BALLEN MEDICAL & WELLNESS

Integrative Medicine New Patient Intake Form

Appointment Date: ____________________

Patient Name: ________________________________ Date of Birth: ______________ Age: ________

Biological Sex: ☐ M ☐ F Preferred Pronouns: ______________ Patient's SSN: ____________________

Address: ____

City: ____ State: ______________ Zip: _______________

Home Phone: ________________________________ Cell Phone: ___________________________________

Email Address: ____

Best way to reach you: ☐ Email ☐ Home Phone ☐ Cell Phone

Can we contact you by email? ☐ Y ☐ N Can we contact you by text? ☐ Y ☐ N

Current Height: ______________________________ Current Weight: ______________________________

Occupation: __________________________________ Hours worked/week: ___________________________

Marital Status: ______________________________ Spouse's Name: _______________________________

Patient Emergency Contact:

Name: ____ Phone: _______________________________

Relation: ____________________________________

IMPORTANT: Please submit a release of information located on page 21 if any of the below apply to you.

- **It is a requirement of the office that you have a primary care physician. If you do not have one, we are happy to provide you with a referral.**
  - **If you do have a primary care physician, please fill out the Release of Information.**
- **Significant medical history including, but not limited to, cardiac, Lyme, mold, autoimmune, infections, thyroid, diabetes, psychiatric disorders.**
- **Previous treatment from another provider for conditions listed above.**

It is imperative we get medical records prior to your appointment, please return your completed paperwork as soon as possible so we may request and receive your medical records prior to your appointment.

Appointment Reminders: Ballen Medical & Wellness' EMR (Electronic Medical Records System), initiates appointment reminder notices via email and/or text 4 days prior to your scheduled appointment.

Insurance Information: Ballen Medical & Wellness is not contracted with any medical insurances, however there are instances where we may require your insurance information (i.e. Lab Orders, Prescription Prior Authorizations, Insurance calls for submitted superbills).**

Insurance Carrier: ___________________________ Insurance Phone Number: ______________________

Subscriber Name: _____________________________ Subscriber Date of Birth: _____________________

Subscriber ID #: _____________________________ Subscriber SSN: ______________________________

Group #: ____________________________________ Relation to Subscriber: _______________________

Primary Care Provider:

Provider Name & Practice Name: ______________________________

Practice Address: ______________________________

Provider Phone Number: ______________________________

Additional Provider(s):

Provider Name: ____________________ Provider Name: ____________________

Address: ____________________ Address: ____________________

Phone Number: ____________________ Phone Number: ____________________

Psychotherapy/Talk Therapy Provider:

Provider Name: ______________________________

Provider Phone Number: ______________________________

Provider Address: ______________________________

Medical History:

Allergies and Sensitivities:

Any know allergies (medication/supplements/food/environment)? Reaction:____________________

____

Do you have a latex allergy? If yes, reaction: ______________________________

____

Any reaction to local anesthesia? If yes, please explain______________________________

____

Medical Illnesses:

- ☐ High blood pressure
- ☐ Heart bypass
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Stroke and/or heart attack
- ☐ Blood clot, DVT and/or a pulmonary embolism
- ☐ Heart arrhythmia or atrial Fibrillation
- ☐ Hemochromatosis
- ☐ Any form of hepatitis or HIV
- ☐ Lupus or other autoimmune disease
- ☐ Frequent blood donation or history of anemia
- ☐ Fibromyalgia
- ☐ Chronic kidney disease
- ☐ Dialysis
- ☐ Sleep apnea
- ☐ Chronic liver disease (Hepatitis, fatty liver, cirrhosis)
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Depression/anxiety
- ☐ Psychiatric disorder
- ☐ Cancer (type): ____________ Year: ____________

Current Medical Diagnosis: Please feel free to include a longer list if needed.

Diagnosis	Diagnosis Date	Diagnosing Provider

Past Medical Diagnosis: Please feel free to include a longer list if needed.

Diagnosis	Treatment Dates

Hospitalizations (not including surgeries or births): ☐ None

Date	Duration of Hospitalization	Reason

Surgeries: ☐ None

Date	Surgery

NOTE: Please feel free to attach a list of your medications or supplements if you need more space.

