Welcome to our Practice

Andrs Wellness Consulting, LLC is based on the belief that much of conventional health care leaves out a vital member of the health care team – the client. In addition, it leaves out parts of the client that are crucial to healing, such as the mind, spirit and community. Andrs Wellness Consulting, LLC includes you as a team member since you are the expert on your body and life.

A full list of our staff and their bios can be found on our website at www.andrswellness.com.

Requested Intake Information

We appreciate your taking the time to review this information, complete the enclosed forms and supply us with the items requested below. It is helpful if you can fax or mail the requested information back to us one week in advance of your scheduled appointment. Please do not mail original copies to us.

Please fill out the enclosed forms completely:

1. Patient Registration
2. Notice That Services Are Not Primary Care
3. Informed Notice and Consent as to Nature of Services
4. Authorizations and Acknowledgments
5. Private Medicare Contract – if you are currently covered by Medicare Insurance
6. Your Health Information Privacy Rights (HIPAA)
7. Confidential Health Inventory
8. Authorization for release of medical records (if necessary)

Additional information requested: Baseline and most recent blood work, and any other test results relevant to your diagnosis, if available.

Initial Consultation – What You Should Expect

While the initial consultation is usually 3 hours, it may be longer (or shorter) depending on the extent of medical history, amount of material to be covered and the number of questions you may have. During this time, Ms. Andrs will review your health history along with other relevant areas of your life. Ms. Andrs will make recommendations, which you will receive as an electronic and/or written Wellness Plan. Please be sure to eat before your appointment and feel free to bring a beverage to drink during your appointment.

Your Wellness Plan

Typically, we find the best results with a combination of specialized dietary and activity recommendations, body/mind practices and nutritional and herbal supplements. We may recommend exercise, dietary changes or other types of therapy, such as acupuncture or counseling. The types of things

we recommend are determined by your current health, constitutional evaluation and your willingness to make changes.

Your Healing
Your Wellness Plan, along with other recommendations we may make, is designed to help your healing process at all levels. It is very important that you know that we want to help you improve your health and well-being. A willingness to change and grow and being open to new ideas and lifestyle changes facilitates and maximizes your healing ability.

Follow-Up Consultations
These are set per your practitioner's recommendation and by mutual agreement. Usually, a given Wellness Plan is followed for 1 to 3 months after which you need to be reassessed so that appropriate changes can be made to your protocol. You may, of course, schedule a consultation prior to your follow-up if you have something you would like to discuss. A follow-up consultation usually requires 30-90 minutes. The 1st follow-up is usually 90 minutes and subsequent follow-ups are generally 30-90 minutes depending on the complexity of your problems.

Advise Us of Any Changes
Please advise us of any changes in your medical protocol, such as new medications or treatments, as well as any changes in your well-being or health. In other words, please keep us informed – the patient message portal is the most efficient means of communication, and the only secure means.

Chemical Sensitivity
When you visit us, we do ask that you not wear cologne, fragrances, or perfumes as a courtesy to others who are chemically sensitive. Some individuals may have adverse health reactions to products commonly used every day, such as scented air fresheners, scented toiletry items, perfumes and colognes.

Grievance Policy
If at any time you feel that you have been mistreated in any way, you may provide this information to:

> The Board of Nursing, Virginia Department of Health Professions
> Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico, VA 23233-1463
> Telephone: 1-800-533-1560 or (804) 367-4691
> Fax: (804) 527-4424

2801 Boulevard, Suite D
Colonial Heights, VA 23834-2323
Phone (804) 733-3333 ♦ Fax (855) 586-3257
Kristin Andrs, NP

PATIENT REGISTRATION FORM

NAME (LAST, FIRST, MI)		DATE OF BIRTH	GENDER M F	SOCIAL SECURITY NUMBER - -
MARITAL STATUS	HOME PHONE NUMBER		CELL PHONE NUMBER	
HOME ADDRESS		CITY	STATE	ZIP CODE
EMAIL ADDRESS		OFFICE PHONE NUMBER		RACE
OCCUPATION		EMPLOYER (OR PARENT'S NAME IF MINOR)		
EMPLOYER ADDRESS		CITY	STATE	ZIP CODE
IN CASE OF EMERGENCY, CONTACT PERSON AND TELEPHONE NUMBER				

May we leave messages at the telephone numbers listed above? ☐ Yes ☐ No

Household Members' Names: 1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

Your Pharmacy: ______________________ Phone: ______________________

Location: ______________________

How did you hear about our practice? ______________________

I hereby certify that the above information is true.
I accept responsibility for all charges to this or subsequent treatment.

