



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

Page 1 of 10

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 our 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 authorized representative _____ Representative Name [Printed] _____ Relationship to patient _____ Date _____

Authorized Facility Signature _____ Date _____



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

Page 2 of 10

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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	Dose _____	Route _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Surgeries

- No surgeries
- Yes - List surgeries below

Surgery	Month	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature Patient _____ Patient Name [Printed] _____ Date _____

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

Authorized Facility Signature _____ Date _____



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

Page 3 of 10

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

- | | | |
|---|---|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease / Circulatory Issues [Explain]
_____ | <input type="checkbox"/> <input type="checkbox"/> Corticosteroid Use | <input type="checkbox"/> <input type="checkbox"/> Stress |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Hives, Eczema, Rash | <input type="checkbox"/> <input type="checkbox"/> Pain at night |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> <input type="checkbox"/> Headaches |
| <input type="checkbox"/> <input type="checkbox"/> Stroke [date]_____ | <input type="checkbox"/> <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> <input type="checkbox"/> Cancer / Tumor [Explain]_____ | <input type="checkbox"/> <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> <input type="checkbox"/> Wear Contacts |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> <input type="checkbox"/> Night sweats |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> <input type="checkbox"/> Recent fever |
| <input type="checkbox"/> <input type="checkbox"/> Osteoporosis/Osteopenia, Where
_____ | <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> <input type="checkbox"/> Hepatitis |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Liver disease | |
| <input type="checkbox"/> <input type="checkbox"/> Birth Control - Type / Dose_____ | <input type="checkbox"/> <input type="checkbox"/> Kidney disease | |
| _____ | <input type="checkbox"/> <input type="checkbox"/> ADD / ADHD | |
| <input type="checkbox"/> <input type="checkbox"/> STD_____ | <input type="checkbox"/> <input type="checkbox"/> Unusual Spots / Moles | |
| <input type="checkbox"/> <input type="checkbox"/> Substance Abuse_____ | <input type="checkbox"/> <input type="checkbox"/> History of Head Injury | |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Sleep Disorders [Sleep apnea, insomnia] | |
| <input type="checkbox"/> <input type="checkbox"/> Mental Health Problems_____ | <input type="checkbox"/> <input type="checkbox"/> Abnormal weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain | |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Thyroid <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper | |
| <input type="checkbox"/> <input type="checkbox"/> Broken Bones / Fractures_____ | <input type="checkbox"/> <input type="checkbox"/> Asthma / Lung disease / Difficulty breathing | |
| <input type="checkbox"/> <input type="checkbox"/> Surgeries / Hospitalizations_____ | <input type="checkbox"/> <input type="checkbox"/> Temperature/Pressure Sensitivity | |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Bruise easily / Bleeding problems | |
| <input type="checkbox"/> <input type="checkbox"/> Other health related issues_____ | <input type="checkbox"/> <input type="checkbox"/> Intestinal disorders [IBS, Ulcers] | |
| _____ | | |

Last physical date _____

Female Patients Only

- Y N
- Are you pregnant? If yes, # weeks _____
- Are you currently breast feeding?

Signature Patient _____ Patient Name [Printed] _____ Date _____

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

Authorized Facility Signature _____ Date _____



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

Page 4 of 10

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 _____
- _____

Signature Patient _____ Patient Name [Printed] _____ Date _____

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

Authorized Facility Signature _____ Date _____



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

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.

We charge a \$50 fee for any appointment canceled or rescheduled with less than 24-hours notice.

Prescription Refill Policy

Burns Integrative Wellness Center will 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 authorized representative

Representative Name [Printed]

Relationship to patient

Date

Authorized Facility Signature

Date



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

Page 6 of 10

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

Patient Name



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

Growth Hormone

Signs & Symptoms [Men & Women]

Never Always

- 1 My hair is thinning.
- 2 My cheeks sag.
- 3 My gums are receding.
- 4 My abdomen is flabby / I've got a "spare tire."
- 5 My muscles are slack.
- 6 My skin is thin and/or dry.
- 7 It's difficult to recover after physical activity.
- 8 I feel exhausted.
- 9 I don't like the world. I tend to isolate myself.
- 10 I feel continuously anxious and worried.

0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4

Add up your overall score

Thyroid

Signs & Symptoms

Never Always

- 1 I'm sensitive to cold.
- 2 My hands and feet are always cold.
- 3 In the morning my face is puffy and my eyelids are swollen.
- 4 I put on weight easily.
- 5 I have dry skin.
- 6 I have trouble getting up in the morning.
- 7 I feel more tired at rest than when I'm active.
- 8 I am constipated.
- 9 My joints are stiff in the morning.
- 10 I feel like I'm living in slow motion,

0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4

Add up your overall score

Patient Name

Hormone Patient Intake Form

Page 8 of 10

Estrogen

Signs & Symptoms [Men & Women]

Never Always

- 1 I am losing hair on the top of my head.
- 2 I am getting thin, vertical wrinkles above my lips.
- 3 I have hot flashes.
- 4 I feel tired constantly.
- 5 I am depressed.

0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4
0	1	2	3	4

Signs & Symptoms [Women Only]

- 6 My breasts are droopy.
- 7 My face is too hairy.

0	1	2	3	4
0	1	2	3	4

Women with periods

- 8 My menstrual flow is heavy [0=moderate | 1-3=low | 4=none]
- 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
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?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Sleep

Y N

- 1 Do you sleep poorly?
- 2 Do you rarely dream?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Memory

Y N

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

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Patient Name _____



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Hormone Patient Intake Form

Page 9 of 10

Skin and Hair

Y N

- | | | | |
|---|---|--------------------------|--------------------------|
| 1 | Do you have wrinkles on your face along the nose, smile lines, or forehead creases? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Do you have wrinkles or crows feet around your eyes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Do you have age spots? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Do you have dry, thin skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Are you losing your hair or is it turning gray? | <input type="checkbox"/> | <input type="checkbox"/> |

Weight Control

Y N

- | | | | |
|---|--|--------------------------|--------------------------|
| 1 | Is your abdomen too plump? Is it distended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | [Women] - Are your breasts too large? Do they get larger before your period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Are your buttocks and thighs too well padded? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Are you pear-shaped? | <input type="checkbox"/> | <input type="checkbox"/> |

Stress and Mood

Y N

- | | | | |
|---|---|--------------------------|--------------------------|
| 1 | Do you suffer from constant fatigue? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Do you have high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Are you anxious, nervous, or irritable? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Do small things set you off? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Are you depressed? | <input type="checkbox"/> | <input type="checkbox"/> |

Joints and Bones

Y N

- | | | | |
|---|--|--------------------------|--------------------------|
| 1 | Do you have arthritis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Do you have osteoarthritis in the hip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Do you have fibromyalgia? [sharp shoulder pain] | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Have you lost muscle mass, tone and strength? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Do you have bone loss of the spine, hips, wrists and feet? | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Name



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

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



Consent for Use and Disclosure of Health Information

We here at Burns Integrative Wellness Center are 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 authorized representative	Representative Name [Printed]	Relationship to patient	Date
---	-------------------------------	-------------------------	------

Authorized Facility Signature	Date
-------------------------------	------