avanti health

CHIROPRACTIC • ANTI-AGING • MASSAGE

850 W Ironwood Dr, Suite 302 • Coeur d'Alene, ID 83814
Phone (208) 664-5225 • Fax (208) 664-5228

PATIENT INTAKE & QUESTIONNAIRE – HRT

Patient Name: _____
First MI Last

Address: _____ **Apt/Bldg #:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: ( ) - **Cell Phone:** ( ) -

Work Phone: ( ) -

Email: _____

Date of Birth: ___ / ___ / ___ **SSN:** _____

Gender: ❑ Male ❑ Female **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Employment Status: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired ❑ Other

Employer/School Name: _____

Address: _____ **Apt/Bldg #:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: ( ) - **Occupation:** _____

Emergency Contact: _____

Relationship to patient: _____ **Phone:** ( ) -

Referral Information – *Please check appropriate box and provide name*.

❑ Family member: _____ ❑ Friend: _____

❑ Physician: _____ ❑ Internet: _____

_____ _____
Patient Signature **Date**

Past Medical History: Please check any medical conditions or health problems that you currently have or have had in the past.

YES	NO	CONDITION	YES	NO	CONDITION
❑	❑	Headaches (Migraines)	❑	❑	Heart Disease
❑	❑	Seizure Disorder	❑	❑	Chest Pain
❑	❑	Recurrent Sinus Infections	❑	❑	Irregular Heartbeat
❑	❑	Seasonal Allergies	❑	❑	High Blood Pressure
❑	❑	Emotional/Psychiatric Illness	❑	❑	Blood Clotting Problems
❑	❑	Depression	❑	❑	Bleeding Disorder
❑	❑	Anxiety/Excessive Stress	❑	❑	Stroke/Vascular Disease
❑	❑	Asthma	❑	❑	Constipation/Diarrhea
❑	❑	Chronic Bronchitis	❑	❑	Hepatitis/Liver Disease
❑	❑	Lung/Breathing Problems	❑	❑	Kidney Disease
❑	❑	Chronic Indigestion	❑	❑	Menstrual Disorders
❑	❑	Stomach Ulcers	❑	❑	Reproductive Problems
❑	❑	Intestinal Disease	❑	❑	Prostate Problems
❑	❑	Skin Problems	❑	❑	Sexual/Libido Problems
❑	❑	Back Pain/Sciatica	❑	❑	Tendonitis
❑	❑	Herniated Disc	❑	❑	Chronic Pain
❑	❑	Neck Pain	❑	❑	Shoulder Problems
❑	❑	Chronic Muscle/Joint Pain	❑	❑	Osteoarthritis
❑	❑	Carpal Tunnel Syndrome	❑	❑	Rheumatoid Arthritis
❑	❑	Fibromyalgia	❑	❑	Artificial Joint(s)
❑	❑	Diabetes	❑	❑	Cancer
❑	❑	Thyroid Disease	❑	❑	Psoriasis or Eczema
❑	❑	Osteoporosis/Osteopenia	❑	❑	Other (please list below)

List any additional health problems not listed above: _____

_____

_____

Preventive Tests	Month/Year of Last Test	Test Results
Cholesterol	_____	_____
Bone Density	_____	_____
Colonoscopy	_____	_____
Exercise Stress Test	_____	_____

List any surgeries/operations you have had and when: _____

_____

_____

_____

Medication/Supplementation: List current medications (or those you have taken within the last year). List any additional on the back of the page if more room is needed.

Medication Name	Date Started	Date Stopped	Dosage (amt/#daily)

Nutritional supplements, vitamins, herbs, homeopathic remedies taken: _____

_____

_____

_____

Medication Allergies: _____

_____

_____

_____

Environmental/Food Allergies: _____

_____

_____

_____

Patient Goal Sheet

Patients have the greatest success on our program when we have a clear understanding of their health goals. These goals may change as you see your health improving. We will ask you to communicate your goals to us on a regular basis to ensure that you are completely satisfied with your program. Place a check mark next to the statements that best describe your goals.