______________________ ______________
Signature of Patient or Legal Guardian Date

Notice That Services Are Not Primary Care

Name: ______________________________ Date of Birth: ____________________

I understand that Kristin Andrs, NP, is not acting as my primary care provider. I understand that even though she may address issues affecting my general health, the practice is focused on a complementary, holistic or integrative approach to medicine. It is in my best interest to also have a primary care physician to ensure that I am fully informed about all available conventional means to address any medical conditions I may have. I understand that Ms. Andrs is not affiliated with any hospitals and does not provide emergency, on-call assistance. Should Ms. Andrs provide treatment for a condition, I understand this assistance does not mean she is taking primary responsibility for managing that condition, but is complementing the care I receive from my primary care provider. I understand that, in addition to a primary care provider, it may be in my best interest to see appropriate specialists, such as a cardiologist, if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand it is my responsibility on an ongoing basis to inform Ms. Andrs of the name of and contact information for my primary care provider and treating specialists, of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions. I also understand it is important for me to let my primary care provider know about any recommendations/ treatments performed by Ms. Andrs, to ensure my care is properly coordinated.

My primary care provider is: Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone ______________________________

I am also being treated for ______________________________

By ______________________________ Phone ____________________

I am also being treated for ______________________________

By ______________________________ Phone ____________________

____
Patient or Guardian Printed Name

______________________________ ____________________
Patient or Guardian Signature Today's Date

Notice and Consent as to Nature of Services

Name: ______________________________ Date of Birth: ____________________

I understand that care I receive from Kristin Andrs, NP may be non-traditional or non-conventional. Such services are commonly referred to as complementary or alternative medicine (ACM or CAM), holistic care, or integrative medicine. This can include a variety of innovative medical treatments as well as acupuncture, nutritional and herbal consultation, and mind-body approaches to care. Many of these services may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, they may still be considered investigational or experimental. I am seeking care from Ms. Andrs in order to benefit from her special training in integrative medicine and receive advice and treatment about such care.

Nutritional and Herbal Guidance: Consultations may include discussion of diet, dietary supplements, and herbal or botanical products. While herbs and botanical products are generally available over-the-counter and considered safe based upon their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will advise Ms. Andrs and my other health care providers what herbs I am taking. I agree to notify Ms. Andrs if I experience any interactions or adverse experiences or reactions; if they are not serious, I will contact her to ask for her assistance. If a reaction is serious, I agree to seek emergency care first before notifying Ms. Andrs.

Recommendations could include fasting, exercise, sauna and other forms of detoxification. While this is generally safe, some people may experience a healing process, which may be a short period in which symptoms increase, or a period of a flu-like illness during which there could be some mild fever, chills, dizziness, loss of appetite, etc. Such an experience, while unpleasant, can signal that the body is effectively detoxifying or undergoing a healing effort.

Mind/Body Medicine: Mind/body medicine is an emerging medical view intended to improve patient well-being by improving lifestyle, capacity to function in a meaningful and effective way, and reversing the impacts of stress. Because stress and emotional states may play an important role in my medical conditions, Ms. Andrs may assist me in recognizing more successful approaches to lifestyle and mind/body approaches such as prayer, meditation, massage, or other stress management techniques.

I understand that while these approaches can provide an important complement to my health care, I should ensure, by discussing my health needs with Ms. Andrs and my primary care providers, that appropriate mainstream care is provided. I understand that Ms. Andrs will discuss potential therapies that she recommends, and I agree to accept the risks explained to me about these procedures by agreeing to undertake these treatments.

