ENDOCRINE WELLNESS

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Patient Information

Date: _____

Full Name: _____ DOB: _____/_____/_____

Address, City, State, Zip: _____

Preferred Phone: _____ Atl. Phone: _____

Email: _____

Sex: M F Age: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____ Height: _____ Weight: _____

Who is your primary care physician? _____

Are you seeing any other healthcare provider? _____

Who may we thank for referring you? _____

Billing Information: You must provide a credit/debit card number below or provide one at time of consultation.

Credit Card Type: Visa / MasterCard / Discover/Amex (please circle one)

CC #: _____ Expiration Date: _____ / _____

CVV: _____ Zip: _____

Consent to Treat

I hereby authorize this office and its doctors to examine and administer care as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all these fees charged by this office for such care.

HIPAA – Notice of Privacy Policies

The notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or other healthcare operations. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health. Please be advised that our office may deem it necessary to discuss your PHI with other treatment facilities, laboratories, or payment centers, among other reasons, with or without your consent. A full explanation of our rights and responsibilities as a healthcare facility and your rights as a patient, under HIPAA requirements, is available upon request.

Disclaimer

Please be advised that the nutritional and herbal programs that are administered by our office, and/or Dr. Annette Schippel are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. Also, be advised that any and all testing ordered by our office and/or Dr. Annette Kutz Schippel, whether it be by saliva, hair analysis and/or blood work is not used to treat or diagnose any disease. These types of testing simply offer guidance on how to use whole food supplements and herbs to support and balance the body, while dealing with imbalances.

Billing

We do not bill insurance for nutritional services, nor do we provide CPT or diagnosis codes for you to do so, as the nutritional work performed by Dr. Annette Kutz Schippel is not designed to diagnose or treat a disease. We would appreciate it if you were prepared to pay your consultation fee at the time of service.

Return Policy

Supplements must be in their original box/package. Boxes and bottles must be unopened. No expired products will be accepted. Any returns, for any reason are subject to a 20% restocking fee. No exceptions.

Please sign to confirm that you have read and understand the above information.

Patient Signature _____ Date _____

Thank you so much for taking the time to fill out this packet of information.
We look so forward to working with and getting to know you. We are dedicated to finding the best individual path for each of our patients.

Top Health Concerns

Please list your top 5 health concerns.

Health Concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications, Supplements & Vaccines

List all medications you are currently/recently on. Include bio-identical hormones, HRT & over the counters.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now.

Type	Date Started	Dosage

List any recent vaccinations, include number of doses and maker.

Vaccine/Immunization	Date

Readiness Assessment

Circle the number that best fits on a scale of 1 (not willing) to 5 (very willing).

To improve your health, how willing are you to:

Significantly modify your diet	1	2	3	4	5
Take nutritional supplements every day	1	2	3	4	5
Keep a record of everything you eat each day	1	2	3	4	5
Modify your lifestyle (e.g., work, sleep habits etc.)	1	2	3	4	5
Practice relaxation techniques	1	2	3	4	5
Engage in regular exercise	1	2	3	4	5
Have periodic lab tests to assess progress	1	2	3	4	5

Signs & Symptoms

Circle the number that best describes the intensity of your current symptoms.
1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.

Section 1:

Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestion?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/Nausea? (circle)	1	2	3

Section 2:

Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
Persistent Gas?	1	2	3
Digestive problems?	1	2	3

Section 3:

Low blood sugar / hypoglycemia?	1	2	3
Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine/stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

Section 4:

Low mood/depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

Section 5:

Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships? (circle)	1	2	3
Decreased initiative/motivation/drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self-image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness/crying? (circle)	1	2	3

Section 7:

Decrease in strength/stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decreased lean muscle mass?	1	2	3
Muscle soreness/weakness? (circle)	1	2	3
Body/joint aches? (circle)	1	2	3
Increased fat on hips/breasts/thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/Migraines? (circle)	1	2	3
Muscle pain/Joint aches/Backache? (circle)	1	2	3

Section 9:

Head hair loss/body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Section 10:

Infertility?	1	2	3
Lowered/Heightened libido? (circle)	1	2	3
Hot flashes?	1	2	3
Erectile Disfunction?	1	2	3
Night sweats?	1	2	3
Palpitations?	1	2	3
Breast tenderness?	1	2	3
Breast cysts?	1	2	3
Vaginal infections/Yeast infections? (circle)	1	2	3
Urinary frequency/Incontinence/Infections? (circle)	1	2	3
Changes to labia/clitoral tissue (Atrophy, thinning, discoloration, itching, burning)? (circle)	1	2	3
Vaginal changes (dryness, tearing, decreasing size)? (circle)	1	2	3
Bone loss/osteoporosis?	1	2	3
Endometriosis?	1	2	3
Pelvic inflammatory disease?	1	2	3
Ovarian cysts?	1	2	3
Fibroids?	1	2	3