- ❑ Lose weight
- ❑ Increase strength/muscle
- ❑ Improve libido/sexual function
- ❑ Lower diabetic risk
- ❑ Improve diabetes control
- ❑ Lower blood pressure
- ❑ Improve cholesterol levels
- ❑ Treat menopausal symptoms
- ❑ Improve mental function
- ❑ Improve fatigue
- ❑ Lower dementia risk
- ❑ Lower cancer risk
- ❑ Improve sleep
- ❑ Decrease pain
- ❑ Balance hormones
- ❑ Increase energy
- ❑ Increase stamina
- ❑ Improve memory
- ❑ Increase bone density
- ❑ Improve skin appearance

Other areas of your health you would like to improve:

_____

_____

_____

_____

_____

_____

Family History: For the conditions listed, check YES or NO if anyone in your family has been affected, then write the relationship of the relative with the condition/disease on the adjacent line.

YES	***NO***	***CONDITION***	***RELATIONSHIP***
❑	❑	Heart Disease	_____
❑	❑	High Blood Pressure	_____
❑	❑	Diabetes	_____
❑	❑	Arthritis	_____
❑	❑	Skin Disorders	_____
❑	❑	Breast Cancer	_____
❑	❑	Uterine/Ovarian Cancer	_____
❑	❑	Prostate Cancer	_____
❑	❑	Colon Cancer	_____
❑	❑	Other Cancer	_____

List any other disease/condition in your family and the relationship: _____

_____

_____

MEN

Date of last Prostate exam: _____

Are you concerned with loss of muscle mass, tone or strength? ❑ No ❑ Yes

Have you had any problems with urination (decreased stream/frequent night urination)? ❑ No ❑ Yes

Do you perform periodic testicular sel-examinations? ❑ No ❑ Yes

Has your abdominal girth and weight been increasing? ❑ No ❑ Yes

WOMEN

Are you pregnant? ❑ No ❑ Yes Last menstrual cycle: _____

Date of last pap/pelvic/breast exam: _____ ❑ Normal ❑ Abnormal: _____

Last Mammogram: _____ ❑ Normal ❑ Abnormal: _____

Do you perform monthly breast self-exams? ❑ No ❑ Yes

How many pregnancies? _____ # of children: _____

Taking/have taken hormones/oral contraceptives: ❑ No ❑ Yes If yes, list any you have taken and when:

_____

List problems or concerns about taking hormone replacement therapy: _____

_____

Have you had a hysterectomy? ❑ No ❑ Yes Where your ovaries removed? ❑ No ❑ Yes

Describe menstrual irregularities: _____

Recent Tests: *Have you had any of these tests in the past 5 years?*

Test	Date	Reason	Result
Chest X-Ray			
EKG			
EGD (stomach)			
Colonoscopy			
Ultrasound			
CT Scan			
MRI			
Bone Density Scan (DEXA)			
Other			

Health Habits: *Which Substances do you consume?*

Substance	How Much?
Caffeine	cups or cans/day
Cigarettes	packs/day x years
Are you interested in quitting?	Yes / No
Alcohol	Type Amount
Drugs	Type Amount
Chew Tobacco	Amount x years
Nutrasweet	Serving per day:
Saccharin	Serving per day:
Splenda	Serving per day:
MSG	Serving per day:

DIET

Please check the most appropriate answer:

1. I consume meals prepared from scratch:
   ❑ Less than 10% of the time ❑ 10% of the time ❑ 25% of the time ❑ 50% of the time ❑ 75% or greater

2. I eat at restaurants:
   ❑ Less than 10% of the time ❑ 10% of the time ❑ 25% of the time ❑ 50% of the time ❑ 75% or greater

3. I eat fast foods:
   ❑ Less than 10% of the time ❑ 10% of the time ❑ 25% of the time ❑ 50% of the time ❑ 75% or greater

4. I tend to crave/eat the following foods:
   ❑ Sugar ❑ Whole Grain ❑ Fruit Juice ❑ Alcohol ❑ Chocolate ❑ Fatty Food/Oil ❑ Bread/Pasta

5. I usually crave at the following times:
   ❑ After Meals ❑ Through Morning ❑ Through Afternoon ❑ Evenings ❑ No Specific Time