Initials ____________

Notice and Consent as to Nature of Services

I have read and understand the nature of the services provided by Ms. Andrs. I represent that I am seeking treatment in order to further my own health and for no other reason. I agree to take a responsible role in improving my own health and discuss advice and suggestions of Ms. Andrs as presented in a treatment plan. I acknowledge that if I do not follow the treatment plan as provided, I may not receive the full benefit of the treatments proposed by Ms. Andrs and I accept responsibility for less than satisfactory results. I am aware that I may withdraw this consent and discontinue following the recommendations at any time.

Patient or Guardian Printed Name ____________________ Date of Birth ____________________

Patient or Guardian Signature ____________________ Today's Date ____________________

Authorizations and Acknowledgements

Name: ____ Date of Birth: ____________________

Treatment Authorization: I authorize wellness and health care treatment of ☐ myself ☐ my minor child, ____, by Kristin Andrs, NP.

Medical Records Release Authorization: I authorize Andrs Wellness Consulting (AWC) to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. I also authorize any physician or health care provider I have seen, to release my medical records to AWC. Such authorization is effective for a period of one year, and extends to records regarding my minor child, if applicable. I also authorize AWC to download my medication history from my pharmacy and from the Virginia Department of Health Professions Prescription Monitoring Program as needed to provide optimal medical care.

Initials ___________

Communications: We no longer use email as a form of communication with patients. We have a HIPPA secure message platform/patient portal through IntakeQ. We will use this for all electronic communication with you other than emails and text messages for appointment confirmations. You are welcome to send AWC secure messages in the patient portal about your health concerns, understanding that messages cannot be urgent in nature and may take 24-48 hours for a response. Questions that are complex may require a consultation (phone, telemedicine or in person). You will be charged for phone conversations with a provider that exceed 5 minutes. These calls cannot be billed to insurance. If you have a matter that is more extensive, it is recommended that you make an appointment.

Initials ___________

Privacy Statement: While AWC is not required to follow the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA), we do respect your privacy and will only release information required to further your treatment, or for managing our own internal operations, or specifically authorized by you.

Initials ___________

Notice as to Possible Non-Coverage of Services: I understand that because of the non-conventional nature of AWC services (wellness, herbal medicine or other complementary and alternative medicine services), insurance reimbursement is not available. Some lab tests that are ordered, particularly those that are used in support of wellness consultations or kits sent to labs using innovative diagnostic approaches may not be reimbursed. Patients requesting CPT codes to submit claims to their insurance company will be charged an administrative office fee to prepare the documents.

Initials ___________

Financial/Insurance Responsibility: I understand that AWC does not participate in any insurance plans. I understand and agree that AWC does not take assignment, which means **payment is required at each visit**. Invoices are due upon receipt. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary. I agree to be responsible for costs and expenses, including court costs, attorney fees, and interest, should it be necessary for AWC to take legal action to secure payment of an outstanding

Name: ____ Date of Birth: ____________________

balance owed. If I should write a check that is returned for insufficient funds, I agree to pay a $50 fee per incident.

Initials ___________

IMPORTANT – Cancellation Policy: Our goal is to provide quality care for all of our patients in a timely manner. We allot a significant amount of time for each patient and appointments are in high demand. We keep a waiting list of patients requesting to move up their appointments to earlier dates, therefore, we require a minimum of 2-weeks notice to cancel any appointment.

Initial appointments require payment in full at the time of scheduling ($750). Andrs Wellness requires a credit card on file at all times to cover any cancellation fee (cash or check payments can be arranged). Your card will ONLY be used for this reason unless you give us permission to charge your card for subsequent appointments or for merchandise. For ALL scheduled appointments, you will be charged the full price of your appointment if you do not provide 2 weeks notice of cancellation.

