Date:__________ Patient Name: ________________________________Age:_____ Birth Date:______________

Address____________________________________ City ______________________State ______Zip___________

SSN___________ Male____ Female____ Home Phone __________________Cell __________________________

Receive Appt. Reminders (Circle all that apply) Home Phone / Cell Phone (Morning, Afternoon, Evening) Text / E-mail

E-mail Address (*for patient portal access*) :____

Check appropriate box: Minor _____ Single______ Married ______ Divorced_____ Widowed______

Patient/Guardian Employer _______________________________________ Work Phone_______________________

Business Address_____________________________ City _______________________State_____ Zip___________

Pharmacy Name ________________________**Location** ______________________**Phone # (** **)**____________

Emergency Contact ___________________________**Phone**________________Relationship__________________

Were you referred to our office? Internet_____ Patient _____________Physician______________ Other_____________

Interested in: **HRT** **Weight Loss** **ADHD** **Thyroid** **Energy** **Pain** **Addiction** **Counseling**

*If PAIN MGMT: Medical Records? YES/ NO Contact Info:____

If Female HRT: Last mammogram?_________________

Deposit Total $ ___________________ Deposit Paid $ ___________________

Initial Appt Date: ______________________Time ________________ Clinician _____________________________

Name of INS. Co.__________________________ Policy Holder Name _____________________________________

INS/Sub ID#____________________________ Group #__________________ Subscribers DOB_________________

Deductible $ _______________ Remaining $ _______________ CO Pay _________Effective Date________________

Insurance Verified By ________________Date ___________

Court Records: YES / NO * Scanned: _______________ **Inspect:** YES / NO *Scanned: ________________

Appointment Verified on Computer By: ___________________________Date: ___________________________________

****In the past few months have you had on going trouble with: Please circle all that apply**

Constipation	Mental fog	Weight	Declining strength
Diarrhea	Frequently losing things	Binge eating	Heart palpitations
Waking up to urinate	Difficulty relaxing	Anxiety	Shortness of breath
Waking up stiff/sore	Feel restless/fidgety	Cranky	Hair Loss
Waking up tired	Depression	Energy level	Headaches
Sleeping/Insomnia	Poor focus	Loss of muscle mass	Muscle/Joint pain
Low motivation	Poor memory	Difficulty falling asleep	Pain
Fatigue	Poor sex drive	Hand tremors	Fibromyalgia
Vaginal dryness	Cold feet	Snoring	Weakness
Hot flashes	Cold intolerance	Dry skin	Light headed when standing up
Night sweats	Erections	Waking frequently at night	Chronic sickness (cold/flu)