6. I tend to overeat:
   ❑ Never ❑ Seldom ❑ Often

7. I drink _____ ounces of water per day:
   ❑ Tap ❑ Well ❑ Bottled ❑ Distilled ❑ Filtered

WEIGHT LOSS

1. How concerned are you about your weight? (Circle; 1 = not at all, 10 = very much)

   1 2 3 4 5 6 7 8 9 10

2. How much help do you need with your weight loss? (Circle; 1 = none, 10 = much)

   1 2 3 4 5 6 7 8 9 10

3. How long has your weight been a problem?

   ❑ < 5 Years ❑ > 5 Years ❑ Lifetime ❑ Since Menopause ❑ Since Pregnancy ❑ Stressful Event

4. Where do you tend to carry most of your weight?

   ❑ Hips and Thighs ❑ Belly ❑ Face ❑ All Over

5. As an adult, my lowest weight has been/is: _____ Date: _____

6. As an adult, my highest weight has been/is: _____ Date: _____

7. What type of workout plan worked best for you in the past? _____

8. Your current weight: _____ Your goal weight: _____

STRESS

1. Rate your overall current stress level:

   ❑ Extreme ❑ High ❑ Medium ❑ Low

2. Evaluate each type of stress: (check as appropriate)

Types of Stress	Rating				Duration of Stress			Resolution Within			
	Extreme	High	Medium	Low	Weeks	Months	Years	1yr	5yrs	10yrs	Never
Family/Relatives	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Home	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Financial	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Work	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Relationship With:	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Illness	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Transition in: Life/Home /Relationship/Work	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Loss of : Loved One/Work	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

3. Check yes or no:

	Yes	No
Do you feel like your life is too busy?	❑	❑
Do you feel burdened with life?	❑	❑
Do you suffer from melancholy?	❑	❑
Do you have a low sexual interest?	❑	❑
Do you have a bleak attitude about life?	❑	❑
Are you angry or frustrated with certain aspects of life?	❑	❑
Is it hard for you to enjoy life in general?	❑	❑
Do you envy other people who seem happier in general?	❑	❑
Are you easily distracted?	❑	❑
Are you impulsive?	❑	❑
Are you plagued with unfinished projects?	❑	❑
Do you lose things or frequently misplace things?	❑	❑

SLEEP

1. How much sleep do you get at night (on average)? _____ Hours

2. My usual bed time is: _____ A.M./P.M.

3. My usual wake up time is: _____ A.M./P.M.

4. Approximate time before falling asleep is: _____ minutes

5. Do you awake in the night? How many times? _____ Why? _____

6. Check YES or NO:

YES	***NO***	
❑	❑	I usually need my alarm to wake up.
❑	❑	My sleep is not restful.
❑	❑	I have difficulty falling asleep.
❑	❑	I wake at night feeling like I am choking, being smothered or kicking my legs.
❑	❑	My partner notices I snore heavily.
❑	❑	My partner notices I stop breathing through the night along with my snoring.
❑	❑	I have restless legs that disturb my evening or sleep.
❑	❑	I wake at night and it's difficult to go back to sleep.
❑	❑	I wake at night hungry or thinking of food.
❑	❑	I have daytime drowsiness or sleepiness.
❑	❑	If I am not active during the day I tend to fall asleep (meetings, driving, etc.).
❑	❑	I am a night shift worker.
❑	❑	I have or might have sleep apnea.

EXERCISE

*Complete first portion only if you are **currently** exercising.*

1. Exercise(s) you participate in:
   ❑ Aerobic ❑ Weights ❑ Walking ❑ Swimming ❑ Bicycling ❑ Running ❑ Other:_____

2. How often do you exercise?
   ❑ Once /week ❑ Twice /week ❑ Three times /week ❑ Four times /week ❑ Five or more times /week
3. What is the average duration of exercise you get at one time? _____ Minutes

4. What motivates you to exercise? _____
   _____

5. Are you experiencing difficulty with your exercise routine? ❑ Yes ❑ No

6. If yes, please explain: _____

*Complete the following if you are **not** currently exercising.*

1. What prevents you from exercising?
   ❑ Time ❑ Interest ❑ Energy ❑ Injury ❑ Motivation

2. Do you experience pain with exercising? ❑ Yes ❑ No

3. If yes, where is the pain located? _____

4. How do you prefer to work out?
   ❑ Gym ❑ With a Partner ❑ With a Trainer ❑ Alone

MOTIVATION

Please reflect on the following statements and circle the most appropriate rating.