Payments are 100% non-refundable unless one of the following takes place:

1. The patient cancels 2 or more weeks in advance of their appointment date, in which case, they will receive a full refund, less a $50 office processing fee.
2. The patient reschedules their appointment at least 2 weeks in advance of their original appointment. In that case, there will be no fee.

Rates for Services: Mrs. Andrs' hourly rate for medical care is $250.00 and applies to all services on your behalf. This includes:

1. Consulting time - face-to-face, by phone, or by telemedicine/video
2. Treatment protocol development and revision
3. Research specific to your case/inquiry
4. Questions answered in the portal or email (portal is preferred as it's HIPPA secure)
5. Consultations with other healthcare practitioners on your behalf

We bill for time spent and do so in increments of 5 minutes. Initials ___________

Late Arrivals: If you are going to be more than 10 minutes late for your appointment, you may either have an abbreviated appointment at the regular price when you arrive, or pay the cancellation fee for providing less than 24 hours notice and reschedule the full appointment for another day.

Initials ___________

Good Faith Estimates: We cannot provide estimates on the cost of treatment until you have been seen at the initial visit, evaluated and diagnosed. Any relevant tests must be completed and reviewed before a full plan can be recommended. A wellness plan is created at the initial visit and revised at follow-up visits. Plans are fluid and will change based on your response to treatment. Therefore, the price of your wellness plan may change as well. If requested, we can provide an invoice for goods, treatments and services for your review before you purchase. Plans are recommendations and you have the right to agree or refuse to adhere to the plan. At any time, you have the right to discontinue care and seek medical care elsewhere.

Authorizations and Acknowledgements

Andrs Wellness reserves the right to discontinue medical services to you at any time; if so, you will be notified in writing.

Initials ____________

Supplements: You are financially responsible for the cost of supplements. Where applicable, consider using your MSA/FSA for the purchase of supplements. If prescribed and purchased from us, we can supply you with an itemized receipt to provide proof of purchase. We stock top-quality medicinals and have a very low mark-up, to help keep your medical expenses to a minimum. Part of our service to you is the benefit of our practitioners' many years of experience and research in the health field. Because of this, some product recommendations are often brand specific. Our practitioners are very conscientious and use only high-quality products that have provided consistent, effective, therapeutic results. You are in no way obligated to purchase your supplements from us. Medicines and supplements obtained through our apothecary require a credit card payment at the time the order is placed. Orders are considered final and cannot be changed or returned.

Initials ____________

Notice to Medicare Patients: Andrs Wellness Consulting, LLC does not participate in the Medicare Program. **It is illegal** to submit a bill for services to Medicare when the provider does not participate in the program.

Initials ____________

No Guarantees: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

Initials ____________

Duration/Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive wellness care and for no other purpose.

Initials ____________

I, ____ (patient's name), a patient of Andrs Wellness Consulting, LLC, have read, acknowledge, understand and agree to the above stated policies and will comply with them in all respects. I understand that my care is not a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment and not submit a bill for reimbursement to my insurance company.

______________________________________	____________________
Patient or Guardian Printed Name	Date of Birth
______________________________________	____________________
Patient or Guardian Signature	Today's Date

Private Medicare Practice

This agreement is between Kristin Andrs, NP, whose principal place of business is 2801 Boulevard, Suite D, Colonial Heights, VA 23843, and

Beneficiary: ____ Medicare ID #: ________________________

Who resides at: ____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Nurse Practitioner has informed Beneficiary or his/her legal representative that the Nurse Practitioner has opted out of the Medicare program effective 4-1-2015. The Nurse Practitioner is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:
(Please initial)

_______ Beneficiary or his/her legal representative accepts full responsibility for payment of the Nurse Practitioner's charge for all services furnished by the physician.

_______ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the Nurse Practitioner may charge for items or services furnished by the Nurse Practitioner.

_______ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_______ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_______ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_______ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_______ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation. Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

_______ Andrs Wellness Consulting, LLC does not participate in Medicare or Medicaid Programs; CMS (Centers for Medicare & Medicaid Services). It is illegal to submit a bill for services to CMS when the provider does not participate. If you do submit a bill or try to collect CMS for any of our services, you will be charged $250 to process the paperwork to CMS stating that you were notified of this law at the time you entered into a private contract with Andrs Wellness Consulting.

