Name:_____ Today's Date:_____

Date of Birth_____ Age:_____ M ( ) F ( ) Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home/Cell Phone:_____ Work Phone:_____

Email Address:_____

Referral Source: How did you hear about Innovative Health? _____

In Case Of Emergency Contact:_____ Relationship:_____

Emergency Contact Cell Phone:_____ Work Phone:_____

Primary Care Physician Name:_____ Phone:_____

Address if known:_____

Marital Status: ( ) Married ( ) Divorced ( ) Widow ( ) Single

In the event we cannot reach you by the means provided above, please list anyone else you would like to grant permission to have your healthcare and treatment at Innovative Health released to. If not listed, no one will be able to obtain information but you.

	Name	Phone
1.	_____	_____
2.	_____	_____
3.	_____	_____

Any Known Allergies/please list: _____

List all current medications/supplements: _____

_____

List all past surgeries and date: _____

_____

Medical Illnesses: Choose all that apply

( ) High Blood Pressure

( ) High cholesterol

( ) Stroke and/or Heart Attack

( ) Blood clot and/or a pulmonary emboli

( ) Arrhythmia

( ) Any form of Hepatitis or HIV

( ) Lupus or any Auto Immune Disease

( ) Fibromyalgia

( ) Trouble passing urine

( ) Diabetes

( ) Thyroid Disease

( ) Arthritis

( ) Depression/Anxiety

( ) Cancer (type): _____ Year _____

( ) Any other know Illness _____

WEIGHT LOSS PATIENT QUESTIONNAIRE

(Only complete if being seen for weight loss)

Do you consider yourself to be in good health at the present time to the best of your knowledge? Yes_____ No_____

Date of most recent routine labs? Month_____ Year_____

Have you ever taken any weight loss supplements? Yes_____ No _____
If yes, please list:
Name:_____ Dates taken:_____
Name:_____ Dates taken:_____
Name:_____ Dates taken:_____

What motivates you for weight loss now? _____

Nutrition Evaluation

Do you have a bathroom scale at home? Yes ____ No ____ How often do you weigh Yourself? Daily _____ Weekly _____ Monthly _____ Never_____

Desired goal weight that would make you happy? _____

Your weight 10 years ago? _____

What is your normal drink of choice at meals? _____ Between meals? _____
How much water do you drink daily? _____
Do you use ( ) Sugar ( ) Sugar Substitute in drinks?

Do you currently smoke? Yes _____ No_____ If yes, how many packs/day? _____

Do you think you are a stressful eater? Yes_____ No_____

Activity Level

Choose one:

Inactive: No regular physical activity with a sit-down job. _____
Light activity – No organized physical activity during leisure time. _____
Moderate activity: Occasionally involved in sporting activities. _____
Heavy activity: Physical activity at work and/or sports activities 3 X or more week.

Innovative Health
Medical Clinic

BHRT CHECKLIST FOR MEN

Name: _____ Date: _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in General Well Being				
Joint Pain/Muscle Ache				
Excessive Sweating				
Sleep Problems/Increased Need for Sleep				
Mood Changes/Irritability				
Nervousness/Anxiety				
Depressed Mood				
Exhaustion/Lacking Vitality				
Declining Mental Ability/Focus/Concentration				
Feeling Burned out/Passed your Peak				
Decreased Muscle Strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Rapid Hair Loss				
Breast Development				
Shrinking Testicles				
Decreased Libido/Desire				
Decreased Morning Erections/Weak Erections				
Decreased Ability to Perform Sexually				
Infrequent or Absent Ejaculations				
No Results from ED Medications				

Other symptoms that concern you:

FEMALE HORMONE QUESTIONNAIRE

(Complete only if being seen for hormone balancing)

Check all that apply:

() Medical/GYN Exam in the last year
() Mammogram in the last 12 months
() Bone Density in the last 12 months
() Pelvic ultrasound in the last 12 months
() Menopause
() Hysterectomy
() Tubal Ligation
() Birth Control Pills/shot/implant
() Vasectomy

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Low / No Energy				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you: