NAME: _____ DATE OF BIRTH: _____

Please complete this patient information form in preparation for your first visit. This will help us be more efficient and provide better care. Please allow approximately 20 minutes to complete.

TODAY'S DATE: _____

APPOINTMENT DATE AND TIME: : _____

PATIENT INFORMATION

Name:

Date of Birth:

Insurance:

Address:

City: State: Zip:

Phone: Cell:

Email:

Occupation/Employer:

PARENT/GUARDIAN INFORMATION

IF PATIENT IS A MINOR

Name of Parent/Guardian:

Relation to Patient:

Address:

City:

State: Zip:

Phone: Cell:

Occupation/Employer:

Patient's Primary Care Physician:

Others at home (name, age, relationship to patient):

Place of Birth: United States or:

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Highest level of education completed: Email:

Pharmacy of choice: Compounding Pharmacy

How did you hear about Robinhood Integrative Health? Check box for any that apply.

☐ Referred by primary doctor	☐ Patient	☐ Website	☐ Conference/Event
☐ Referred by specialist	☐ TV, Radio	☐ Newspaper	☐ BestHealth
☐ Referred by friend/neighbor	☐ Newsletter	☐ Flyer/brochure	☐ Natural Triad

COMMUNICATION

What is the **BEST** way to communicate with you between office visits?

☐ E-mail @ ☐ Home phone@ ☐ Work phone@ ☐ Cell phone@

Is there any place you do **NOT** want us to leave a message?

May your provider discuss your private medical information with you via e-mail? ☐ Yes ☐ No

Please be aware that e-mail may not be a secure communication and that discussion of your medical care will become part of your medical record.

May we send you educational/promotional materials such as newsletters via e-mail? ☐ Yes ☐ No

NAME: _____ DATE OF BIRTH: _____

PLEASE PROVIDE THE NAME OF ANY THERAPISTS LISTED BELOW WHO HAVE PARTICIPATED IN YOUR CARE IN THE PAST 6 MONTHS.

Acupuncturist:

Biofeedback therapist:

Chiropractor:

Dentist:

Nutritionist/Dietician:

Physical/Occupational Therapist:

Psychologist:

Priest/Rabbi/Pastor:

PREVENTATIVE HEALTH MAINTENANCE: WHEN APPLICABLE PLEASE LIST DATE:

Last Mammogram:

Last Thermogram:

Last Pap smear:

Last Breast exam:

Last Colonoscopy:

Last menstrual period? ☐ N/A

YOUR ***MOST*** CONCERNING DIAGNOSIS OR SYMPTOMS:

1:

2:

WHAT CURRENT BEHAVIORS OR LIFESTYLE HABITS DO YOU REGULARLY ENGAGE IN THAT YOU BELIEVE SUPPORT YOUR HEALTH? (PLEASE LIST)

1:

2:

3:

WHAT CURRENT BEHAVIORS OR LIFESTYLE HABITS DO YOU REGULARLY ENGAGE IN THAT YOU BELIEVE ARE SELF-DESTRUCTIVE LIFESTYLE HABITS?

1:

2:

3:

WHAT OBSTACLES DO YOU FORESEE THAT COULD KEEP YOU FROM **ADDRESSING** ANY LIFESTYLE FACTORS THAT MAY BE UNDERMINING YOUR HEALTH?

WHAT OBSTACLES DO YOU FORESEE THAT COULD KEEP YOU FROM **ADHERING** TO THERAPEUTIC PROTOCOLS WHICH I WILL BE SHARING WITH YOU?

NAME: _____ DATE OF BIRTH: _____

WE ARE VERY INTERESTED IN HELPING YOU ACHIEVE YOUR **HEALTH GOALS** BY INTEGRATING BODY, MIND, SPIRIT AND RELATIONSHIPS (HOLISTIC CARE) FOR OPTIMAL HEALTH. PLEASE CHOOSE **UP TO THREE HEALTH GOALS** THAT YOU HAVE **TODAY**.

