TOTAL ⚜ HEALTH

Physical Medicine & Wellness

821 N. Nolan River Rd. • Cleburne,76033 • Phone (817) 556-2000 • Fax (817) 556-2031

PATIENT INFORMATION TODAY'S DATE: _____ DATE OF INJURY (DOI): _____

PATIENT NAME: _____ GENDER: Male ☐ Female ☐

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MAIN PHONE #: _____ ☐ Home ☐ Cell ☐ Other: _____

ALTERNATE PHONE #: _____ ☐ Home ☐ Cell ☐ Other: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ AGE_____ SOCIAL SECURITY #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: _____

POLICY NUMBER: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER SOCIAL #: _____

POLICY HOLDER DOB: _____

SECONDARY INSURANCE NAME: _____

POLICY NUMBER: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER SOCIAL #: _____

POLICY HOLDER DOB: _____

WORKER'S COMPENSATION INSURANCE CARRIER INFORMATION:

EMPLOYER: _____ SUPERVISOR: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ PHONE #: _____ FAX #: _____

INSURANCE NAME: _____ CLAIM #: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE #: _____

ADJUSTOR: _____

ATTORNEY INFORMATION (IF APPLICABLE):

ATTORNEY NAME: _____

TEL#: _____ FAX #: _____

PATIENT SIGNATURE: _____ *DATE:* _____

Name: _____ Date: _____

Quantitative ADAM Questionnaire

Question	Y	N
1. Do you have a decrease in libido (sex drive)?		
2. Do you have a lack of energy?		
3. Do you have a decrease in strength and/or endurance?		
4. Have you lost height?		
5. Have you noticed a decreased "enjoyment in life"?		
6. Are you sad and/or grumpy?		
7. Are your erections less strong?		
8. Have you noticed a recent deterioration in your ability to play sports?		
9. Are you falling asleep after dinner?		
10. Has there been a recent deterioration in your work performance?		

Patient signature: _____

Office Use Only

Total Score: ____/50 Testosterone level:_____

Is this the initial ecaluation? Y or N

IF no, what was the initial qADAM score? ____/50 Initial Testosterone:_____

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Name: _____ Sex: M or F Date of Birth:_____ Today's Date: _____

If MALE select all that apply:

- ☐ Erectile dysfunction
- ☐ Low testosterone
- ☐ Male infertility
- ☐ Low sex drive
- ☐ Family hx of prostate cancer
- ☐ Personal hx of prostate cancer

If FEMALE, select all that apply:

- ☐ Menstrual irregularities
- ☐ Absence of menstruation
- ☐ Pre-menopausal
- ☐ Menopausal/Perimenopausal
- ☐ History of hysterectomy
- ☐ Infertility
- ☐ Low sex drive
- ☐ Pregnant

Personal Medical History (Please select all that apply)

- ☐ Taking medication
- ☐ Use of vitamin supplement
- ☐ Bruise easily
- ☐ Cold hands/feet
- ☐ Wake up feeling tired
- ☐ Lack of energy
- ☐ Feeling uneasy/out of sorts
- ☐ Feeling weak
- ☐ Chronic Pain
- ☐ Headaches
- ☐ Feeling dizzy
- ☐ Get sick easily ☐ Cough/cold
- ☐ Hypothyroidism
- ☐ Thyroid issues
- ☐ Family history of thyroid disorder
- ☐ Hormonal issues
- ☐ Weight gain
- ☐ Weight loss
- ☐ Inability to lose/gain weight
- ☐ Increased appetite
- ☐ Low appetite
- ☐ Feeling anxious
- ☐ Feeling depressed
- ☐ Excessive sweating
- ☐ Hair loss
- ☐ Use of tobacco
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Family history of diabetes
- ☐ Elevated glucose/prediabetes
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Personal History of Stroke
- ☐ Personal History of Heart Attack
- ☐ Metabolic Syndrome
- ☐ Family history of heart disease
- ☐ Chest pain
- ☐ Shortness of breath

Please list any other conditions you may have:

_____

_____

Please list medications you are currently taking:

_____

_____

Patient Signature: _____ **Date:** _____

Physician Signature _____ **Date:** _____