CC #:_____ **Date:**_____

GENERAL INFORMATION:

Patient Last Name_____First Name_____Email_____

Address_____Care of_____Phone (Cell) _____

(Parent or financially responsible person)

City State	ZIP	Phone (wk)
Driver's Lic. # _____	No. Children _____	Phone (hm) _____

O M O F O Married O Single O Widowed O Divorced DOB__/___/____ SS# ——— ——— ———

Patient's Employer:_____Occupation_____

Employers Address:_____City_____Zip_____

Employment: O Full Time O Part Time O Retired D Not Employed Student: O Full Time O Part Time

Out of State Address_____Phone_____

Spouse's Name_____ Spouse's Employer_____Native Language_____

Referred to the Clinic by:

O Health Fair/Expo O Medical Doctor O Internet O Chiropractor O Ad in Natural Awakenings O Staff

O lifestyle Magazine O Walk-In O Insurance Listing D Patient_____ O Other_____

Primary Care Physician:_____

INSURANCE INFORMATION, IF APPLICABLE

COMMERCIAL INSUSRANCE AND MEDICARE ONLY

PRIMARY INSURANCE COMPANY NAME:	*COMPLETE ONLY IF PATIENT IS NOT THE INSURED* Insured's Information Insured's Name:
Type o Group o Private	O M O F o Married o Single D Widowed D Divorced
Membership/Cert. #	Patient's Relationship to Insured:
Policy/Group#	Insured's Date of Birth: / /
	Insured's Employer:
SECONDARY INSURANCE COMPANY NAME:	Insured's Name:
Type OGroup OPrivate	O M O F O Married O Single O Widowed D Divorced
Membership/Cert. #	Patient's Relationship to Insured:
Policy/Group#	Insured's Date of Birth: / /
	Insured's Employer:

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature_____ Date ———————

Please complete this form to the best of your ability. The doctor will review your answers during your visit.

Primary Care Doctor	Office Number	Last Physical Exam
Height Weight	*For Weight loss Patients:* Goal Weight	Lowest Adult Weight (after age 18)
Main Reason for Visit		REFERRED BY

MEDICAL & FAMILY HISTORY	SELF	FAMILY		SELF	FAMILY		SELF	FAMILY
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder disease/stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular heart rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpitations			Arthritis		
Obesity/Overwei ght			Heart Valve disorder			Gout		
Diabetes Mellitus (OM)			Heart Failure (CHF)			Osteopenia or Osteoporosis		
High blood sugar			High Blood Pressure			Kidney Disease or stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Depression or Anxiety		
			Cancer (type:)			Eating Disorder		
Other						Other Psychiatric Illness		

MD Notes:

SURGERIES & HOSPITALIZATIONS

Reason/Diagnosis	Year

Have you ever had a foreign body material and dental filling Amalgam? Y / N
Have you ever had artificial metal/plastic? Y / N

SPECIALISTS (If any)

Reviewed by:_____

MEDICATION ALLERGIES **n** *NO KNOWN ALLERGIES*

Name of Medications	Reaction

PRESCRIPTION MEDICATIONS

Medication Name	Dose & Frequency	Approx Start Date	Reason for use

SUPPLEMENTS & OVER-THE-COUNTER MEDICATIONS

Supplement/Medication Name	Dose & Frequency	Approx. Start Date	Reason for use

SCREENING

TEST	Last date done	Results (-) o, state/indinfl.S
Blood Sugar, Cholesterol		
Colonoscopy		
PAP Smear (women)		
Mammogram (women)		
Prostate exam.PSA (men)		
Cardiac test (EKG, echo, stress, etc.)		
Transvaginal Ultrasound		

FEMALE patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Sleep disorder				
Anxiety/nervousness				
Irritability				
Depression/emotional swings				
Food cravings				
Hot flashes				
Night sweats				
Vaginal Dryness/Bleeding				
Urine Leakage				
Dry skin/wrinkles				
Dry hair				
Fatigue				
Memory loss				
Concentration loss				
Hair Loss				
Loss of libido/orgasm				
Muscle weakness/loss				
Muscle and Joint pain				
Loss of pubic hair				