PHYSICAL

- ☐ LESS PAIN; MORE COMFORTABLE AND SENSE OF EASE
- ☐ BETTER SLEEP, MORE RESTED
- ☐ BETTER WEIGHT
- ☐ LOWER RISK OF CANCER, HEART DISEASE OR DIABETES
- ☐ BREATHE EASIER, LESS COUGHING OR WHEEZING
- ☐ MORE ENERGY OR VITALITY
- ☐ LESS NAUSEA, STOMACH PROBLEMS
- ☐ BETTER COORDINATION OR BALANCE
- ☐ FEWER INFECTIONS, BETTER IMMUNITY
- ☐ FEWER ALLERGIES

MENTAL-EMOTIONAL

- ☐ BETTER CONCENTRATION
- ☐ CALMER
- ☐ MORE CHEERFUL OR JOYFUL
- ☐ MORE ALERT
- ☐ LESS IRRITABLE
- ☐ LESS WORRIED OR ANXIOUS
- ☐ MORE CONFIDENT MORE FLEXIBLE OR ADAPTABLE
- ☐ MORE PATIENCE
- ☐ MORE DEDICATED
- ☐ MORE SELF-DISCIPLINE
- ☐ LESS IMPULSIVE

SPIRITUAL

- ☐ KINDER
- ☐ MORE ACCEPTING
- ☐ MOVE LOVING
- ☐ MORE COMPASSIONATE
- ☐ MORE HOPEFUL
- ☐ MORE CONNECTED TO NATURE, SPIRIT OR SOMETHING GREATER THAN SELF
- ☐ MORE ETHICAL
- ☐ GREATER SENSE OF MEANING OR PURPOSE
- ☐ MORE GENEROUS
- ☐ MORE ARTISTIC OR MUSICAL
- ☐ MORE PRESENT

RELATIONAL

- ☐ BETTER LISTENER
- ☐ BETTER RELATIONSHIPS IN FAMILY OR WITH FRIENDS
- ☐ LESS ISOLATED
- ☐ MORE EMPATHETIC
- ☐ MORE LOYAL
- ☐ MORE RESPONSIBLE TO OTHERS
- ☐ MORE TRUTHFUL
- ☐ BETTER CITIZEN
- ☐ BETTER TEAM PLAYER
- ☐ MORE GENEROUS

WHICH OF THESE GOALS IS ***MOST IMPORTANT*** TO YOU TODAY?

_____

NAME: _____ DATE OF BIRTH: _____

PATIENT'S PAST MEDICAL HISTORY

PLEASE LIST YOUR KNOWN MEDICAL PROBLEMS:

DO YOU TAKE ANY PRESCRIPTION MEDICATIONS? ☐ NO ☐ YES

(IF YES, PLEASE COMPLETE) IF MORE SPACE IS NEEDED PLEASE LIST AT THE END OF THIS FORM.

NAME OF MEDICATION, DOSAGE, AND HOW OFTEN

ARE YOU CURRENTLY TAKING ANY VITAMINS OR SUPPLEMENTS? ☐ NO ☐ YES

(IF YES, PLEASE LIST TYPE AND DOSAGE)

NAME OF SUPPLEMENT, DOSAGE, AND HOW OFTEN

DO YOU HAVE ANY **DRUG** ALLERGIES? ☐ NO ☐ YES (IF YES, PLEASE COMPLETE)

NAME OF PRODUCT/MEDICINE	AGE AT REACTION	TYPE OF REACTION

NAME: _____ DATE OF BIRTH: _____

FAMILY MEDICAL HISTORY (CHECK ONE) IF YES, DESCRIBE WHO:
MOTHER, FATHER, SIBLING, GRANDMA, GRANDPA AND APPROXIMATE ONSET AGE IF KNOWN.

