INTAKE FORMS

First & Last Name:			
Address: City:	State:	Zip Code:	
Phone Number:		DL#:	
Email:		Occupation:	
Height:	Weight:	Goal Weight:	BP if Known:
Birth Date:	Age:		
Emergency Contact:		Phone Number:	
Marital Status: Single Married Divorced Widowed Domestic Partner			
Primary Physician: Date of Last Visit:			
List any major Hospitalizations, Operations, or Illnesses:			

LIST YOUR PRIMARY SYMPTOMS OF CONCERN YOU WANT TO ADDRESS BY PRIORITY:

SYMPTOMS/CONCERN	DATE OF ONSET	FREQUENCY	SEVERITY
EX. Headaches	*June 2014*	*4x weekly*	*Mild, Moderate, Severe*

IMPORTANT- PLEASE READ CAREFULLY BEFORE SIGNING: I certify that the information provided is true and correct and that I am a competent adult of at least 18 years of age, or that I am a minor under the age of 18. I understand that the consent of my parent/guardian/person having legal custody will be required before treatment. FURTHER, I UNDERSTAND A COMPLIMENTARY CONSULTATION IS PROVIDED BY THE PHYSICIAN'S APPOINTED NON-MEDICAL REPRESENTATIVE AND IS STRICTLY TO PROVIDE PROGRAM/TREATMENT INFORMATION. ANY DIAGNOSIS AND/OR TREATMENT MUST BE MADE BY THE LICENSED PHYSICIAN DURING THE PHYSICAN FACE-TO-FACE CONSULTATION.

_____

Patient Signature Date

FAMILY HISTORY INFORMATION-CHECK ALL THAT APPLY

CHILD	SIBLINGS	FATHER	MOTHER	SELF	DISEASE/DISORDERS	PHYSICIAN NOTES
					ABNORMAL BLOOD PRESSURE	
					ARTHRITIS OR JOINT PROBLEMS	
					ASTHMA, BRONCHITIS	
					AUTOIMMUNE DISEASE	
					BLOOD DISORDERS/ANEMIA	
					CANCER, TUMOR, CYSTS	
					COLITIS	
					CROHN'S DISEASE	
					DEPRESSION/MENTAL ILLNESS	
					DIABETES	
					ECZEMA/PSORIASIS	
					ENDOCRINE DISORDER	
					EPILEPSY	
					EXCESSIVE BLEEDING	
					GALL STONES	
					HEART DISEASE	
					HERPES/COLD SORES	
					HIGH CHOLESTEROL/LIPIDS	
					HIV	
					HEPATITIS	
					HPV/HUMAN PAPILOMAVIRUS	
					JAUNDICE/LIVER DIEASE	
					KELOID SCARRING	
					KIDNEY INFECTIONS/STONES	
					EMPHYSEMA	
					MELANOMA/ SKIN CANCER	
					PARASITES	
					PHLEBITIS/VARICOSE VEINS	
					PNEUMONIA	
					REOCCURING INFECTIONS	
					RHEUMATOID ARTHRITIS	
					THYROID DISEASE	
					TUBERCULOSIS	
					SEIZURES	
					STROKE	
					ULCERS	
					YEAST INFECTIONS (CANDIDA)	

LIST CURRENT RX MEDICATIONS OR USED WITHIN THE PAST 6 MONTHS

CHECK ALL THAT APPLY

BLOATING, GAS, FLATULENCE	HAIR LOSS- FALLING OUT	SENSITIVE TO COLD
HEARTBURN, REFLUX	DRY HAIR	PALPITATIONS/FLUTTERS
CONSTIPATION	THINNING HAIR	DIFFICULTY FALLING ASLEEP
HEMORRHOIDS	NAUSEA/VOMITTING	INSOMNIA
BOWEL HABIT CHANGES	EARS RINGING/DIZZINESS	PSORIASIS/ACNE FLAREUPS
COUGHING/WEEZING	FATIGUE	DRY SKIN
FOOD ALLERGIES/INTOLERANCES	TIRED UPON WAKING	URINARY TRACT INFECTIONS
SEASONAL ALLERGIES/HAY FEVER	FRONTAL HEADACHES/SINUSITIS	ARTHRITIS/JOINT ACHES & PAINS
CRAVINGS-SWEETS	COLD HANDS/FEET	LOWERBACK PAIN/STIFFNESS
CRAVINGS-SALT	POOR CIRCULATION	DEPRESSION, WEEPINESS
CRAVINGS- BEER, WINE,LIQUOR	PUFFY FACE, SWOLLEN EYELIDS	ANXIETY, IRRITABILITY, TEMPER

FEMALE HORMONE HISTORY

DATE OF LAST PERIOD: ARE YOUR MENSTRUAL CYCLES: 21 DAY 28 DAY 31DAY IRREGULAR
ARE YOU CURRENTLY PREGNANT: # OF TOTAL PREGNANCIES: LIVING: MISCARRIAGES:
LAST DATE OF PAPS SMEAR: DATE OF LAST MAMMOGRAM:
HAVE YOU EVER USED ORAL CONTRACEPTIVES: BEGAN AT WHAT AGE: AGE STOPPED: EXPLAIN ANY PROBLEMS WHILE TAKING CONTRACEPTIVES:
HAVE YOU HAD BREAST CANCER: WHEN: HAVE YOU HAD OVARIAN CANCER: WHEN: HAVE YOU HAD FIBROCYSTIC BREASTS: HAVE YOU HAD UTERINE FIBROIDS:
HAVE YOU HAD A HYSTERECTOMY: OVARIES REMOVED: TUBIL LIGATION: WHAT WAS THE REASON FOR YOUR HYSTERECTOMY? WHAT WAS THE DATE OF YOUR SURGERY?