Medications:

Please list **ALL** current prescription(s) and Over the Counter medications. Include current hormone replacement therapy:

Medication	Dose	Frequency	Start Date	Purpose

Past Hormone Replacement Therapy: ______________________________

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy):

Supplement	Brand	Dose	Frequency	Start Date	Reason for Use

What do you hope to achieve with us? ____

____

____

Top 3 most bothersome problems?

1. ____
2. ____
3. ____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When was the last time you felt well? ____

Did something trigger your change in health? ____

What makes you feel worse/better? ____

Preventative Test & Date of Last Test	**Date**		**Date**
Full physical exam (including GYN for females)	________	Upper Endoscopy	________
Colonoscopy	________	Upper GI Series	________
Cardiac stress test	________	Ultrasound	________
EKG	________	Digital Rectal Exam	________
Hemoccult Test – stool test for blood	________	Mammogram: ☐ Normal ☐ Abnormal	________
MRI	________	Pap smear: ☐ Normal ☐ Abnormal	________
CT Scan	________	Bone scan: ☐ Normal ☐ Low	________

Injuries:

Please explain: ____

Antibiotic use as a child: ☐ 0 times a year ☐ 1-2 times a year ☐ More than 3 times a year ☐ Unknown

Medical History Comments: ____

____

____

Roles/Relationships:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widowed ☐ Living with partner

Gender (biological sex) of sexual partner(s): ☐ Male ☐ Female

Are you satisfied with your sex life? ☐ Yes ☐ No

Family Members/People Living in Your Household

Name	Relation	Age	Gender	Occupation

Total number living in household: _____

Resources for emotional support (check all that apply):

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _________________

Dental History:

Do you have a dentist? ☐ Yes ☐ No

Name of Dentist: ____________________________________ Date of last dental exam: ________________

Check all that apply:

- ☐ Silver mercury fillings
- ☐ Gold fillings
- ☐ Root canals
- ☐ Implants
- ☐ Tooth pain
- ☐ Bleeding gums
- ☐ Gingivitis
- ☐ Problems w/chewing

Do you floss regularly? ☐ Yes ☐ No

Nutrition History:

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

How often to you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you avoid any particular food/follow a special diet? ☐ Yes ☐ No

The most important thing I should change about my diet to improve my health is: ______________________________

____

List the three worst foods you eat in a week.	List the three best foods you eat in a week.
1. ______________________	1. ______________________
2. ______________________	2. ______________________
3. ______________________	3. ______________________

Smoking/Tobacco:

☐ Currently smoking cigarettes or cigars _____/day
☐ Previous smoker
☐ Secondhand smoke exposure

Alcohol Intake:

How many drinks currently per week? (1 drink = 5 oz. wine, 12 oz. beer, 1.5 oz. spirits)
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10

Previous alcohol intake? ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you ever take a drink to get going when you wake? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Other Substances:

Caffeine intake: _____ cups per day ____ ounces per day _____ energy drink per day

Are you currently using recreational drugs? ☐ Yes ☐ No

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

Marijuana: ☐ Smoke ____ ounces ____ times per day ☐ Edibles ____ mg ____ times per day

Exercise:

Type	Frequency

Any problems that limit activity? ☐ Yes ☐ No

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

Do you usually sweat when exercising? ☐ Yes ☐ No

Psychosocial:

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Have you experienced major losses or life stressors recently in your life? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

How often do you laugh? _____ times a day Do you have a spiritual practice? ☐ Yes ☐ No

What brings joy to your life? How do you nurture yourself? ____

____

Is sexual abuse/molestation and/or physical violence an issue to discuss? ☐ Yes ☐ No

Exposure:

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic radiation ☐ Mold?

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Do you have a known history of significant exposure to any harmful chemicals such as the following?

☐ Herbicides/Pesticides ☐ Insecticides (frequent visits of exterminator)

☐ Heavy metals ☐ Organic solvents ☐ Tick bite

☐ Water damaged buildings ☐ Other: ____________________________________

Stress/Coping:

Are you currently in therapy? ☐ Yes ☐ No Have you ever sought counseling? ☐ Yes ☐ No

Do you currently have excessive stress? ☐ Yes ☐ No

Daily stressors-scale of 1-10:

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No

What do you do to cope with stress? ____

____

Sleep/Rest:

Average number of hours you sleep per night: ☐ > 10 ☐ 8-10 ☐ 6-8 ☐ < 6

Do you have trouble falling asleep? ☐ Yes ☐ No Do you have trouble staying asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No Do you use sleeping aids? ☐ Yes ☐ No

Family History:

Check family members that apply.