____ ________________

Signature of Beneficiary or his/her legal representative — Date of Birth

____ ________________

Signature of Kristin Andrs, NP — Date Contract Executed

Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care providers generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers, it is our responsibilities to keep your information safe and secure. We also need to make sure your information is protected in a way that does not interfere with your optimal health care. It is important you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly, but we will never share confidential details of your case with another provider without first asking for and obtaining your consent.
- To communicate with your family, friends, relatives, or others that you identify as being involved in your health care or health care bills.
- To protect the public's health, such as reporting when a communicable disease is in your area.
- To make required reports to the police, such as in instances of abuse.
- To obtain payment from third party payers, such as insurance companies.

In order to provide you with service that best meets your privacy needs, please tell us the method by which you would like to be contacted when needed. Please check all that apply:

___ Please do not phone me at home; use this alternate phone number: ______________________________

___ Please do not phone me at work; use this alternate phone number: ______________________________

___ Please do not leave messages on my answering machine.

___ Please do not contact me by email.

___ Please send mail, including my bills, to this alternate address:

____

___ Other request (please describe): ____

**Our practitioners and staff may, at times, communicate health information with you via email. Please list everyone with whom we may discuss your medical information. If they are not listed, we are not permitted to talk to them.

____

____

____

______________________________________	______________
Patient or Guardian Printed Name	Date of Birth
______________________________________	______________
Patient or Guardian Signature	Today's Date

2801 Boulevard, Ste. D, Colonial Heights, VA 23834 ■ Phone: 804-733-3333 ■ Fax: 855-586-3257
info@andrswellness.com ■ www.andrswellness.com

NEW PATIENT FORM **HEALTH INVENTORY**

Andrs Wellness

____________________________ ______________ ______________

Name | Date of Birth | Today's Date

What is the primary reason for your visit? ____

CONDITIONS – ✓ all conditions you have now or have had in the past

- ☐ ADD/ADHD
- ☐ AIDS/ HIV+
- ☐ Alcoholism
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Anxiety/Panic Attacks
- ☐ Appendicitis
- ☐ Arthritis: ☐ Gout ☐ Osteoarthritis ☐ Psoriatic ☐ Rheumatoid
- ☐ Asthma
- ☐ Autism
- ☐ Bell's Palsy
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Breast Lump/cysts
- ☐ Broken or fractured bones
- ☐ Bronchitis
- ☐ Cancer (where: ________________)
- ☐ Celiac
- ☐ Cervical Dysplasia
- ☐ Chemical Dependency
- ☐ Chicken Pox ☐ Shingles ☐ Cold Sores
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ COVID-19
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Dental fillings - silver
- ☐ Depression
- ☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Gestational
- ☐ Diverticulosis/Diverticulitis
- ☐ Drug Addiction
- ☐ Eczema/Psoriasis
- ☐ Emphysema (COPD)
- ☐ Epilepsy/seizures
- ☐ Eye problems: ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retina problems
- ☐ Fibromyalgia
- ☐ Gallbladder Problems
- ☐ Gastroparesis (slow digestion)
- ☐ GERD or acid reflux
- ☐ Gluten Intolerance
- ☐ Goiter (enlarged thyroid)
- ☐ Gum disease/gingivitis
- ☐ Head injury or concussion
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Rhythm Problems
- ☐ Heart Valve Problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia (where: ______________)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HPV/Genital Warts
- ☐ Kidney Disease/Problems
- ☐ Kidney Stones
- ☐ Lactose Intolerance
- ☐ Liver Problems
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Neuropathy (nerve damage)
- ☐ Osteoporosis/Osteopenia
- ☐ Ovarian Cysts ☐ Ruptured
- ☐ Overweight or Obese
- ☐ Pacemaker/Defibrillator
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Raynaud's Syndrome
- ☐ Rheumatic or ☐ Scarlet Fever
- ☐ Root Canal
- ☐ Rosacea
- ☐ Sarcoidosis
- ☐ Scoliosis
- ☐ Sexually transmitted disease
- ☐ Sinus problems/infections
- ☐ Sleep apnea
- ☐ Stomach or ☐ Esophageal Ulcers
- ☐ Stroke/Mini-Stroke
- ☐ Suicide Attempt
- ☐ Thrush, ☐ Yeast Infections, ☐ Athlete's Foot
- ☐ Thyroid Problems
- ☐ Tick Bite
- ☐ Tonsillitis
- ☐ Tuberculosis (TB)
- ☐ Urinary Tract Infections
- ☐ Uterine Fibroids
- ☐ Vaginal Infections
- ☐ Vitamin D deficiency
- ☐ Other ____________________