	1 = Do Not Agree, 5 = Strongly Agree				
I am prepared to make changes in my life.	1	2	3	4	5
It is important to make the changes now, not later.	1	2	3	4	5
I will find the time to exercise regularly.	1	2	3	4	5
I am willing to eat differently.	1	2	3	4	5
I am willing to take my supplements as my doctor prescribes.	1	2	3	4	5
I will take my medications as my doctor prescribes.	1	2	3	4	5
I will work with my doctor to find the right regimen for me.	1	2	3	4	5
I will not expect instant results and perfect outcomes.	1	2	3	4	5
I recognize that this is a long-term process, not a quick-fix.	1	2	3	4	5

Do you currently have any of the following symptoms?

Metabolic, T3, or Adrenal	Yes	No
Migraines		
Constipation		
Fluid Retention		
Crave Caffeine		
Dry Coarse Skin		
Deepening Voice		
Dry or Thinning Hair		
Cold Hands and Feet		
Elevated Cholesterol		
Low Body Temperature		
Fatigue/Exhausted by Day's End		
Brittle Unhealthy Nails		
Fibromyalgia		
Chronic Fatigue		

Metabolic or T4	Yes	No
Decreased Memory		
Depression		
Anxiety		
Cannot Multi-task as well		
Low Ambition/Motivation		
Decreased Concentration		
Foggy/Spacey/Muddled Mind		
Hard to Follow a Train of Thought		

Adrenal	Yes	No
Fainting/Collapse		
Palpitations		
Salt Craving		
Muscle Tension		
Easily Frustrated		
Sweat Easily (palms/armpits)		
Sugar Craving		
Panic Attacks		
Feeling Overwhelmed		
Excessive Hunger		
Prone to Infections/Sickly		
Low Blood Pressure		
Light Headed When Standing Up		
Racing Mind, Prevent Sleep		
Sluggish in Morning – Slow Start		
Need Sunglasses in Bright Light		
Low Back Pain – Worse w/Fatigue or Stress		

Cardiovascular/Respiratory	Yes	No
Chest Pain		
Blood in Sputum		
Unusual Cough		
Shortness of Breath		
Swollen Ankles		
Rapid Heart Beat		
Leg Pain with Walking		
Snoring Excessively		

Gastro-Intestinal	Yes	No
Fluid Retention, Puffy Extremities		
Bright Blood in Stool		
Difficulty Swallowing		
Loss of Appetite		
Persistent Nausea		
Bloating		
Abdominal Pain		
Acid Reflux		
Recent Change in Bowel Habit		
Weight Loss (unexpected)		
Black Tarry Stools		
Fainting/Collapse		

Urinary	Yes	No
Blood in Urine		
Urgent Urination		
Frequent Urination		

Hypersensitivity	Yes	No
Symptoms are Year-Round		
Symptoms are Seasonal		
Irritated Tongue		
Recurrent Canker Sores		
Diarrhea Alternated with Constipation		
Dandruff/Itchy Scalp		
Eczema/Dermatitis		
Dizziness		
Wheezing		
Chronic Cough		
Sinus Congestion		
Nasal Congestion		
Excessive Mucus		

Metabolism	Yes	No
Excessive Thirst		
Cannot Skip Meals		
Headache if Meal is Missed		
Craving for Sugar and Carbs		
Mid-Afternoon Drowsiness		
Low Energy Periods Relieved w/Food		
Jittery/Irritable Episodes Relieved w/Food		
Alt. Bet. High/Low Moods		
Alt. Bet. Sluggish/High Energy		
High Blood Pressure		
Skin Tags at Neck/Armpits		
High Cholesterol/Triglycerides		
Increased Fat Around Abdomen		
Prone to Inflammation /Bursitis		