Enter ages and conditions for multiple family members of the same relation in the same column.

M = Mother F = Father B = Brother S = Sister C = Child
Ma = Maternal Pa = Paternal Gma = Grandmother Gpa = Grandfather A = Aunt
U = Uncle

	M	F	B	S	C	Ma Gma	Ma Gpa	Pa Gma	Pa Gpa	A	U
Age (if still alive)	____	____	____	____	____	____	____	____	____	____	____
Age at death	____	____	____	____	____	____	____	____	____	____	____
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Testicular cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer: ____________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis Rheumatoid, Psoriatic, Ankylosing Spondylitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto Immune disease ____________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory bowel disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food allergies or intolerances	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Environmental sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia/Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Motor Neuron diseases (ALS)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse (alcohol or drugs)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

M = Mother F = Father B = Brother S = Sister C = Child
Ma = Maternal Pa = Paternal Gma = Grandmother Gpa = Grandfather A = Aunt
U = Uncle

	M	F	B	S	C	Ma Gma	Ma Gpa	Pa Gma	Pa Gpa	A	U
Environmental toxins	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mold	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lyme disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
*Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
*Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
*ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
*Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
*Bipolar	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you checked any boxes on the last 5 items that have a * beside them, please explain. ______________________

____

____

Male Reproductive Health

☐ Decreased libido
☐ Inability to concentrate/mental fatigue
☐ Muscle soreness
☐ Decrease physical stamina
☐ More emotional than past
☐ Elevated PSA
☐ Vasectomy
☐ BPH or prostate enlargement
Year: _________ (estimate if unknown)
☐ Unexplained weight gain/Increased abdominal fat/fat distribution around chest/hips

Female Reproductive Health

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe Last menstrual period _____________

Pregnancies ________ Caesarean ________ Breastfeeding (# mo.) ________
Miscarriage ________ Gestational Diabetes ________ Postpartum Depression ________
Abortion ________ Preeclampsia ________ Living children ________
Vaginal deliveries ________ Baby over 8 pounds ________

Type of contraception/birth control method:
☐ Birth control pills ☐ IUD ☐ Oophorectomy (removal of ovaries)
☐ Tubal ligation ☐ Vasectomy ☐ Infertility
☐ Menopause ☐ Hysterectomy (removal of ovaries)
☐ Partial hysterectomy (uterus only)?
☐ Other: ____

Age of first period __________ Menses frequency _______ Length of Period________

Check all that apply.

Female Reproductive

- ☐ Breast cysts/lumps
- ☐ Breast tenderness
- ☐ Mood swings
- ☐ Ovarian cyst(s)
- ☐ Vaginal discharge
- ☐ Vaginal pain w/sex
- ☐ Vaginal odor/itch
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Fibrocystic breasts
- ☐ Loss of control of urine
- ☐ Joint pains
- ☐ Breast biopsy
- ☐ Palpitations
- ☐ Concentration/memory problems
- ☐ Infertility
- ☐ Polycystic ovaries (PCOS)
- ☐ Epilepsy/seizures
- ☐ Weight gain
- ☐ Decreased libido
- ☐

Premenstrual

- ☐ Bloating/breast tenderness
- ☐ Decreased/increased sleep
- ☐ Diarrhea
- ☐ Constipation
- ☐ Facial hair growth
- ☐ Irritability or depression
- ☐ Fatigue
- ☐ Acne
- ☐ PMS

Menstrual

- ☐ Cramp
- ☐ Heavy periods
- ☐ Irregular periods
- ☐ No periods
- ☐ Scanty periods
- ☐ Spotting between
- ☐ Breast pain
- ☐ Pelvic pain
- ☐ Painful periods
- ☐ Menstrual migraines

Menopausal Females only

- ☐ Hot flashes
- ☐ Mental fogginess
- ☐ Disinterest in sex
- ☐ Mood swings
- ☐ Depression
- ☐ Painful intercourse
- ☐ Shrinking breasts
- ☐ Facial hair growth
- ☐ Acne
- ☐ Increased vaginal pain
- ☐ Increased vaginal dryness
- ☐ Increased vaginal itching
- ☐ Hormone Replacement Therapy
- ☐ Uterine bleeding after menopause