☐ NO	☐ YES	ALLERGIES:
☐ NO	☐ YES	ANEMIA:
☐ NO	☐ YES	ASTHMA:
☐ NO	☐ YES	RHEUMATOID ARTHRITIS:
☐ NO	☐ YES	CANCER:
☐ NO	☐ YES	CHRONIC FATIGUE:
☐ NO	☐ YES	CELIAC:
☐ NO	☐ YES	IRRITABLE BOWEL:
☐ NO	☐ YES	CHRONIC LUNG DISEASE:
☐ NO	☐ YES	DIABETES:
☐ NO	☐ YES	DRUG ABUSE PROBLEMS:
☐ NO	☐ YES	ALCOHOL ABUSE:
☐ NO	☐ YES	EPILEPSY:
☐ NO	☐ YES	FIBROMYALGIA:
☐ NO	☐ YES	GLAUCOMA:
☐ NO	☐ YES	GOUT:
☐ NO	☐ YES	HEART DISEASE:
☐ NO	☐ YES	HIGH BLOOD PRESSURE:
☐ NO	☐ YES	HIGH CHOLESTEROL:
☐ NO	☐ YES	KIDNEY DISEASE:
☐ NO	☐ YES	LUPUS:
☐ NO	☐ YES	LEARNING DISABILITY:
☐ NO	☐ YES	MENTAL ILLNESS:
☐ NO	☐ YES	MULTIPLE SCLEROSIS:
☐ NO	☐ YES	ADD/ADHD:
☐ NO	☐ YES	OBESITY:
☐ NO	☐ YES	STROKE:
☐ NO	☐ YES	PSORIASIS:
☐ NO	☐ YES	ECZEMA:
☐ NO	☐ YES	TB:
☐ NO	☐ YES	ULCERS:

NAME: _____ DATE OF BIRTH: _____

SYSTEM REVIEW – IN THE PAST 6 MONTHS HAVE YOU EXPERIENCED:

GENERAL	CHILLS OR FEELING COLD?	☐ YES ☐ NO
	FATIGUE?	☐ YES ☐ NO
	FEVERS, NIGHT SWEATS?	☐ YES ☐ NO
	TROUBLE SLEEPING?	☐ YES ☐ NO
	PAIN?	☐ YES ☐ NO
EYE TROUBLE	BURNING, STINGING, PAIN, DISCHARGE?	☐ YES ☐ NO
EARS, NOSE, THROAT	EARACHES OR EAR INFECTIONS?	☐ YES ☐ NO
	FREQUENT COLDS OR SINUS INFECTIONS?	☐ YES ☐ NO
	FREQUENT NOSEBLEEDS?	☐ YES ☐ NO
	FREQUENT SORE THROATS?	☐ YES ☐ NO
	DENTAL PROBLEMS?	☐ YES ☐ NO
HEART	HAVE YOU BEEN TOLD YOU HAVE A HEART MURMUR?	☐ YES ☐ NO
	HAD HEART TROUBLE OR CHEST PAIN?	☐ YES ☐ NO
	HAD HIGH BLOOD PRESSURE?	☐ YES ☐ NO
	DIZZINESS OR PASSING OUT?	☐ YES ☐ NO
	RACING OR IRREGULAR PULSE?	☐ YES ☐ NO
	INTOLERANCE FOR EXERCISE (EASY FATIGUE)?	☐ YES ☐ NO
LUNGS	WHEEZING OR ASTHMA?	☐ YES ☐ NO
	COUGH WITH LAUGHING OR EXERCISE?	☐ YES ☐ NO
GASTRO-INTESTINAL TRACT	HAVE YOU HAD NAUSEA OR VOMITING RECENTLY?	☐ YES ☐ NO
	ABDOMINAL PAIN?	☐ YES ☐ NO
	BEEN CONSTIPATED?	☐ YES ☐ NO
	HAD DIARRHEA (LOOSE STOOLS) RECENTLY?	☐ YES ☐ NO
GENITOURINARY TRACT	DECREASED SEX DRIVE	☐ YES ☐ NO
	HAD A KIDNEY INFECTION?	☐ YES ☐ NO

