
Other pain	
Muscle Point Tenderness (pis. Describe)	
Skin:	
Acne	☐ ☐
Dry Skin	☐ ☐
Oily skin	☐ ☐
Loss of Collagen/Firmness	
Wrinkles	
Pigmentation/Scarring	
Any History of Skin Cancer?	
Do you Wear Sunblock?	
After Sun Exposure, Do you (Check):	
Cellulite	
Questions on Aesthetic Services: Botox, Juvéderm or Lasers?	
Interest in Skin Care Consultation?	
Emotional:	
Do you See Counselor or Psychiatrist?	
Depression	
Anxiety	
Stress	

FEMALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Loss of energy/fatigue				
Loss of sex drive/orgasm				
Fat gain				
Muscle weakness/loss				
Difficulty Sleeping				
Anxiety/Nervousness				
Irritability				
Depression/Emotional Swings				
Decline in Memory				
Decline in Concentration				
Hot Flashes				
Night Sweats				
Vaginal Dryness				

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FEMALE Patients

Symptoms	Severity	Date Started	Frequency	Describe
Vaginal Dryness				
Urine Leakage				
Dry Skin/Wrinkles				
Dry Hair				
Hair Loss				
Muscle and Joint Paint				
Loss of Pubic Hair				
Food Cravings				
Sugar Cravings				
Salt Cravings				
List any other Symptoms				
1)				
2)				
3)				

MALE Patients

Symptoms	**Severity**	Date Started	Frequency	Describe
Loss of Energy/Fatigue				
Loss of Motivation				
Loss of Confidence				
Loss of Sex Drive/Orgasm				
Difficulty Maintaining Erection				
Difficulty Achieving Erection				
Premature Ejaculation				
Fat Gain				
Muscle Weakness/Loss				
Difficulty Sleeping				
Anxiety/Nervousness				
Irritability				
Depression/Emotional Swing				
Decline in Memory				
Decline in Concentration				
Urine Leakage				
Dry Skin/Wrinkles				
Dry Hari				
Hair Loss				
Muscle and Joint Pain				
Loss of Pubic Hair				
Food Cravings				
Sugar Cravings				
Salt Cravings				
List any other Symptoms				
1)				
2)				
3)				

Your signature below attests that you have been truthful and have completed this health questionnaire to the best of your ability.

Signature: _____

Print Name: _____

Date: _____

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Pre-Treatment Questionnaire - 1

Name: _____ Date: _____

Please evaluate your feelings about your health on each of the following categories. Check (use a check mark) the number that corresponds to your self-assessment, where the range is from: 10 = excellent to 1 = very poor

	←Excellent									Very Poor →
	10	9	8	7	6	5	4	3	2	1
Muscle Strength										
Muscle Size										
Recovery time following exercise										
Joint Flexibility										
Ability to tolerate exercise										
Endurance										
Overall Energy										
Percent Body Fat										
Absence of fat deposits										
Lean Body Mass										
Metabolism										
Skin thickness										
Skin texture										
Skin oiliness										
Skin elasticity										
Lack of wrinkles										
Hair growth rate										
Hair retention										
Hair color retention										
Hearing										
Vision										
Healing of injuries										
Resistance to disease										
Freedom from allergies										

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Pre-Treatment Questionnaire - 2

Name: _____ Date: _____

	←Excellent									Very Poor →
	10	9	8	7	6	5	4	3	2	1
Sexual desire										
Genital function										
Frequency of urination										
Frequency of nighttime urination										
Regular bowel movements										
Lack of inappropriate sweating or chills										
Healthy appetite										
Control of eating										
Ability to sleep										
Feeling rested in the morning										
Mental Energy										
Emotional stability										
Social interactions										
Memory										
Concentration										
Feeling of well-being										
Attitude toward life										

DO NOT fill out this portion			
Condition	Suggested	ICD-10	Supported
Hypogonadism			
Primary Ovarian Failure			
Central Hormonal Deficiency			
Depression – Hormonal			
Adult GH Insufficiency			
Traumatic Brain Injury			

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Hormonal Imbalances in the brain can cause symptoms that can present in one or more of the following manners. Please check off accordingly with:

0 = Never, 1 = 25%, 2 = 50%, 3 = 75%, and 4 = 100% of the time.