Adrenal Fatigue Screening

- ☐ Difficulty getting up in the morning
- ☐ Continuing fatigue not relieved by sleep
- ☐ Craving for salt or salty foods
- ☐ Lethargy (lack of energy)
- ☐ Increased effort to do everyday tasks
- ☐ Decreased sex drive
- ☐ Decreased ability to handle stress
- ☐ Increased time to recover from illness, injury, or trauma
- ☐ Light-headed when standing up quickly
- ☐ Mild depression
- ☐ Less enjoyment or happiness with life
- ☐ Increased PMS
- ☐ Thoughts less focused, thoughts fuzzier
- ☐ Symptoms increase if meals are skipped/inadequate
- ☐ Memory less accurate
- ☐ Decreased Tolerance for frustrating situations/people
- ☐ Don’t really wake up until 10 am
- ☐ Decreased energy between 3 pm and 4 pm
- ☐ Increased energy in the evening
- ☐ Decreased productivity

GI (Gastrointestinal) History:

Have you ever been diagnosed with IBS (irritable bowel syndrome)? ☐ Yes ☐ No

Have you ever been diagnosed with GERD (Gastroesophageal reflux disease)? ☐ Yes ☐ No

Digestion

- ☐ Bad teeth
- ☐ Bleeding gums
- ☐ Canker sores
- ☐ Cold sores
- ☐ Cracking at corner of lips
- ☐ Dentures w/poor chewing
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Coated tongue/fuzzy debris
- ☐ Heartburn
- ☐ Use antacids
- ☐ Intolerance to gluten (wheat, rye)
- ☐ Intolerance to corn
- ☐ Intolerance to fatty foods
- ☐ Pain after eating
- ☐ Bloating of whole abdomen
- ☐ Vomiting
- ☐ Lower abdominal pain
- ☐ Indigestion & fullness last 2-4 hours after eating
- ☐ Feel like you digest your food well
- ☐ Abnormal liver function tests
- ☐ Excess flatulence/gas
- ☐ Cramp
- ☐ Diarrhea
- ☐ Alternating diarrhea & constipation
- ☐ Feeling bowels do not empty completely
- ☐ Hemorrhoids
- ☐ Fissures
- ☐ Blood in stools
- ☐ Clay colored stools
- ☐ Greasy stools
- ☐ Use laxatives
- ☐ Burping
- ☐ Foods "Repeat" (Reflux)
- ☐ Indigestion
- ☐ Intolerance to lactose
- ☐ Intolerance to greasy/high fat goods
- ☐ Intolerance to eggs
- ☐ Intolerance to yeast
- ☐ Bloating of lower abdomen
- ☐ Nausea
- ☐ Upper abdominal pain
- ☐ Hungry 1-2 hours after meal
- ☐ Sense of fullness after meals
- ☐ Liver disease/Jaundice
- ☐ Anal spasms
- ☐ Gas
- ☐ Constipation
- ☐ More than 3 bowel movements per day
- ☐ Foreign travel
- ☐ Other: ____________________

Symptom Questionnaire:

Please check all current symptoms occurring or present in the past 6 months.

General

- ☐ Cold hands & feet
- ☐ Low blood pressure
- ☐ Early waking
- ☐ Fever
- ☐ Cold/heat intolerance
- ☐ Daytime sleepiness
- ☐ Fatigue
- ☐ Flushing/sweating no reason
- ☐ Difficulty falling asleep
- ☐ Insomnia
- ☐ Night waking/sweats
- ☐ Nightmares

Head, Eyes and Ears

- ☐ Ear fullness
- ☐ Hearing loss
- ☐ Migraine
- ☐ Distorted sense of smell or taste
- ☐ Ear pain
- ☐ Sensitivity to loud noises
- ☐ Ear ringing or buzzing
- ☐ Eye pain
- ☐ Headaches
- ☐ Vision problems (other than glasses)
- ☐ Ever been diagnosed with head, ear, or eye problems? If yes, please specify: ________________________________

____

Eating

- ☐ Binge eating
- ☐ Can't maintain healthy weight
- ☐ Carbohydrate cravings (bread)
- ☐ Caffeine dependence
- ☐ Bulimia
- ☐ Frequent dieting
- ☐ Sweet/salt cravings
- ☐ Can't gain/lose weight
- ☐ Poor appetite
- ☐ Irritable if meals missed