NAME: _____ DATE OF BIRTH: _____

SYSTEM REVIEW – IN THE PAST 6 MONTHS HAVE YOU EXPERIENCED:

MUSCULOSKELETAL	HAD MUSCLE WEAKNESS OR SORENESS?	☐ YES ☐ NO
	SWELLING OR PAIN IN THE JOINTS?	☐ YES ☐ NO
	BACK PAIN?	☐ YES ☐ NO
RASHES OR SKIN PROBLEMS	ON THE SKIN OR SCALP?	☐ YES ☐ NO
	MOUTH SORES?	☐ YES ☐ NO
	ACNE?	☐ YES ☐ NO
	ECZEMA?	☐ YES ☐ NO
NEUROLOGIC	HAD CONVULSIONS, EPILEPSY OR SEIZURES?	☐ YES ☐ NO
	BEEN UNCONSCIOUS? PASSING OUT?	☐ YES ☐ NO
	HEADACHES?	☐ YES ☐ NO
	NUMBNESS OR TINGLING IN FINGERS OR TOES?	☐ YES ☐ NO
	TICS?	☐ YES ☐ NO
ENDOCRINE	RECENT WEIGHT GAIN OR LOSS?	☐ YES ☐ NO
	FREQUENT URINATION OR THIRST?	☐ YES ☐ NO
	LOW BLOOD SUGAR?	☐ YES ☐ NO
	EARLY OR LATE SEXUAL DEVELOPMENT?	☐ YES ☐ NO
	INTOLERANCE OF HEAT?	☐ YES ☐ NO
	INTOLERANCE OF COLD?	☐ YES ☐ NO
PSYCHOLOGIC	DEPRESSION, BI-POLAR, OR SUICIDAL THOUGHTS?	☐ YES ☐ NO
	ANXIETY OR UNUSUAL FEARFULNESS?	☐ YES ☐ NO
	ADD/ADHD?	☐ YES ☐ NO
	ALCOHOL/SUBSTANCE ABUSE?	☐ YES ☐ NO
	OBSESSIVE OR COMPULSIVE BEHAVIORS?	☐ YES ☐ NO
	ANGER/RAGE/VIOLENCE?	☐ YES ☐ NO
BLOOD	ANEMIA (LOW BLOOD)?	☐ YES ☐ NO
	EASY BLEEDING OR BRUISING?	☐ YES ☐ NO
ALLERGIC/IMMUNE	ALLERGIES?	☐ YES ☐ NO
	RECURRENT INFECTIONS?	☐ YES ☐ NO
	ARTHRITIS?	☐ YES ☐ NO

NAME: _____ DATE OF BIRTH: _____

SURGICAL HISTORY

PLEASE LIST SURGERIES (IF ANY). PLEASE INCLUDE DATE OF SURGERY.

STRESS

In the past year have you or family experienced any stressful events?
i.e. arguments with family/friend, peer problems, death, divorce, illness, financial problems.
☐ No ☐ Yes, please explain:

How would you rate the stress in your life?

☐ 0 (No Stress) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1 0 (Extreme)

RELAXATION AND STRESS MANAGEMENT
WHAT DO YOU DO TO RELAX OR MANAGE STRESS? (CHECK ALL THAT APPLY)

- ☐ TAKE TIME OUT
- ☐ SPEND TIME IN NATURE
- ☐ HIT THINGS
- ☐ GO TO BED
- ☐ YOGA
- ☐ CALMING SELF-TALK
- ☐ WATCH TV
- ☐ TAKE A BATH OR SHOWER
- ☐ TALK WITH FRIEND OR FAMILY MEMBER
- ☐ EXERCISE
- ☐ DEEP BREATHING
- ☐ PRAY
- ☐ LISTEN TO MUSIC
- ☐ EAT
- ☐ TALK ON PHONE
- ☐ MEDITATE
- ☐ BIOFEEDBACK
- ☐ PUNCH A PILLOW

OTHER:

Favorite music?