Name: _____ Date: _____

How often do you feel:	0 Never	1 25%	2 50%	3 75%	4 100%	Comments
1. Angry						
2. Fatigued						
3. Impatient						
4. Blaming						
5. Dissatisfied						
6. Moody/Grumpy						
7. Fearful						
8. Discontented						
9. Hypersensitive/Easily Annoyed						
10. Mentally exhausted						
11. Bored						
12. Aggressive						
13. Unloved						
14. Unappreciated						
15. Tense (anxious)						
16. Touchy						
17. Unloving						
18. Lonely						
19. Hostile						
20. Overwhelmed						
21. Destructive						
22. Demanding						
23. Frustrated						
24. Withdrawn/detached						
25. Mean						
26. Sad (depressed feeling)						
27. Scared						
28. Numb/insensitive						
29. Explosive						
30. Defensive						
31. Denies Problems						
32. Self-Critical						
33. Troubled						
34. Desire to Over-eat						
35. Drug or Alcohol Use						
36. Excitable						
37. Withdrawn into TV						
38. Overworked						
39. Sleep more						
40. Impulsive						
41. Worried						
42. Argumentative						
43. Sarcastic						
44. Jealous						
45. Uncommunicative						

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Notice of New HIPAA Guidelines

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your periodical medical reports:

I wish to be contacted in the following manner(s):
(Check off all that apply)

√	Home Phone:	√	Mobile Phone:
	Leave message with detailed information here.		Leave message with detailed information here.
	Leave message with callback number only.		Leave message with callback number only.
	Email Report		Written Communications
	Leave message with detailed information here.		Please continue to send to my home
	Send all reports by email when they are available.		
	I also authorize you to be able to speak with my physicians or family member listed here:		

Patient's Signature and Date

Printed Name and Date of Birth

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Guarantee of Results

Traumatic Brain Injury (TBI)

Initials

I, _____, have had the opportunity to discuss the potential benefits and risks of a hormone replacement/supplementation Program with my physician: Dr. James D. Thacker, M.D. _____

It is my clear understanding that there are no guarantees as to the ultimate outcome and benefits that I will personally glean from being placed on a Treatment Protocol addressing both insufficiencies and deficiencies of my neurosteroids and neuroactive steroids as defined by laboratory testing with Replenish Wellness Center. _____

I understand that results are unpredictable and vary from person to person and that my chances of having the results that I am looking for will be based upon the following:

1. Adhering to the nutritional supplementation, dietary recommendations, and hormonal replacement strategies as directed by Dr. Thacker; _____
2. Following the timing of the recommended office visits with/without laboratory testing; _____
3. Adverse influences of opioids, narcotics, psychotropic medication, alcohol, and other medications and drugs. _____

It is my full understanding that the chances of obtaining the outcome that I am looking for is greatest when I follow these recommendations although; I have not been given any guarantees. _____

I understand that regardless of the results that prior patients have attained, I was never given any guarantee that I will achieve the same responses. _____

I have performed my own due diligence as well as I have had the opportunity to speak with the office regarding getting any additional questions answered. I thereby understand and accept the possibility that I will not fully recover from my condition or symptoms that I am looking to obtain. _____

Printed Name: _____

Signature: _____ Date: _____

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Consent to Medical Care & Treatment

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned treatment. You have received over one hour of specific education regarding the proposed hormonal treatment based upon your assessment. We have reviewed benefits and risks. You have had an opportunity to ask questions and to request additional information.

I authorize **James D. Thacker, M.D.** and such physicians, associates, assistants, and other personnel of the Replenish Wellness Center, to perform the following: **Hormonal Assessment and Treatment,** and/or do any other procedure that in his judgment may be advisable to my well-being, including such procedures as are considered medically advisable to obtain the maximal benefits with the least risks in regards to the above proposed program of Hormonal Replacement Therapy.

_____ GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the Treatment, which have been described and I have discussed with Dr. Thacker.

_____ SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this treatment protocol/program as described by Dr. Thacker which included: Risks of breast and prostate cancer in association with the use of Testosterone, Estrogens, and Growth Hormone. Weight gain, increased muscular mass, decreased body fat, hair growth, change in hair color, hypoglycemia, disclosure of latent diabetes, transient fluid retention, carpal tunnel syndrome, transient joint pain, headaches, and death.

_____ ALTERNATIVE TREATMENT: I am satisfied with my understanding of alternative treatments and their possible benefits and risks including: **Testosterone Injections, Oral Estrogen/Progesterone replacement, Topical Testosterone, Estrogen, Progesterone replacement or sublingual Testosterone replacement, Isoflavones, Vitamin and mineral replacement.**

_____NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes, or risks if no treatment is rendered.

_____SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment from another physician with credentials from the A4M or any physician of my choosing.

_____LIMITATION OF MEDICAL CARE: I understand that the Replenish Wellness Center, Dr. James Thacker, is providing specific hormonal treatment and protocol and that he is not taking responsibility for any other aspect of my ongoing medical health. **My personal physician shall continue to provide all of my standard and continuous medical care. I hereby authorize Dr. Thacker to speak directly with my Primary Care Physician when medically necessary regarding my past and present medical care and treatment.**

_____OTHER QUESTIONS: I am satisfied with my understanding of the nature of the treatment and all of my additional questions about the treatment have been answered.