Respiratory

- ☐ Bad breath
- ☐ Productive cough
- ☐ Hay Fever
- ☐ Postnasal drip
- ☐ Snoring
- ☐ Bad odor in nose
- ☐ Hoarseness
- ☐ Nasal/sinus stuffiness
- ☐ Sinus fullness
- ☐ Wheezing
- ☐ Dry cough
- ☐ Sore throat
- ☐ Nose bleeds
- ☐ Sinus infection

Cardiovascular

- ☐ Angina/chest pain
- ☐ Irregular pulse
- ☐ Swollen ankles/feet
- ☐ Breathlessness
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Heart murmur
- ☐ Phlebitis

Itching Skin

- ☐ Skin in general
- ☐ Ears canals
- ☐ Hands
- ☐ Nose
- ☐ Vagina
- ☐ Anus
- ☐ Eyes
- ☐ Legs
- ☐ Penis
- ☐ Arms
- ☐ Feet
- ☐ Nipples
- ☐ Roof of mouth

Skin, Dryness of:

- ☐ Eyes
- ☐ Hair
- ☐ Mouth/throat
- ☐ Skin in general
- ☐ Feet, w/ cracking
- ☐ Hands, w/ cracking
- ☐ Scalp
- ☐ Feet, w/ peeling
- ☐ Hands, w/ peeling
- ☐ Dandruff

Urinary

- ☐ Bed wetting
- ☐ Kidney disease
- ☐ Prostate infection
- ☐ Hesitancy (trouble getting started)
- ☐ Leaking/incontinence
- ☐ Infection
- ☐ Pain/burning/urgency/frequency

Mood/Nerves

- ☐ Agoraphobia
- ☐ Anxiety/panic disorder
- ☐ Difficulty concentrating

- ☐ Difficulty w/balance or speech
- ☐ Depression
- ☐ Dizziness (spinning)
- ☐ Fainting/light headedness
- ☐ Difficulty w/thinking/memory
- ☐ Irritability
- ☐ Suicidal thoughts
- ☐ Fearfulness/paranoia
- ☐ Other phobias
- ☐ Numbness/tingling
- ☐ Tremor/trembling
- ☐ Seizures/epilepsy
- ☐ Nervousness
- ☐ Visual/auditory hallucinations

Musculoskeletal

- ☐ Back muscle spasms
- ☐ Calf cramps
- ☐ Chest tightness
- ☐ Food cramps
- ☐ Joint deformity
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle spasms
- ☐ Muscle stiffness
- ☐ Muscle twitches around eye
- ☐ Muscle twitches arms or legs
- ☐ Muscle weakness
- ☐ Neck muscle spasm
- ☐ Tendonitis
- ☐ Tension headache
- ☐ TMJ problems

Any issues with hair, skin, or nails (i.e. hair loss, brittle nails, skin spots)? If so, please specify: _______________

____

Lymph nodes: ☐ Enlarged/tender areas? ☐ Neck

BALLEN MEDICAL & WELLNESS

Hormone Consent

I, ____, authorize and give my Informed Consent to Sara Jean "SJ" Struckmeyer, MS, CNM, WHNP-BC for the administration of hormone replacement therapy.

Expected Benefits of Hormone Replacement Therapy

______ Expected benefits include control of symptoms associated with declining hormone levels. Possible benefits of this therapy may help prevent, reduce, or control physical diseases and dysfunction associated with declining hormone levels, through hormonal replacement.

______ I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration.

______ I understand that my healthcare provider cannot guarantee any health benefits or that there will be no harm from the use of hormone replacement therapy.

Risks and Side Effects of Hormone Replacement Therapy

______ Some of the following risks/adverse reactions are derived from the official Food and Drug Administration "FDA" labeling requirements for these drugs, for therapeutic drug levels in the blood stream. My healthcare provider may prescribe these medications at dosages designed to achieve physiologic levels of hormones in my blood stream or urine generally associated with those of a 20-25-year-old person and would be within the "normal" or "average" blood concentrations of that age group.

General:

______ I understand that the general risks of this proposed therapy may include, but are not limited to, bruising, soreness or pain, and possible infection for hormones administered by injection or implantation.

______ I understand that there are risks (both known and unknown) to any medical procedure, treatment and therapy, and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these known and unknown general risks.