SLEEP

What is your usual bedtime? Wake up time?

Do you nap? ☐ No ☐ Yes; how long and how often?

Do you have difficulty falling asleep or waking during the night?
If Yes, what strategies have you tried to improve sleep? How well do they work? ☐ No ☐ Yes

Are you interested in any tips on improving sleep? ☐ No ☐ Yes

ENVIRONMENT

Are you concerned about: toxic chemicals, loud sounds or noise, excessive light or darkness, mold or obnoxious odors in your food or environment? ☐ No ☐ Yes
If Yes, please describe:

NAME: _____ DATE OF BIRTH: _____

FAMILY LIFE/ HABITS

Does your child(ren) also live at another home? ☐ No ☐ Yes, with home?

How many times have you moved in the last year? ☐ 1 ☐ 2 ☐ 3 times

Does anyone in your household smoke? ☐ No ☐ Yes If Yes, packs/day

How many hours a day do you watch TV?

How many hours a day do you play or work on a computer or play video games?

In the past year, have you ever felt threatened or unsafe in your home? ☐ No ☐ Yes

In the past year, has your partner or other family member pushed you, hit you, or threatened you with something? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes If Yes, how often?

Do you smoke? ☐ No ☐ Yes If Yes, packs/day

Do you drink coffee? ☐ No ☐ Yes If Yes, How many cups a day?

Do you drink tea? ☐ No ☐ Yes If Yes, How many glasses a day?

Do you drink soda? ☐ No ☐ Yes ☐ Diet ☐ Regular? How many a day?

Has anyone in the household tried to cut down on alcohol in the past year? ☐ No ☐ Yes

Does anyone in the household ever have more than 5 drinks at one time? ☐ No ☐ Yes

Has anyone in the household ever had a drug problem? ☐ No ☐ Yes

Has anyone in the household tried to cut down on drugs in the past year? ☐ Not Applicable ☐ No ☐ Yes

SPIRITUAL LIFE:

Does your family attend church, temple, mosque or other regular religious meeting? ☐ No ☐ Yes, which?

Do you observe a daily religious practice? ☐ No ☐ Yes, what?

How strong are your family's religious beliefs? ☐ Strong ☐ Moderate ☐ A little ☐ Not at all

GOOD THINGS

What are you most proud of about yourself?

List three things have you said or done this week that is kind, helpful or loving?

1) 2) 3)

What about your life gives you the most joy and pleasure?

What is your greatest hope for yourself?

What are the resources that are most helpful for you

in achieving these hopes?

What else do you think is important for us to take the best care of you?

What is the main thing you would like to accomplish at today's visit?

NAME: _____ DATE OF BIRTH: _____

Health As It Ought To Be
Robinhood Integrative HEALTH

OUR COMMITMENT

Robinhood Integrative Health, (RIH) believes "Health As It Should Be" involves the integration of all aspects of one's life by treating the total patient and not merely the symptoms. Some components of integrative care that we utilize to promote optimal health and well being currently do not have the FDA's stamp of approval. However, at RIH we make sure that there are scientific studies which support all practices we employ.

We utilize the following tools among others; proper nutrition, tailored supplements, bioidentical hormones, exercise and pharmaceutical medications when needed. We will also offer various courses, programs and lectures which will benefit you as a patient. Additionally, as a service and time savings convenience for our patients, we offer various supplements and products that have been carefully chosen in terms of quality and cost effectiveness available for purchase at our office.

Presently, some tests that make medical sense may not always be reimbursed by insurance companies. Also, certain medications particularly those that come from a compounding pharmacy, may not be covered by insurance. We are sensitive to the fact that you will have to cover these expenses. With every decision or recommendation that RIH makes, your cost obligations are considered. Ultimately we feel any expense you bear today will be an investment in a future that produces a lifetime of optimal health and well being.

