BURNS INTEGRATIVE WELLNESS CENTER

Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059

Personal Information

Name _____ Age _____ Date of Birth _____
Height _____ Weight _____ Gender ☐ Male ☐ Female

Address _____
City _____ State _____ Zip _____

☐ Married
☐ Divorced
☐ Single
☐ Widow
Children _____

Home Phone _____
Cell Phone _____
Work Phone _____
Email Address _____

Spouse _____ Phone _____
Emergency Contact _____ Phone _____

Occupation _____ ☐ FT ☐ PT
Employer _____

Primary Care Physician _____ Phone _____
☐ Y ☐ N Is it okay if we contact them about your care?

☐ Y ☐ N Would you like to subscribe to out newsletter? [No more than 1-2 emails per month] Our newsletter includes health-related articles and healthy recipes.

☐ Y ☐ N Is it okay if we send SMS text appointment reminders to your mobile phone?

How Did You Learn About Our Office?

☐ Attorney ☐ Family ☐ Google ☐ Other _____
☐ Mailer ☐ Co-Worker ☐ Yelp ☐ Counselor / Therapist
☐ Friend ☐ Physician ☐ Facebook ☐ Instagram

If referred, by whom _____

Signature Patient | Patient Name [Printed] | Date

If needed, Signature of authroized representative | Representative Name [Printed] | Relationship to patient | Date

Authorized Facility Signature | Date

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Medical History

Current Medical Complaint_____

_____

_____

Allergies

☐ No known allergies
☐ Yes - Known allergies - list all medications, Foods, Environmental Allergies, etc…

_____

_____

_____

_____

Medications [please include prescription, herb and over-the-counter]

☐ No current medications ☐ Yes - Current medications listed

			Oral	Topical	Injection	Other	
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____

Surgeries

☐ No surgeries ☐ Yes - List surgeries below

Surgery	Month	Year

_____ _____ _____
Signature Patient Patient Name [Printed] Date

_____ _____ _____ _____
If needed, Signature of authroized representative Representative Name [Printed] Relationship to patient Date

_____ _____
Authorized Facility Signature Date

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Please Check YES or NO for ALL of the Following Regarding Your Health

Y N
☐ ☐ High Blood Pressure
☐ ☐ Heart Disease / Circulatory Issues [Explain]
_____
_____
_____
☐ ☐ Stroke [date]_____
☐ ☐ Cancer / Tumor [Explain]_____
_____
_____
☐ ☐ Osteoporosis/Osteopenia, Where
_____
_____
☐ ☐ Birth Control - Type / Dose_____
_____
_____
☐ ☐ STD_____
☐ ☐ Substance Abuse_____
_____
☐ ☐ Mental Health Problems_____
_____
_____

Y N
☐ ☐ Rheumatoid Arthritis
☐ ☐ Corticosteroid Use
☐ ☐ Hives, Eczema, Rash
☐ ☐ Urinary Problems
☐ ☐ Prostate Problems
☐ ☐ Menstrual Problems
☐ ☐ Multiple Sclerosis
☐ ☐ Dizziness / Fainting
☐ ☐ Epilepsy / Seizures
☐ ☐ Liver disease
☐ ☐ Kidney disease
☐ ☐ ADD / ADHD
☐ ☐ Unusual Spots / Moles
☐ ☐ History of Head Injury
☐ ☐ Sleep Disorders [Sleep apnea, insomnia]
☐ ☐ Abnormal weight ☐ Loss ☐ Gain
☐ ☐ Thyroid ☐ Hypo ☐ Hyper
☐ ☐ Asthma / Lung disease / Difficulty breathing
☐ ☐ Temperature/Pressure Sensitivity
☐ ☐ Bruise easily / Bleeding problems
☐ ☐ Intestinal disorders [IBS, Ulcers]

Y N
☐ ☐ Diabetes
☐ ☐ Stress
☐ ☐ Pain at night
☐ ☐ Headaches
☐ ☐ HIV / AIDS
☐ ☐ Wear Contacts
☐ ☐ Night sweats
☐ ☐ Recent fever
☐ ☐ Hepatitis

☐ ☐ Broken Bones / Fractures_____
☐ ☐ Surgeries / Hospitalizations_____
_____
_____
☐ ☐ Other health related issues_____
_____
_____

Last physical date_____

Female Patients Only

Y N
☐ ☐ Are you pregnant? If *yes*, # weeks _____
☐ ☐ Are your currently breast feeding?