____

____

SURGERIES – Please list any surgeries or major hospitalizations that you have had

Year	Hospital	Surgery or reason for hospitalization

Andrs Wellness

NEW PATIENT FORM **HEALTH INVENTORY**

ALLERGIES – Please list all allergies to medications or other substances

MEDICATIONS – List all medications you are taking
(including prescriptions, over-the-counter, injections, topical, inhaled, vitamins, dietary supplements, and herbs & teas)

Name of Medication	Dose	How often?	What is it for?

Estimate the last time you took antibiotics: ______________________________

Do you think you need all the medications you are taking? ☐ Yes ☐ No

How would you rate your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

NEW PATIENT FORM **HEALTH INVENTORY**

Andrs Wellness

SYMPTOMS – ✓ symptoms you have now or have had recently, and rate severity - 1 (mild), 2 (moderate) or 3 (severe)

GENERAL	R	NOSE/EARS	R	DIGESTION	R
☐ Fevers		☐ Nose bleeds		☐ Nausea (sick to stomach)	
☐ Chills		☐ Stuffy nose/congestion		☐ Vomiting	
☐ Sweats (day or night)		☐ Runny nose		☐ Diarrhea or loose stools	
☐ Weakness		☐ Sinus pain		☐ Constipation or hard stools	
☐ Fatigue		☐ Snoring		☐ Alternating diarrhea & constipation	
☐ Decreased activity		☐ Loss of smell		☐ Heartburn	
☐ Feeling bad in general		☐ Dizziness/vertigo		☐ Abdominal or stomach pain	
☐ Loss of appetite		☐ Hard of hearing ☐ L ☐ R ☐ both		☐ Change in frequency of stools	
☐ Weight gain _____ lbs.		☐ Ringing in ears ☐ L ☐ R ☐ both		☐ Change in stool color	
☐ Weight loss _____ lbs.		☐ Ear pain/ache ☐ L ☐ R ☐ both		☐ Trouble swallowing	
Average energy level (0-10) _________		☐ Ear drainage ☐ L ☐ R ☐ both		☐ Hemorrhoids	
EYES	**R**	☐ Problem with excessive ear wax		☐ Black, tarry stools	
☐ Yellow eyes		**LUNGS/BREATHING**	**R**	☐ Mucous in stools	
☐ Eye drainage ☐ L ☐ R ☐ both		☐ Shortness of breath		☐ Blood in stools	
☐ Blindness ☐ L ☐ R ☐ both		☐ Cough		☐ Blood on toilet paper	
☐ Blurred vision ☐ L ☐ R ☐ both		☐ Coughing up sputum or phlegm		☐ Pain in rectum	
☐ Double vision		☐ Sputum/phlegm (color_________)		☐ Bloating	
☐ Dry eyes ☐ Itching eyes		☐ Coughing up blood		☐ Excessive gas	
☐ Excessive tearing		☐ Wheezing		☐ Excessive burping/belching	
☐ Eyes sensitive to light		☐ Waking up choking or coughing		☐ Unable to hold stool (accidents)	
☐ Seeing spots or "floaters"		☐ Stops breathing when sleeping		☐ Food allergies or intolerances	
☐ Seeing flashing lights or halos		☐ Breathes easier leaning forward		☐ Gets full quickly when eating	
☐ Eye pain ☐ L ☐ R ☐ both		☐ Chest pain with deep breaths		☐ Excessive, uncontrolled eating	
☐ Red eye ☐ L ☐ R ☐ both		☐ Ribs or chest soreness		☐ Eating when not hungry	