______ I understand that the conventional medical community and many Medical Doctors believe that Testosterone supplementation is contra-indicated in a patient with history of prostate cancer and/or prostatic hypertrophy (BPH). I have been made fully informed by Leah Hughes, ACNP-BC, APRN of Ballen Medical and I am completely satisfied with my understanding that the conventional medical community may view this proposed treatment as new, controversial, or detrimental, and unnecessary by the Food and Drug Administration, given the present state of knowledge regarding the human aging process.

______ While a study published in the New England Journal of Medicine, January 2004 reviewed 72 medical studies and found no evidence that testosterone therapy causes prostate cancer; however, I understand that questions have been raised about Testosterone as a cause of prostate cancer, since it is an anabolic hormone and can increase the growth rate of cancer cells.

Testosterone is a prescription hormone; given by injection, pellet implantation, transdermal cream/gel, or patch.

______ Risks of testosterone replacement include, but are not limited to, stimulation of benign and malignantprostate tumor. Testosterone hormone replacement therapy is contraindicated in patients with known prostate cancer.

______ Side effects of testosterone replacement may include, but are not limited to an increase in the red blood cells determined by periodic measuring of your red blood. It is not a common occurrence and generally poses no health risk; it can be corrected by donating blood or with a therapeutic phlebotomy. Male pattern baldness, gynecomastia (breast enlargement), diminished sperm production and a reduction in the size of the testicles may develop in men.

______ Testosterone Replacement may reduce insulin requirements in insulin-dependent diabetics. Older male patients may be at a slightly increased risk for the development of prostate enlargement when replacing testosterone. The concurrent use of testosterone with corticosteroids may enhance edema (fluid retention) formation. Edema may be a complication with testosterone replacement in patients with pre-existing cardiac, renal, or hepatic disease. It is unknown whether testosterone replacement therapy will increase the risk for prostate cancer.

______ The most common immediate side effects (occurring in approximately no more than 6% of users) include, but are not limited to oily skin, acne, application site reaction, headache, hypertension (increased or high blood pressure), abnormal liver function tests, and non-cancerous prostate disorder. Other side effects may include moodiness, irritability, slight bruising at the injection site, greasy hair and skin, a strong body odor, increased hematocrit, exacerbation of sleep apnea, aggressiveness, alteration in insulin resistance, alteration of lipid profile. Adjusting the dose can typically alter any side effect. I agree to cease using the testosterone, contact my provider, and if necessary, seek immediate medical attention, in the event I knowingly develop any adverse side effects.

______ I understand that careful monitoring is crucial with Testosterone replacement therapy and agree to comply with monitoring recommendations while receiving Testosterone replacement therapy. Therapy monitoring to include but not limited to blood tests every 3-6 months, annual physical examination, prostate exam (males) on the schedule that will be individually recommended, and mammogram and pap test (females) on the schedule that will be individually recommended.

Estrogen is a prescription hormone, given by injection, orally or by transdermal cream or patch.

______ Risks associated with estrogen replacement include, but are not limited to heart attacks, blood clot formation, gallstones, increased risk of uterine cancer (if progesterone is not administered with concurrently) and fibroid tumors. The Women's Health Initiative study demonstrated increased risk when estrogen replacement initiated 10 or more years after menopause.

______ Estrogen is not a recommended course of therapy in women with a history of the following conditions: breast or uterine cancer, phlebitis and blood clots, gall bladder disease, uterine fibroma, and liver disease.

______ Side effects may include, but are not limited to increased body fat, fluid retention, uterine bleeding, depression, headaches, impaired glucose tolerance, and aggravation of migraines.

Progesterone is prescription hormone, given orally or by transdermal cream.

______ Risks of progesterone replacement include but are not limited to: Progestins are not the same as natural progesterone. Progestins may cancel the protective effect of estradiol and promote constriction of the coronary arteries to a significant degree. Natural progesterone, on the other hand, may protect the endometrium, preserve the beneficial effects of estrogen on the cardiovascular system and exert no negative effects on the blood vessels that supply your heart. Progestins may cause birth defects, damage to nerve cells, blood clots, and breast cancer.

______ Side effects of progesterone replacement may include, but are not limited to nipple or breast tenderness, drowsiness, fluid retention, slight dizziness, anxiety, difficulty sleeping, depression, acne, rashes, hot flashes, appetite increases and weight gain.

Thyroid Hormone is a prescription hormone taken by mouth.