SCORE USING THE FOLLOWING: 0=NEVER, 1=SOMETIMES, 2=REGULARLY, 3=OFTEN, 4=CONSTANTLY

IRREGULAR PERIODS	SWOLLEN TENDER BREASTS	FACE IS WRINKLED AND SLACK
LIGHT MENSTRUAL FLOW	SWOLLEN BELLY	LOSS OF MUSCLE TONE
VAGINAL DRYNESS	IRRITABLE & AGGRESSIVE BEHAVIOR	INCREASED BELLY FAT
CRAMPS	HEAVY PERIODS	FATIGUED, FEELING EXHAUSTED
PAINFUL INTERCOURSE	PAINFUL PERIODS	REDUCED LIBIDO
HOT FLASHES	LOSS OF SELF CONTROL	MEMORY LAPSES/MENTAL FOG
HAIR LOSS ON TOP OF HEAD	RESTLESS, LIGHT SLEEP	WEIGHT GAIN-WAIST, HIPS, THIGHS
DEPRESSED	ANXIOUS	

SCORE EACH FROM 0-10, WITH 10 BEING THE HIGHEST:

CURRENT LEVEL OF BACK PAIN	STRESS LEVEL PAST 30 DAYS	ENERGY LEVEL IN THE MORNING
CURRENT LEVEL OF JOINT PAIN	STRESS LEVEL PAST 6 MONTHS	ENERGY LEVEL IN AFTERNOON

Therapy Management Agreement

This agreement between _____ ("Patient") and Wellington IV LLC ("PP") establishes guidelines and conditions for the use of hormone replacement therapy ("HRT") involving DEA "controlled" or "scheduled" medications. PP and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and, therefore, these agents are prescribed with caution.

The patient agrees and accepts to the following conditions:

1. I understand that the medications I am receiving or will receive are prescribed for me based on diagnoses derived from my submitted medical history, and the results of lab work and a physical examination. The medications are to be used exclusively for treatment of hormonal deficiencies and related medical conditions in accordance with applicable state and Federal law.

2. I understand and agree that no medical treatment or medication provided to me by Wellington IV LLC , will be used for the purposes of bodybuilding, performance enhancement or physical appearance.

3. I certify that the answers I provided to the health questions on the Health History laboratories are accurate and correct to the best of my knowledge and that I have not been coached by any third party nor have I knowingly been deceptive for secondary gain, for medical treatment or prescription of a medication.

4. I will not attempt to obtain HRT medications from any other health care practitioner without disclosing my current medical usage of HRT or other medications. I understand that it may be against the law to do so.

5. I have discussed and understand the risks and benefits associated with HRT. I will immediately report any adverse side effect related to the use of my HRT to Wellington IV LLC, and discontinue use until advised to resume usage by Progressive Health Institute. I voluntarily assume any and all possible risks which may be associated with HRT.

6. I understand that representatives of Wellington IV LLC, and/or Licensed Physician's Assistant are available for questions and/or concerning during normal business hours throughout the course of my treatment.

7. I agree that the HRT medications furnished by Wellington IV LLC, are for my personal use only and for no other purpose. I will not share, sell, or trade my medications. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.

8. I will be able to purchase the medications from the pharmacy designated by Wellington IV LLC, and the pharmacy will send medication directly to me. I understand I have the right to purchase my medications from any pharmacy of my choice. If I chose to obtain medications from a pharmacy of my own choice, I must notify Pro Performance Anti-Aging in writing of my intention to do so and include the name of the pharmacy in my request.

9. I agree and understand that federal regulations prohibit the return of prescribed medications.

10. I understand that HRT treatment and medications are not covered by health insurance. I agree that all services and medications provided by Wellington IV LLC, or its associated providers are to be paid for in advance. I will not seek reimbursement through my health insurance company, Medicare, Medicaid, or other third-party payer.

11. I agree that the Wellington IV LLC, patient/physician relationship is not intended to replace the existing patient/physician relationship with my current primary care provider (PCP) and the treatment provided by Wellington IV LLC, will be in conjunction with the care provided by my current PCP.

12. I agree that I will use my medication at the prescribed rate and dosage and will keep the medication in its respective labeled container.

13. I understand that Wellington IV LLC, only treats patients over the age of 30 with documented symptoms of hormone deficiencies (Hypogonadism and Adult Growth Hormone Deficiency). No prescription will be provided unless a clinical need exists based on required lab work, physician consultation, and current health history through either patient's personal physician or a Progressive Health Institute - affiliated physician. Agreeing to lab work does not automatically qualify patient to clinically necessity and prescription of HRT.

I have read and agree to the terms of this the Therapy Management Agreement.

Patient Signature: _____

Printed Name: _____

Date: _____