MALE patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Dry skin				
Dry hair				
Sleep disorder				
Fatigue				
Memory loss				
Concentration loss				
Anxiety/nervousness				
Irritability				
Depression				
Loss of libido/orgasm				
Difficulty maintaining erection				
Difficulty achieving erection				
Premature ejaculation				
Muscle weakness				
Muscle Loss				
Muscle and Joint pain				
Loss of masculinity/confidence/aggressiveness				

Have you ever been sick with a fever: Y / N
Severe diarrhea? Y / N
Rash? Y / N
Do you use artificial sweeteners? Y / N

OB/GYN HISTORY (Female patients)

Last Menstrual Period:	Age at first onset of period:
If still menstruating: cycle _____ days	Circle if (+): Heavy periods, irregularity, spotting or pain
Are you pregnant: NO YES Are you trying for a pregnancy: NO YES	Are you breastfeeding: NO YES
Number of pregnancies: _____ Living children: _____ (Vaginal _____ C-section _____)	Abortions _____ _____ Miscarriages
History of Sexual Abuse: NO YES	

PERSONAL & SOCIAL HISTORY

Occupation:		Stress level (0-10):	
Marital Status:		Do you feel safe in your relationship?	
# of Living Children _____		YES NO:	
Use of alcohol NO YES	If YES, what kind:	How many drinks/week: _____	
Tobacco: NO YES	If YES, number of years total Cigarette packs/day	Past use-quit date: _____ Cigars/day	Chew/day Pipe/day
Recreational or street drug use: NO YES	If YES, have you ever taken street drugs with a needle: NO YES		
Sexually active NO YES	heterosexual bisexual homosexual	Contraceptives: Current Method _____ Past method _____	
Hobbies/Interests			

REVIEW OF SYSTEMS

Please check YES to any symptom that you experience.

	YES	If any YES answer, please provide a brief description.
Fever/chills		
Excess fatigue		
Weight loss/gain		
Enlarged lymph nodes		
Frequent bruising		
Blurry vision		
Ringing in ears		
Hearing difficulty		
Mouth sores		
Sinus problems		
Cardiovascular:		
Chest pain at rest or exercise		
Cold hands/cold feet		
Swelling of legs		

	YES	
Gastrointestinal		
Constipation		# bowel movements/day _____
Diarrhea		
Bloating:		
Excessive belching		
Gas/acidity		
Blood in stool		
Thirst: Lack of/too much		#glasses of water/day
Genitourinary		
Pain of urination		
Cloudy/bloody urination		
Urinatine: too many times		# times per day
Difficulty urinating		
Loss of urine		
Do you see a chiropractor		
Any regular body treatment/massage		
Back pain		
Neck pain		
Shoulder pain		
Arm pain		
Hip pain		
Knee pain		
Other pain		
Muscle point tenderness (Dis. Describe)		
Skin		
Acne		
Dry skin		
Oily skin		
Loss of collagen firmness		
Wrinkles		
Pigmentation/Scarring:		
Any history of skin cancer?		
Do you wear sunblock?		
After sun exposure, do you (circle)		Burn Sometimes burn Rarely burn Never burn Tan
Cellulite		
Questions on aesthetic services: Botox, Juvederm or lasers?		
Interest in skin care consultation		
Emotional		
Do you see a counselor or psychiatrist?		
Depression		
Anxiety		
Stress		

I have answered the above to the best of my abilities.

_____**Patient Signature**

Nutrition Evaluation

Vegetable intake (pls. circle)	<10%	20-40%	41-60%	>60%
Number of meals per day: _____		_____		
Snacks per day: _____		What snacks & when?		
Food Allergies				
Food Dislikes				
Food(s) you crave		Any specific time of day/month you crave **food?**		
Do you awaken hungry during the night? YES NO		If yes, what do you do?		
Behavior style (check only one):				
□ Always calm & easygoing		□ Seldom calm and persistently driving for advancement		
□ Usually calm & easy going		□ Never calm and have overwhelming ambition		
□ Sometimes calm with frequent impatience		□ Harddriving and can never relax		

