



REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

First Name:	Middle:	Last:	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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Email:	D.O.B.	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Street Address:

City:	State:	Zip Code:
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Home phone:	Cell phone:
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Occupation:	Employer:	Employer phone:
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Referred by / How you heard about us:

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Cell phone:
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Patient/Guardian signature

Date

General Consent for Care and Treatment Consent

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended Diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary examinations, testing and treatment. By signing below, you are indicating that:

- (1) You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended
- (2) You consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your practitioner about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request the health care providers or the designees as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative _____

Printed Name of Patient or Personal Representative _____

Relationship to Patient _____ *Date* _____

Cancellation Policy

If you need to cancel or reschedule an appointment, please give 24 hours advance notice to ensure you will not be charged for the appointment. If less than 24 hours notice is given and we are unable to fill your time slot, you will be charged for the appointment. (Remember, our confirmation texts do not receive replies. You must call or email to change or cancel an appointment.)

Return Policy

All supplement sales are final.

I have read and understand the Cancellation and Return Policies.

Signature of Patient or Personal Representative

NOTICE OF PRIVACY PRACTICES

Effective January 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Your Health Information & Rights

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information is referred to as your health or medical record. This Notice of Privacy Practices describes how we use or disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Although your health records are the property of the practice, this information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
2. Obtain a paper copy of this notice of privacy practices
3. Inspect and request a copy of your medical record as provided for in 45 CFR 164.524
4. Amend your health record as provided in 45 CFR 164.526
5. Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
6. Request communications of your health information by alternative means and locations

Living Health's Responsibilities:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our legal duties and privacy practices with respect to your health information
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. The current Notice of Privacy Practices can be reviewed by contacting us and requesting that a revised copy be sent to you in the mail. We will not use or disclose your health information without your authorization, except as described in this notice.

For more information or to report a problem:

If you have questions and would like additional information, you may contact the office at (830) 632-5906. If you believe that your privacy rights have been violated, you can file a complaint with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations:

Living Health will use your health information for treatment. Your health information may be released to other healthcare professionals with the hospital and the community for the purpose of providing you with quality healthcare. For example: information obtained by one of our staff including providers, nurses and administrative staff will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent healthcare provider, such as a nursing home, home health care agency or physical therapy office, with copies of various reports that will assist them in treating outside of this office as necessary.

We will use your health information for payment. For example: a bill may be sent to your insurance company or other third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, tests and supplies used in the course of your care in our office.

If you understand the above notice and information contained within, we ask that you sign and date that you acknowledge receipt of this information from our office. We will keep a copy of this signed notice in your medical record and provide you a copy for your own records if requested.

Disclosures

Business Associates: There are some services provided in our clinic through contracts with business associates. Examples include physician services in the emergency department and radiology, certain lab tests, transcription services and billing companies. Through a signed agreements, we require all business associates to comply with HIPPA laws and requirements to safeguard your health information.

Notification: We may use or disclose information to notify a family member, personal representative, or other person responsible for your care, your location and general condition.

Communication with Family: Our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food & Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized to comply with Texas laws relating to the workers compensation program.

Public Health: As required by Texas law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Communicable Disease: We may disclose health information as required by Texas law to a person who may have been exposed to communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government agent authorized to receive such information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing & Patient Satisfaction Surveys: We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

Law Enforcement: We may disclose health information for law enforcement purposes as required by Texas law or in response to a valid subpoena or court order.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Military & Veterans: If you are a member of the armed services, we may disclose health information as required by military command authorities.

Signature of Patient (or legal representative)

Date



CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

You have been diagnosed with or have an increased risk of having a hormone deficiency(s) and your doctor has recommended treatment with bio-identical hormone replacement therapy (BHRT). Some of the Bio-Identical hormone preparations that may be prescribed for you are compounded. The use of this therapy as it relates to your diagnosis, while common in alternative and weight loss practices, may be debated in the traditional medical community.