______ Risks/adverse reactions include but are not limited to palpitations and rapid heart rate, heart arrhythmias, excitability, increased metabolism. Cardiac sensitivity is a contraindication to thyroid replacement therapy. Excess amounts may increase the risk for osteoporosis in some people and suppress the body's own ability to manufacture its own thyroid hormone.

______ Side effects may include, but are not limited to sleep disturbances, fine trembling of fingers, excessive hunger and thirst, sweating, anxiety, and headaches.

DHEA is classified as a dietary supplement, given by mouth or by transdermal cream.

______ Risks of DHEA replacement include but are not limited to worsening of certain cancers and should be avoided by men with existing prostate cancer and in women with breast cancer. DHEA replacement is not generally recommended in adults under age 35.

______ Side effects of DHEA replacement are generally dose related and may include but are not limited to: acne or oily skin, hair growth on the face, arms or legs, acne in women, and prostate enlargement in men male pattern baldness, decreased HDL cholesterol, fatigue, mood changes, weight gain, and insomnia.

Alternatives to Hormone Replacement Therapy:

______ I understand the reasonable alternatives to hormone replacement therapy, which include leaving the hormone levels as they are and doing nothing. Risks may include but are not limited to experiencing symptoms of hormone deficiency, and increased risk for aging-related diseases or dysfunction resulting from declining hormone levels. This alternative may result in the need to treat diseases or dysfunction associated with declining hormone levels as they appear clinically. Treating the symptoms of declining hormone levels as they develop with non-hormonal therapies

______ Risks may include but are not limited to increased risk for aging-related diseases resulting from declining hormone levels.

My Compliance Obligation while Receiving Hormone Replacement Therapy

______ I agree to comply with the proposed treatment and therapy as prescribed, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or administrating the hormone(s) that may be prescribed to me, and consent to periodic monitoring, when requested, which may include:

- Laboratory monitoring of blood or urine chemistries and hormone levels, physical examinations, and regular screening evaluations.

______ I agree to notify you regarding all signs or symptoms of possible reactions to my therapy.

______ I agree to comply with all other healthy lifestyle activities that have been individually recommended for me. I have completely disclosed my medical history, including prescription and non-prescription medications that I am currently taking or plan to take during my treatment, as well as any other over-the-counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements to you. I agree to comply with the recommendations regarding the continuation or discontinuation of these preparations.

______ In the future, I will receive recommendations in advance from you before stopping any prescribed therapeutic regimens or taking additional preparations that are not recommended by you. I certify that I am under the care of a physician(s) for all other medical conditions.

Research and Economic Interest:

______ I understand that the prescribing practitioner is not engaged in any personal research and has no economic interests unrelated to my immediate care or treatment that may affect the physician's choice of treatment or medical judgment.

______ I certify that I have been given the opportunity to ask any and all questions I have concerning the proposed treatment, and I received all requested information, and all questions were answered. I fully understand that I have the right to not consent to hormone replacement therapy. I believe I have adequate knowledge upon which to base an informed consent.

______ I do now attest to reading and fully understanding this form and the contents and clinical meanings of such and discussing these procedures with my healthcare provider and consent to this treatment, and hereby affix my signature to this authorization for this proposed long-term treatment. I have been given a copy of this consent form, and I understand fully any and all of the possibly represented implications and meanings of its writing and expectations.

____ ____________________

Client's Printed Name Date

____

Client's Signature

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. Please read it carefully.****

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 Ballen Medical and Wellness in any form, whether electronically, on paper, or orally are kept properly confidential. HIPAA gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this is if you are referred to a primary care doctor or another specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit. (Please note that Ballen Medical and Wellness does not submit to insurance.)
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would-be patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement or other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related enemies and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to “opt out” with respect to receiving fundraising communications from us.

The following use and disclosures of your PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes (these are not part of your medical record under HIPAA).
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations.
- Disclosures that constitute a sale of PHI under HIPAA.
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI

- The right to request restrictions in certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket," in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of the initial date of service and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Executive Director for more information, in person or in writing.

Receipt of Notice of Privacy Practices and Written Acknowledgement Form

Patient Name: ____ Date of Birth: _________________

I am a patient of Ballen Medical and Wellness. I, __________________________________ hereby acknowledge receipt of Ballen Medical & Wellness' Notice of Privacy Practices.