	NO	YES		NO	YES	If not you, WHOM?
Partner or spouse overweight?			I plan my meals			
By how much _____lbs.			I cook my meals			
I eat out daily			I shop for food			
I eat out _____times/week			Use shopping list for groceries?			
I eat "fast foods" daily			Time of day I usually shop			
I eat "fast foods" _____times/wk			I use sugar substitute			Which?
I drink cola drinks			I use butter			
I eat when I'm stressed			I use margarine			
I am currently stressed			I drink coffee or tea How many cups/day _____			
I skip meals			I eat on behalf of someone else			

If weight Loss is an aim for you, pleases answer the following questions	
Goal Weight:	In what time frame would you like to be at your goal weight:
Birth Weight:	Weight o ne year ago:
Highest weight (non-pregnant) and when:	Lowest Adult Weight (>age 18)
Main reason for your decision to lose weight	
When did you begin gaining excess weight? (Give reasons, if known):	
Previous Diets followed	Approximate date & results of weight loss

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	**Where:** _____	**Where:** _____
With whom: _____	With whom: _____	With whom: _____

Activity Level: (check only one)

- o Inactive: no regular physical activity with a sit-down job.
- o Light activity: no organized physical activity during leisure time.
- o Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- o Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or activities at least three times per week.
- o Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Please describe your general health goals and improvement you wish to make: _____

_____

_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Patient Signature: _____

Consent for Purpose of Treatment, Payment and Healthcare Operations

I hereby request and consent to the performance of medical treatment and other procedures, within the scope of practice afforded by the licensed healthcare professionals and other clinical staff members of St. Louis Body Balance and Weight Loss (STLBBWL) on me or patient named below, for whom I am legally responsible.

> I understand that any recommendations and care received at St. Louis Body Balance and Weight Loss are supportive only, and do not substitute for regular medical care. I understand that I must continue to see my regular treating healthcare providers as directed by them and take my regular medications as prescribed.

I understand that the methods of treatment provided by STLBBWL include, but are not limited to, Bio-identical hormone restoration, Homeopathic medicine, weight loss, detoxification, nutritional restoration, facials and peels, body treatments, spa services, leg veins, Botox/Dysport cosmetic,Restylane/Belotero/Radiesse/Artefill/Juvederm, facial RF, dermal fillers, Herbs, teas and/or nutritional supplements,Weight loss medications [Phentermine Phendimetrazine,Topamax,bentyl,Belvig and others] to promote health and well-being, dietary and life style counseling. I understand that some of the herbs and supplements recommended by STLBBWL may have occasional side effects. I will immediately notify STLBBWL by telephone or in-person of any side effects associated with my use of these herbs and/or supplements.

I understand that methods of treatment may involve insertion of various sized needles into different areas of my body, along with stimulation of these needles, either by hand or with an approved electrical device, and that there may be some discomfort and/or bruising during or following treatment.

I understand that I have the right to question any therapy proposed and/or provided by STLBBLW, and that all of my questions will be answered prior to receiving such treatment. I understand that I have not been and will not be given a guarantee of beneficial or specific results. I affirm that I have and/or will always, to the best of my ability, disclose my complete current and past medical history to STLBBWL. I understand this history is essential for STLBBWL to be able to assess and provide competent care and treatment to me. I understand that the treatment I receive from STLBBWL and its health care professions is in large part based upon my disclosures to them.

I acknowledge that, while at STLBBWL, among those who may attend to me are medical ,nursing and other healthcare personnel who are in training. I consent to their presence and participation in my evaluation and treatment as a part of their education and training. I acknowledge that such personnel are not employees of agents of STLBBWL. I consent to such personnel who are in training having access to my medical records regardless of whether I am present or whether such personnel have ever seen me.

I consent to the use or disclosure of my protected health information to STLBBWL for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bill, or to conduct healthcare operations. I understand that treatment by STLBBWL may be conditioned upon my authorization as evidenced by my signature on this Consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of STLBBWL. STLBBWL is not required to agree to any restrictions I may request. However, if STLBBWL agrees to any such restriction, the restriction is binding on STLBBWL.

I have the right to revoke this Consent in writing, at any time, except to the extent STLBBWL has taken action in reliance on this Consent.