If at any time you prefer a traditional medical approach please inform us and we will happily comply.

If you have any disappointments please talk to our office manager Shelley Garnick.

INITIAL: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice.

Uses and Disclosures
We may use and disclose your health information for different reasons.

- Treatment: To assist in your diagnosis and treatment.
- Payment: In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- Health Care Operations: For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan. Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

NAME: _____ DATE OF BIRTH: _____

We must disclose, when required by law, for the following examples:

- Avoid threat to health or safety. Disclose to law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- Coroners, Funeral Directors, Organ Donation. To said professionals such that they can carry out their duties.
- Health oversight activities. To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- Health-related benefits or services. For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- Law Enforcement, judicial and administrative proceedings. In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- National security and intelligence. As required by military officials for security and military purposes.
- Public health activities. To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- Research. For medical research – Such circumstances include taking steps to protect your privacy.
- Victims of abuse, neglect or domestic violence. To government agencies and law enforcement personnel as required by law.
- Workers' compensation. In compliance with workers' compensation laws.

Authorization

- Any uses or disclosures other than those described above will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

- Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Robinhood Integrative Health. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.
- Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to your work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact Robinhood Integrative Health.. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.
- Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Robinhood Integrative Health and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.
- Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Robinhood Integrative Health. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

NAME: _____ DATE OF BIRTH: _____

- Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting . The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.
- Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.
- Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Robinhood Integrative Health to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

By filling out the box below I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient (if other than self): _____

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

Signature: _____ Date: _____

ROBINHOOD INTEGRATIVE HEALTH PLLC

Any other comments?

NAME: _____ DATE OF BIRTH: _____

RIH
Health As It Ought To Be
Robinhood Integrative HEALTH
P 336-768-3335

HORMONE HEALTH QUIZ

ESTROGEN SIGNS AND SYMPTOMS	NEVER				ALWAYS
1. I am losing hair on top of my head	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. I am getting thin vertical wrinkles above my lip	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. My breast are droopy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. My face is too hairy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. My eyes are dry and easily irritated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I have hot flashes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I feel tired constantly	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I am depressed	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I am forgetful and have trouble concentrating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
WOMEN WITH PERIODS					
10. My cycles are irregular (too short or too long)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
WOMEN WITHOUT PERIODS					
11. I do not feel like making love anymore	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

SCORE: 10 OR LESS OK 11-20 POSSIBLE **ESTROGEN** DEFICIENCY OVER 21 PROBABLE **ESTROGEN** DEFICIENCY

NAME: _____ DATE OF BIRTH: _____

DHEA SIGNS AND SYMPTOMS	NEVER				ALWAYS
1. My hair is dry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. My skin and eyes are dry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. My muscles are flabby	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. My belly is getting fat	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Losing underarm hair	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. Workouts are not as good	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I do not handle stress well	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. Limit sexual contact	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I don't tolerate noise well	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. My libido is low	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

SCORE: 10 OR LESS OK **11-20** POSSIBLE **DHEA** DEFICIENCY **OVER 21** PROBABLE **DHEA** DEFICIENCY

PROGESTERONE SIGNS AND SYMPTOMS	NEVER				ALWAYS
1. My breasts are large	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. My close friends complain I'm nervous & agitated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. I feel anxious	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. I sleep lightly and restlessly	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
The following are premenopausal or are post menopausal on HRT with periods					
5. My breasts are swollen and tender	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. My lower belly is swollen	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I'm irritable or aggressive	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I lose self- control	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I have heavy periods	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. My periods are continuously painful	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
MENOPAUSAL NOT BLEEDING					

SCORE: 4 OR LESS OK **5-8** POSSIBLE **PROGESTERONE** DEFICIENCY **9** PROBABLE **PROGESTERONE** DEFICIENCY

MENSTRUATING

SCORE: 10 OR LESS OK **11-20** POSSIBLE **PROGESTERONE** DEFICIENCY **OVER 21** PROBABLE **PROGESTERONE** DEFICIENCY

NAME: _____ DATE OF BIRTH: _____

TESTOSTERONE SIGNS AND SYMPTOMS	NEVER				ALWAYS
MEN & WOMEN					
1. Face has gotten slack and more wrinkled	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Loss of muscle tone	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. My belly gets fat	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Constantly tired	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Making love less than I used to	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