Signature: _____

Date: _____ Time: _____AM/PM

Primary Physician: _____ Telephone #: _____

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Medical Services Agreement (Medicare)

_____(PATIENT) and(Physician) James D. Thacker, M.D., hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT acknowledges and agrees that this agreement has been entered into before the PHYSICIAN has provided the services specified herein to the PATIENT.

2. The Replenish Wellness Center and its PHYSICIANS are only responsible for the evaluation and prescription of hormone replacement therapy when indicated by appropriate laboratory testing. All laboratory tests can be billed separately by the laboratory performing those services or else the patient May request to pay a discounted fee.

3. The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.

4. The services to be provided to the PATIENT consist of performing diagnostic tests and providing assessment of their chemical and hormonal status. All laboratory tests have an interpretation fee and report fee added to their cost.

5. **[★]* The PATIENT agrees not to request that a health insurance claim form be submitted in their behalf under the Social Security Act (MEDICARE) for the services, even if such services are otherwise covered under health insurance or MEDICARE.**

6. **The PATIENT agrees to be responsible for the SERVICES.** Although hormone replacement therapy is medically beneficial, insurance companies have not yet accepted this position. At this point in time, neither insurance companies nor MEDICARE will reimburse for preventive care or anti-aging/hormone-balancing replacement therapy. As a result of this, medical records will not be provided to any insurance company or MEDICARE. The United States Department of Health and Human Services, Office of Inspector General take the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this, **it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity**. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government. Even though the use of human growth hormone in adults has been approved by the Food and Drug Administration, it has not been recognized by the Federal Government as "medically necessary" and therefore, could, be interpreted as fraudulent.

7. The PATIENT acknowledges that health insurance companies or "Medigap plans" (42 U.S.C., section 1882) will not provide reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a - 1848g) **will** apply to the amounts PHYSICIANS charge for their SERVICES.

8. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.

9. [ ]* **By signing this agreement, the PATIENT understands that they are foregoing their rights to receive insurance/MEDICARE benefits for the SERVICES, but that PATIENT is not forfeiting all health insurance benefits for other services from other health insurance/MEDICARE providers.**

Patient's Signature _____ Date: _____

Physician Signature _____ Date: _____

Witness Signature _____ Date: _____

***** An additional Medicare Contract will be needed for any person who is receiving any financial assistance from Medicare or is of age to receive benefits from Medicare.**

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Reimbursement of Testimony & Subpoena Costs

After reviewing literature on your services involving the diagnosis and treatment of hormone related dysfunction, secondary to neurotrauma, I would like to be evaluated to determine if I am suffering from symptoms caused by a previous or recent injury. You have informed me that you will not agree to accept my case unless I agree to reimburse you for certain expenses that may result from participation in the evaluation of my case; (i.e. personal injury, social security claim, disability claim, insurance claim, etc.).

This document acknowledges that you are not being retained as an expert witness or will be used as one, but that your services for me are as a physician and care giver.

I understand that the evaluation of my case and myself may cause you to be called upon either voluntarily or by subpoena to testify or provide evidence regarding your evaluation (reports, copies of medical records, etc.). I understand that in so doing, you will expend time and incur costs in preparing to give testimony, giving testimony, preparing and producing documentation and possibly retaining counsel to assist you. Therefore I agree as follows:

1. I agree not to designate you as an expert witness in my medical case.
2. I agree that if you are required to either voluntarily or by subpoena to testify or provide evidence regarding your evaluation, I shall compensate you with the following amounts which shall be in addition to your standard fees in your capacity as my consulting physician:
    a. $500 per hour for any time spent in consulting with you or counsel;
    b. $5,000/day for any deposition or testimony I am required to provide in your case regardless of whether I am testifying voluntarily or subject to subpoena.
    c. Reimbursement for Business Class travel, hotel accommodations and food.
3. All payments and travel arrangements shall me paid and arranged in advance.
4. I shall reimburse you reasonable attorneys' fees if you determine it necessary to retain your own counsel to represent you.

By signing below I agree to the above referenced terms.

Name: _____

Signature:_____Date: _____

If you are actively involved in a legal proceeding, please have your attorney review this document and provide the following information:

_____

Attorney name, signature, contact phone number or email

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Informed Consent for Telemedicine Services – Page 1

Patient Name:			Date of Birth:	Medical Record:
Patient Address:	City:	State:	Zip:	Date Consent Discussed:
Physician Name:			Location:	
Consultant Name:			Location:	
Consultant Name:			Location:	

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____

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Informed Consent for Telemedicine – Page 2

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. James D. Thacker, M.D. has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform James D. Thacker, M.D. of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in the course of my diagnosis and treatment.

I hereby authorize James D. Thacker, M.D., to use telemedicine in the course of my diagnosis and treatment.

_____ _____

PATIENT'S SIGNATURE **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

_____

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

_____ _____

WITNESS **DATE**

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

I have been offered a copy of this consent form. _____(Patient's Initials)