Neuro-Cognitive/Psych	Yes	No
Loss of Self-Esteem		
Feeling of Hopelessness		
Feeling Defeated		
Loss of Confidence		
Mood Swings		
Sense of Powerlessness		
Decreased Sense of Well-Being		
Apathy/Losing Interest in Life		
Vision Deteriorating		
Hearing Deteriorating		
Memory Deteriorating		
Balance Deteriorating		
Coordination Deteriorating		
Change in Headaches		
Double Vision		
Dizzy/Spinning		

Immune System	Yes	No
Frequent Colds or Flu		
Rash Across Face and Cheeks		
Patchy Red Rash on Body		
Arthritis in Fingers/Hands		
Asthma/Wheezing		
Patchy Hair Loss		

Other	Yes	No
Unusual Bruising		
Nose Bleeds		
Prolonged Bleeding		

Authorization for Release of Information of Medical Records

Patient Name: _____

Address: _____ Apt/Bldg #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ SSN: _____

Name of Clinic or Physician: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the above-named individual or organization to disclose the above named patient's health information as described below, to the following recipient. **For continuing medical care, copies of all responsive documents should be sent by mail or fax to the following:**

Avanti Health
850 W. Ironwood Dr., Suite 302,
Coeur d 'Alene, ID. 83814
Phone: (208) 664-5225
Fax: (208) 664-5228

INFORMATION TO BE RELEASED:

- ❑ Current CBC, CMP, Cholesterol and any hormone testing. For men, last PSA.
- ❑ Current History and Physical.
- ❑ For Women, current PAP report and mammogram report.
- ❑ Current Colonoscopy report.

Information obtained from the above-named individual or organization shall not be disclosed to anyone other than Avanti Health and its representatives, NP-C to conduct a personal review of disclosed information and to orally discuss this information to develop a plan of care. I understand that the information provided may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed.

REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to Avanti Health, at the address set forth above. The revocation will not apply to records and information that have already been provided.

EXPIRATION: This authorization will expire when the request has been filled. PHOTOCOPIES OF THE AUTHORIZATION ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize to use or disclose my health information in the manner described above.

_____ _____

Patient / Legal Representative Signature **Date**

PREFERRED CONTACT AUTHORIZATION

The privacy of your protected health information is of utmost importance to us. As such, we wish to contact you in the most efficient and effective manner as possible. Please help us by completing the following information.

I, _____, authorize Avanti Health and its representatives to contact me regarding appointments, payment information, prescription refills, or general health, utilizing the following methods. If I wish for certain information to be omitted on messages or call screening, I will check the appropriate box and provide instruction in the area provided below.

Best/preferred method to reach you: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Can we contact/leave a message on your home Phone?	❑ Yes	❑ No	❑ See instructions below
Can we contact/leave a message on your cell phone?	❑ Yes	❑ No	❑ See instructions below
Can we contact/leave a message on your work phone?	❑ Yes	❑ No	❑ See instructions below
Can we contact you via email?	❑ Yes	❑ No	❑ See instructions below

Note: only general/appointment information will be emailed.

Instructions: _____

_____

_____

CONSENT TO SHARE PROTECTED INFORMATION (OPTIONAL)

I give permission to Avanti Health and its representatives to share my protected information regarding:

❑ Appointments ❑ Payments/Insurance ❑ General Health ❑ Prescription Information

With the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Name (print) Date

_____

Patient Signature

_____ _____

Guardian Signature Date

_____ _____

Guardian Name Relationship to Patient

CONSENT FOR PURPOSES OF
CONSENT FOR PURPOSES OF
TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS
AND PRIVACY NOTICE

I, _____, consent to Avanti Health (Avanti) for use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for Avanti general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Avanti diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by Avanti, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of Avanti, but that Avanti is not required to agree to these restrictions. However, if Avanti agrees to a restriction that I request, the restriction is binding on Avanti.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or Avanti has acted in reliance on this consent.

I have been given the opportunity to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. This document is attached to the clipboard used for new patient intake. Please notify our front desk if you wish to have a copy of our Notice of Privacy Practices.

By way of signature, I provide Avanti Health with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

I have read the Privacy Notice and understand my rights contained in the notice.

Patient Name (print)	Date
Patient Signature	
Guardian Signature	Date
Guardian Name	Relationship to Patient