WOMEN: SCORE: 5 OR LESS OK **6-10** POSSIBLE **TESTOSTERONE** DEFICIENCY **OVER 11** PROBABLE DEFICIENCY

MEN ONLY					
1. I have man boobs	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Less self- confident more hesitant	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Sexual performance is poorer than it used to be	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Hot flashes or night sweats	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I tire easily with physical activity	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

MEN: SCORE: 10 OR LESS OK **11-20** POSSIBLE **TESTOSTERONE** DEFICIENCY **OVER 21** PROBABLE DEFICIENCY

THYROID SIGNS AND SYMPTOMS	NEVER				ALWAYS
1. I'm sensitive to cold	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. My hands and feet are always cold	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. In the AM I have a puffy face & swollen eyelids	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. I put on weight easily	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I have dry skin	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I have trouble getting up in the morning	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I feel more tired at rest than when I am active	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I am constipated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. My joints are stiff in the morning	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. I feel like I am in slow motion	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

SCORE: 10 OR LESS OK **11-20** POSSIBLE **THYROID** DEFICIENCY **OVER 21** PROBABLE **THYROID** DEFICIENCY

NAME: _____ DATE OF BIRTH: _____

CREDIT CARD PAYMENT AUTHORIZATION

Robinhood Integrative HEALTH
Health As It Ought To Be

3288 Robinhood Road
Winston-Salem, NC 27106
(336) 768-3335

Thank you for choosing Robinhood Integrative Health as your healthcare provider. As per our office policy and in an effort to keep health care costs as low as possible, we require you keep a credit card on file. This is to your advantage, since health care costs in general can be substantial. By using a credit card, you have the ability to spread the cost over time, making payments to your credit card company, rather than paying the cost all at once. Of course, you can always use and alternative method of payment at check-out if you desire.

This form authorizes Robinhood Integrative Health to charge your expenses to the card on file unless an alternative method of payment is presented. This includes payments at the check-out window, payments over the phone, payments for purchases in our store and payments that are 90 days in arrears. (You will have received three billing statements).

Please note: Only one credit card is held on file at a time and it is the last card that you have used.

If you have any questions, please do not hesitate to call us.

PRINTED NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____

I understand that this authorization will remain in effect until I cancel it in writing. I certify that I am an authorized user of this credit card on file and that I will not dispute any payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

NAME: _____ DATE OF BIRTH: _____

PERMISSION TO COMMUNICATE WITH FAMILY & FRIENDS FORM/VOICEMAIL

Health As It Ought To Be
Robinhood Integrative HEALTH

3288 Robinhood Road
Winston-Salem, NC 27106
(336) 768-3335

NAME: _____ DATE OF BIRTH: _____

So that we may provide you with better quality of care, you have the option of providing us with a list of family and friends with whom we may discuss your health information. You are **not required** to provide a list but it is helpful. If you **do not** want us discussing any information with anyone other than yourself please right "None" on the line below.

By listing the names below an signing this form I give consent to Robinhood Integrative Health to discuss health information with the people listed below who assist with my care. **If I do not want certain information discussed, I have listed it below. *THIS FORM WILL STAY IN EFFECT UNTIL YOU NOTIFY ANY CHANGES.**

Do not discuss information about _____

NAME	PHONE NUMBER	RELATIONSHIP

☐ I give Robinhood Integrative Health permission to leave Normal lab/test results on my answering machine/voicemail.

☐ I **do not** give Robinhood Integrative Health permission to leave Normal lab/test results on my answering machine/voicemail.

_____

Patient/Patient Representative Signature Date Print Name

_____

Witness Date