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Physical / Social History

Exercise

☐ None
☐ Moderate
☐ Heavy
Days/week_____

Work Activity

Y N
☐ ☐ Sitting
☐ ☐ Standing / Bending
☐ ☐ Light Labor
☐ ☐ Heavy Labor

Drug and Alcohol History

Y N
☐ ☐ Tobacco Cigarettes / day _____
☐ ☐ Alcohol Drinks / week _____
☐ ☐ Caffeine Drinks / day _____
☐ ☐ Cocaine / Meth
☐ ☐ Opiates/Prescription, heroin or methodone
☐ ☐ Hallucinogens [Ecstasy, LSD, Mushrooms]
☐ ☐ Other_____

Y N NA
☐ ☐ ☐ Would you like help quitting?

General

Y N
☐ ☐ High Stress_____
_____

Family History

Mother's side

Y N
☐ ☐ Cancer [Type]_____
☐ ☐ Heart Disease - Age_____
☐ ☐ Stroke - Age_____
☐ ☐ High Blood Pressure
☐ ☐ Diabetes
☐ ☐ Rheumatoid Arthritis
☐ ☐ Other_____
☐ ☐ _____

Father's side

Y N
☐ ☐ Cancer [Type]_____
☐ ☐ Heart Disease - Age_____
☐ ☐ Stroke - Age_____
☐ ☐ High Blood Pressure
☐ ☐ Diabetes
☐ ☐ Rheumatoid Arthritis
☐ ☐ Other_____
☐ ☐ _____

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Cancellation Policy

To better serve our patients, we require 24-hour notice if an appointment is to be canceled or rescheduled. This will ensure maximum availability to all patients who need to see us.

If you do not provide us 24 hours advance notice of cancellation you will be responsible for the entire payment of the office visit.

Prescription Refill Policy

Burns Integrative Wellness Centerwill call in prescription refills within 48 hours of receiving the request on business days, Monday through Friday, except for holiday schedules. Please plan your refills accordingly.

Information Provided

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Signature Patient	Patient Name [Printed]		Date
If needed, Signature of authroized representative	Representative Name [Printed]	Relationship to patient	Date
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Progesterone

Signs & Symptoms

		Never				Always
1	My breasts are large.	0	1	2	3	4
2	My close friends complain I'm nervous and 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
	Questions 5-10 are for women who are non-menopausal or on replacement therapy [estrogen and/or progesterone]					
5	My breasts are swollen and tender or painful before my period.	0	1	2	3	4
6	My lower belly is swollen.	0	1	2	3	4
7	I'm irritable and aggressive.	0	1	2	3	4
8	I lose my self-control.	0	1	2	3	4
9	I have heavy periods.	0	1	2	3	4
10	My periods are painful.	0	1	2	3	4
	Add up your overall score					

Testosterone

Signs & Symptoms [Men & Women]

		Never				Always
1	My face has gotten slack and more wrinkled.	0	1	2	3	4
2	I've lost muscle tone.	0	1	2	3	4
3	My belly tends to get fat.	0	1	2	3	4
4	I'm constantly tired.	0	1	2	3	4
5	I feel like making love less often than I used to.	0	1	2	3	4
	Signs & Symptoms [Men Only]					
6	My breasts are getting fatty.	0	1	2	3	4
7	I feel less self confident and more hesitant.	0	1	2	3	4
8	My sexual performance is poorer than it used to be.	0	1	2	3	4
9	I have hot flashes and sweats.	0	1	2	3	4
10	I tire easily with physical activity	0	1	2	3	4
	Add up your overall score					

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Growth Hormone

Signs & Symptoms [Men & Women]