You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so that you make an informed decision whether or not to undergo the procedures after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may have the information needed to give or withhold your consent to the procedure or treatment.

Therapeutic Basis: Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or andropause or inability to lose weight may also benefit from these therapies. Bio-identical hormone replacement therapy can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident.

- Estrogen therapy can maintain vaginal and urethral function and slow the progression of osteoporosis. It may also improve sleep, decrease pain and perhaps cognitive function, and improve libido and overall well-being. This therapy may contain one or any combinations of the following medications: estriol, estradiol, and/or estrone.
- Progesterone hormone replacement therapy can offer protection from endometrial cancers, treatment of irregular menstruation, and other low progesterone conditions. It also can improve sleep quality and decrease anxiety. For males, low dose progesterone therapy in conjunction with testosterone therapy can maximize the hormone ratios, reducing side effects.
- Testosterone replacement therapy is used to treat symptoms or lab tests suggesting suboptimal hormone levels as determined by your doctor. Low testosterone is associated with elevated cholesterol, blood pressure, diabetes and prostate problems. There are ongoing discussions within the medical community whether treating to optimize testosterone will increase or decrease these problems.
- DHEA is the abbreviated form for a chemical called dehydroepiandrosterone, a hormone produced within the body. DHEA is a hormonal precursor responsible for producing both testosterone and estrogen.
- **Nutritional Supplements:** May be recommended to optimize nutritional status and augment benefits of your treatment recommendations.

Objectives: Bio-identical hormone replacement therapy is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones.

Potential Risks:

Safety of any of these hormones during pregnancy cannot be guaranteed. Notify your physician or if you are pregnant, suspect that you have become pregnant, or if you are planning to become pregnant during this therapy.

Estrogen Therapy: Bio-identical estrogens are available in various forms including oral capsules, troches, patches and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g.-from blood clots or cancer) and mood swings.

High potency conjugated estrogens (e.g. Premarin), and perhaps even estradiol, have been associated with an increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole

area of estrogen replacement is undergoing further evaluation. Do not take estrogen if you have breast cancer.

Progesterone Therapy: Bio-identical progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

Testosterone Therapy: Bio-identical testosterone therapy is available in various forms including sublingual drops, troches, topical creams, and injection. Side effects include acne, chronic priapism (persistent, abnormal erection of the penis), change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance in males, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur. In women, excessive testosterone or DHEA doses could increase the risk of diabetes or facial hair.

Although the use of bio-identical hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with use bio-identical hormones

Statement of patient:

I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a Living Health physician, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc. at least on a yearly basis.

I agree to immediately report to Living Health any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of Bioidentical and other hormone treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

Signature of Patient _____ Date _____

Name (PRINT) _____

Witness _____



Female Symptoms Questionnaire

Patient Name: _____ ALLERGIES: _____

Please circle a number for each symptom for how you feel CURRENTLY

	Low-----Moderate-----Severe	Comments, if any
Sleep Disturbances	0 1 2 3 4 5 6 7 8 9 10	_____
Anxiety	0 1 2 3 4 5 6 7 8 9 10	_____
Low Sex Drive	0 1 2 3 4 5 6 7 8 9 10	_____
Fatigue	0 1 2 3 4 5 6 7 8 9 10	_____
Digestion (bloating)	0 1 2 3 4 5 6 7 8 9 10	_____
Body or Joint Pains	0 1 2 3 4 5 6 7 8 9 10	_____
Constipation	0 1 2 3 4 5 6 7 8 9 10	_____
Vaginal Dryness	0 1 2 3 4 5 6 7 8 9 10	_____
Hot Flashes	0 1 2 3 4 5 6 7 8 9 10	_____
Foggy thinking	0 1 2 3 4 5 6 7 8 9 10	_____
Mood Swing	0 1 2 3 4 5 6 7 8 9 10	_____
Weight gain	0 1 2 3 4 5 6 7 8 9 10	_____
Palpitations	0 1 2 3 4 5 6 7 8 9 10	_____
Painful Intercourse	0 1 2 3 4 5 6 7 8 9 10	_____
Night Sweats	0 1 2 3 4 5 6 7 8 9 10	_____
Breast Tenderness	0 1 2 3 4 5 6 7 8 9 10	_____
Hair Loss	0 1 2 3 4 5 6 7 8 9 10	_____
Retaining fluid	0 1 2 3 4 5 6 7 8 9 10	_____
Headaches	0 1 2 3 4 5 6 7 8 9 10	_____
Energy slump in PM	0 1 2 3 4 5 6 7 8 9 10	_____
Frequent infections	0 1 2 3 4 5 6 7 8 9 10	_____