Patient Signature: ____ Date: ______________________

Parent/Guardian Signature: _______________________________________ Date: ______________________
(if patient is under the age of 15)

Cancellation Policy

****Highlighted sections MUST be completed**

Patient Name:____

______ I understand that payment is due at the time of service and will be collected prior to my appointment. Please note, any prepayment made for services provided by Ballen Medical & Wellness will be nonrefundable and nontransferable after 180 days from payment unless other arrangements have been made.

______ Any outstanding balance on my account **MUST** be paid **BEFORE** scheduling the next appointment and may affect any medication refill requests. **Any returned check or disputed payment by cardholder will be subjected to a $25 processing fee: in addition to the amount of the check or payment.**

______ In the event that my outstanding balance is not paid in full in a reasonable amount of time, I acknowledge Ballen Medical & Wellness may take further legal action as necessary to recover the amount outstanding. Should Ballen Medical & Wellness find it necessary to take legal action to recover any amount due, I agree to be liable for all reasonable collection costs incurred, including but not limited to, reasonable attorneys' fees.

______ I hereby authorize Ballen Medical & Wellness to use the provided credit card information or the credit card on file to charge my account for appointments, cancellations with less than 24 business hour notice, or no shows.

NO SHOW/LATE CANCELLATION POLICY

As you are aware, medical offices tend to be very busy and often have waiting lists for emergency cases. To better serve our patients and assure they have a fair opportunity to have an appointment as soon as possible, we ask for the following assistance:

______ If you are going to be more than 10 minutes late for an appointment, please call us to ensure that we can still work you into our schedule. There is no guarantee that we can hold your appointment, but we will do our best. If you do not call until your appointment has passed, you will still be charged for the appointment time.

______ If you need to cancel or reschedule an appointment, please call us 24 business hours prior to your appointment. We can often get patients in who are in need of our care.

______ We compound your customized IV formulas in the morning, therefore, you **MUST cancel 24-business hours prior to your appointment, or you will be charged**.

****You MUST cancel 24 business hours PRIOR to your appointment, or you will be charged.**

______ I understand the importance of the 24 business hours cancellation policy, and that I will be charged the full price of the scheduled appointment if Ballen Medical & Wellness does not receive the proper notice. **All Monday appointments needing to be canceled, need to be canceled by 12:00 pm the Friday prior**.

______________________________________ ______________________

Patient Signature | Date

Financial Responsibility

The following page, Release of Information (ROI), MUST be completed for anybody other than the patient providing ANY payment for ANY service.

Name: ______________________________ Relation: ____________________

Address:____

Phone: __________________________ SSN: ____________________________

Credit Card (optional): ____________________ Expiration:__________ CVV: ________

Billing address : ____

6081 S. Quebec Street, Suite 100
Centennial, CO 80111
Phone: (720) 222-0550
Fax: (720) 496-4948
www.ballenmedical.com

Authorization for Release of Healthcare Information

Patient Name: ______________________ Date of Birth: ______________

Maiden/Previous Name: ______________________ Phone Number: ______________

Full Address: ____

I authorize Ballen Medical & Wellness to release and receive my healthcare information to and from the following healthcare provider(s)/person(s).

Number of Entities/Individuals specified below: ________

1. Name: ______________________ Type of Provider: ______________
   Phone: ______________________ Fax: ______________
   Address: ____

2. Name: ______________________ Type of Provider: ______________
   Phone: ______________________ Fax: ______________
   Address: ____

3. Name: ______________________ Type of Provider: ______________
   Phone: ______________________ Fax: ______________
   Address: ____

Information to be Released/Received:

- Service Dates: From: ____________ To: __________ **OR** All future records until this authorization expires

- Entire Medical Record
- Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*
- Discharge Summary
- Clinic Visit Notes
- Immunization Records
- Radiology Reports
- ER Records
- Psychological Evals/Assessments
- Lab/Pathology Reports
- Billing Statements
- History & Physical
- EKG/Cardiology Reports
- Radiology Images
- Alcohol/Drug Treatment Records: ______________________________
- Other: ______________________________

- **Do not release alcohol or drug treatment records protected under federal law**

I understand that this healthcare information may include mental health, alcohol, and/or drug treatment and will be used for the purposes of evaluation and treatment. I also understand that the authorization is completely voluntary and may be revoked at any time by submitting a written request to revoke the authorization to the office of Ballen Medical & Wellness (address listed above). I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits.

This authorization will expire on ______________ (**or one year from date signed**).

______________________________ ______________

Patient Signature Date