		Never				Always
1	My hair is thinning.	0	1	2	3	4
2	My cheeks sag.	0	1	2	3	4
3	My gums are receding.	0	1	2	3	4
4	My abdomen is flabby / I've got a "spare tire."	0	1	2	3	4
5	My muscles are slack.	0	1	2	3	4
6	My skin is thin and/or dry.	0	1	2	3	4
7	It's difficult to recover after physical activity.	0	1	2	3	4
8	I feel exhausted.	0	1	2	3	4
9	I don't like the world. I tend to isolate myself.	0	1	2	3	4
10	I feel continuously anxious and worried.	0	1	2	3	4
	Add up your overall score					

Thyroid

Signs & 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 morning my face is puffy and my eyelids are swollen.	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'm 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'm living in slow motion,	0	1	2	3	4
	Add up your overall score					

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Estrogen

	Signs & Symptoms [Men & Women]	Never Always
1	I am losing hair on the top of my head.	0 1 2 3 4
2	I am getting thin, vertical wrinkles above my lips.	0 1 2 3 4
3	I have hot flashes.	0 1 2 3 4
4	I feel tired constantly.	0 1 2 3 4
5	I am depressed.	0 1 2 3 4
	Signs & Symptoms [Women Only]	
6	My breasts are droopy.	0 1 2 3 4
7	My face is too hairy.	0 1 2 3 4
	Women with periods	
8	My menstrual flow is heavy [0=moderate | 1-3=low | 4=none]	0 1 2 3 4
9	My cycles are irregular [0 for short or < 27 days | 2 for normal | 4 for long or > 31 days]	0 1 2 3 4
	Women without periods	
10	I do not feel like making love anymore.	0 1 2 3 4
	Add up your overall score	

Energy

		Y N
1	Do you have a hard time getting up in the morning?	☐ ☐
2	Do you have a hard time getting up in the morning?	☐ ☐

Sex

		Y N
1	Do you lack sexual desire?	☐ ☐
2	Does your penis or clitoris seem less sensitive?	☐ ☐
3	Have you lost attraction towards your partner?	☐ ☐
4	[Men] - Are your erections not firm enough?	☐ ☐
5	[Women] - Do you lack vaginal lubrication?	☐ ☐

Sleep

		Y N
1	Do you sleep poorly?	☐ ☐
2	Do you rarely dream?	☐ ☐

Memory

		Y N
1	Do you suffer from short or long-term memory loss?	☐ ☐
2	Do you have trouble concentrating?	☐ ☐

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Skin and Hair

		Y	N
1	Do you have wrinkles on your face along the nose, smile lines, or forehead creases?	☐	☐
2	Do you have wrinkles or crows feet around your eyes?	☐	☐
3	Do you have age spots?	☐	☐
4	Do you have dry, thin skin?	☐	☐
5	Are you losing your hair or is it turning gray?	☐	☐

Weight Control

		Y	N
1	Is your abdomen too plump? Is it distended?	☐	☐
2	[Women] - Are your breasts too large? Do they get larger before your period?	☐	☐
3	Are your buttocks and thighs too well padded?	☐	☐
4	Are you pear-shaped?	☐	☐

Stress and Mood

		Y	N
1	Do you suffer from constant fatigue?	☐	☐
2	Do you have high blood pressure?	☐	☐
3	Are you anxious, nervous, or irritable?	☐	☐
4	Do small things set you off?	☐	☐
5	Are you depressed?	☐	☐

Joints and Bones

		Y	N
1	Do you have arthritis?	☐	☐
2	Do you have osteoarthritis in the hip?	☐	☐
3	Do you have fibromyalgia? [sharp shoulder pain]	☐	☐
4	Have you lost muscle mass, tone and strength?	☐	☐
5	Do you have bone loss of the spine, hips, wrists and feet?	☐	☐

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Consent for Use and Disclosure of Health Information

We here at Burns Integrative Wellness Centerare very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Burns Integrative Wellness Center, it's staff or employees, may from time to time schedule appointments for other healthcare providers, when requested. These providers are not partners or contractors of Burns Integrative Wellness Center. All health and patient information disclosed to Burns Integrative Wellness Center, it's employees or staff, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA, are complied with.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding.

Your Right to Revoke Your Authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Signature Patient | Patient Name [Printed] | Date

If needed, Signature of authroized representative | Representative Name [Printed] | Relationship to patient | Date

Authorized Facility Signature | Date