Any Changes in your History & Physical ____Yes____No

Any Changes in medications ____Yes____No

Patient Signature: _____

Date:_____



Health History Questionnaire

Name:

Date:

Main problem(s) with which you would like help
Problem or Disease:
Past Medical History (please include dates)
Significant Illnesses (circle): Cancer, Diabetes, Hepatitis, High Blood Pressure, Heart Disease, Rheumatic Fever, Thyroid Disease, Seizures, Venereal Disease
Other:
Have you been vaccinated for childhood diseases? Yes No
Surgeries:
Significant Trauma (auto accidents, falls, etc.)
Birth History (prolonged labor, forceps delivery, etc.):
Allergies (drugs, chemicals, foods):

Family Medical History
<input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Seizures <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease Other: _____
Occupation:
Occupational Stress (chemical, physical, physiological. Etc.)
Do you have a regular exercise program? Please describe.

Medicines taken within the last two months (Include vitamins, over-the-counter drugs, herbs, etc)

Are you now or have you ever been on a restricted diet? _____ What kind? _____

Please describe your average daily diet:

Morning:

Afternoon:

Evening:

How many packs of cigarettes a day do you smoke? _____

How much coffee, tea or cola do you drink per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes:

General

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Strong Thirst (cold or hot drinks) | |
| <input type="checkbox"/> Sudden Energy Drop (What time of day?) _____ | | |

Skin and Hair

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Change in Hair or Skin Texture | | |
| Any Other hair or skin problems? _____ | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in Front of Eyes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Sores |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Jaw Clicks | |
| <input type="checkbox"/> Headaches (Where and When?) _____ | | |
| Any other head or neck problems? _____ | | |

Cardiovascular

- | | | |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of the Hands | <input type="checkbox"/> Swelling of the Feet |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in Breathing |
| Any other heart or blood vessel problems? _____ | | |

Respiratory

- | | | |
|---|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with a Deep Breath |
| <input type="checkbox"/> Difficulty in Breathing when Lying Down | | |
| <input type="checkbox"/> Production of Phlegm (What color?) _____ | | |
| Any other lung problems? _____ | | |

Gastrointestinal

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramps | | |
| <input type="checkbox"/> Chronic Laxative Use | | |

Any other problems with your stomach or intestines? _____

Genito-Urinary

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Decrease in Flow | <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on Genitals |

Do you wake up to urinate? _____ How often? _____

Any particular color to your urine? _____

Any other problems with your genital or urinary system? _____

FEMALE ONLY SECTION: Pregnancy and Gynecology

- | | | |
|---|--|---------------------------------------|
| _____ Number of pregnancies | _____ Number of Births | _____ Premature Births |
| _____ Miscarriages | _____ Abortions | _____ Age at first Menses |
| _____ Period between menses | _____ Duration | First date of last menses _____ |
| <input type="checkbox"/> Unusual Character (Heavy or Light) | | |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Clots | <input type="checkbox"/> Last PAP |
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Breast Lumps |
| <input type="checkbox"/> Changes in body / psyche prior to menstruation | | |

Do you practice birth control? _____ What type and for how long? _____

Musculoskeletal

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Muscle Pains | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot / Ankle Pains |
| <input type="checkbox"/> Hand / Wrist Pains | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain |

Any other joint or bone problems? _____

Neuropsychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Easily Susceptible to Stress | |

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____