My "protected health information" means health information including demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearing house. This protected health information relates to my past, present, or future physical health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review STLBBWL's Notice of Privacy Practices prior to signing this Consent. The Notice of Privacy Practices describes my rights and STLBBWL's duties with respect to my protected health information. The Notice of Privacy Practices describes the uses and disclosures of my protected health information that may occur during my treatment,

payment of bills or in the performance of healthcare operations. A copy of STLBBWL's Notice of Privacy Practices has been provided to me. A copy of the Notice of Privacy Practices is also available at the reception desk.

STLBBWL reserves the right to change the privacy practices described in its Notice of Privacy Practices. I may obtain any such revised Notice of Privacy Practices by requesting a copy from STLBBWL's staff or by requesting a copy be sent to me by mail.

Furthermore, I understand I am responsible for full payment of services at the time they are rendered and for any unpaid balances in the event of third party or insurance claims. I hereby acknowledge and accept full responsibility for any and all costs incurred.

By voluntarily signing below, I affirm that I have read or have had read to me, the above consent to treatment. I have been advised of the risks and benefits of the procedures provided to me, and I have had the opportunity to ask questions regarding each such procedure. I understand this Consent covers the entire course of treatment provided by STLBBWL for my present condition and for any future condition(s) for which I seek treatment.

_____

Signature of Patient or Person legally empowered to execute this Consent for patient who is a minor or physically or mentally incompetent.

_____

Printed Name of Patient or Person Legally empowered to execute this Consent for a patient who is a minor or physically or mentally incompetent.

_____

Date

_____

STLBBWL Medical Representative

Weight loss and HORMONE RESTORATIVE THERAPY

Office policies

Office visits

Please schedule your next fellow-up visit at the time that you check out. This allows proper entry into the system so that if you need to reschedule, the staff will know exactly how long your appointment will be and its purpose. Please ask your provider for a lab request for any tests that may be needed for your next visit before you leave the office.

Prescriptions

Weight loss medications and Hormone therapy prescriptions will be written to provide you with enough refills until your next scheduled office visit. If you are unable to come to your scheduled visit due to unforeseen circumstances, a one month refill may be issued (if deemed medically appropriate) to allow you to re-schedule the missed appointment. If this re-scheduled visit is missed, we will be unable to issue any further refills until you are seen. in the office.

You may call the office (314) 849-0923 for prescription requests. Please allow 72 hours for refills. These calls/emails are handled only during business hours.

Laboratory testing

Some labs offer a physician's discount for testing which we will extend to any of our patients. If you are paying out-of-pocket or have a high deductible on your insurance plan, please ask the front desk at checkout regarding your options .

WEIGHT LOSS PATIENTS-medication given for weight loss require follow and labs as directed by STLBBWL.

MALE patients on Testosterone

- Testosterone, PSA, Estradiol and CBC levels are monitored every 6 months (or sooner if medically necessary)

Please check with your insurance if they will cover the cost of these tests since some insurance plans may only cover PSA levels once a year. If you have no insurance coverage for this test or if you have a high deductible, please check with our front desk for your options..

FEMALE patients on Estradiol

- Estradiol, Estrone, Progesterone levels are monitored every 6 months (or sooner if medically necessary)

Please check with your insurance if they will cover the cost of these tests since some insurance plans may only cover them once a year. If you have no insurance coverage for this test or if you have a high deductible, please check with our front desk for your options. prices.

Physical Exams

Annual physical exams with prostate/rectal exam (males) or with GYN exam (females) are required in our office if we are prescribing your hormones.But we can honor duly documented exams done with your primary care physician or ob/gyn specialist. This is done for your safety and in compliance with standards set by medical boards.

I have read and understood the above information.

_____

Patient Signature Date

Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 pound to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.4 -505(I)G), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes

I have read the above:

Patient's Signature _____ Date _____

Waiver of Childproof Containers

Federal regulations require packing of most medication in child-resistant containers for households where young children are present. The purpose of the regulations is to prevent accidental ingestion.

If you prefer that we DO NOT use this type of packing for your needs, please sign the waiver below for our records.

Please Use Conventional Packaging for My Medications and/or Nutritional Supplements

Print Name: _____

Signature: _____

Witness: _____

Date: _____

Release of Medical Records

I give my permission for my medical records (blood work, chart, EKG) to be released to:

_____

_____

_____

Printed Name _____

Signature _____

Date _____