☐ Poor vision close up or far away		**HEART/CIRCULATION**	**R**	☐ Eating excessively fast	
☐ Wears glasses		☐ Chest pain ☐ L ☐ R ☐ Center		☐ Exaggerated effects of alcohol	
☐ Wears contacts		☐ Palpitations/skipping beats/irregular		Freq. of bowel movements: ___________	
MOUTH/THROAT	**R**	☐ Slow heart beat ☐ Fast heart beat		**KIDNEYS/URINE**	**R**
☐ Bleeding gums		☐ Can't tolerate exercise		☐ Pain or burning with urination	
☐ Cavities		☐ Swelling in legs, ankles, feet		☐ Blood in urine	
☐ Broken or missing teeth		☐ Fainting		☐ Change in urine stream	
☐ Painful tooth or gums		☐ Varicose veins		☐ Getting up at night to urinate	
☐ Bad breath		☐ Pain in legs at night		☐ Unable to hold urine (accidents)	
☐ White coating on tongue		☐ Pain in legs when walking		☐ Frequent urination	
☐ Sore throat		☐ Pain in legs when resting		☐ Trouble getting started	
☐ Sores in mouth/tongue/gums		☐ Cold hands ☐ Cold feet		☐ Urinating small amounts	
☐ Change in taste or loss of taste		☐ Difficulty breathing when lying down		☐ Trouble making it to the bathroom	
☐ Dry mouth		☐ Dizziness after changing positions		☐ Urine leakage (with sneeze/cough/laugh)	
NEUROLOGICAL	**R**	# of pillows you sleep on: _______		☐ Trouble maintaining urine stream	
☐ Problem with:		**SKIN**	**R**	**BLOOD/LYMPH**	**R**
☐ balance ☐ coordination		☐ Rashes		☐ Bruising easy	
☐ Confusion		☐ Itching		☐ Bleeding easy	
☐ Numbness (where_____________)		☐ Scrapes		☐ Swollen glands	
☐ Tingling (where_______________)		☐ Burns		**IMMUNE SYSTEM**	**R**
☐ Skin sensitivity:		☐ Dryness		☐ Currently or recently on chemo.	
☐ decreased ☐ Increased		☐ Bruises		☐ On steroids	
☐ Headaches		☐ Change in moles		☐ On steroid inhalers	
☐ Migraines: ☐ with aura ☐ without		☐ Sores or open wounds		☐ Previous organ transplant	
☐ Seizures		☐ Calluses on feet		☐ Previous radiation therapy	
☐ Weakness in: ☐ legs ☐ arms		☐ Discolored fingernails or toenails		☐ On immunosuppressant drugs	
☐ Tremors		☐ Hives		☐ Frequent colds	
☐ Burning pain (where___________)		☐ Acne		☐ Almost never gets colds	
☐ Feeling of skin crawling		☐ Boils			

NEW PATIENT FORM **HEALTH INVENTORY**

Andrs Wellness

SYMPTOMS – ✓ symptoms you have now or have had recently, and rate severity - 1 (mild), 2 (moderate) or 3 (severe)

MUSCLES/JOINTS/BONES	R	MOOD/SPIRIT	R	MEN ONLY	R
☐ Back pain		☐ Depression or profound sadness		☐ Discharge from penis	
☐ Joint pain		☐ Anxiety-Nervousness-Panic attacks		☐ Sores on or around penis	
☐ Muscle pain		☐ Suicidal at times		☐ Erectile dysfunction/impotence	
☐ Muscle cramps/spasms:		☐ Thinks about death a lot		☐ Testicle: ☐ pain ☐ nodule/lump	
☐ at rest ☐ when walking		☐ Feeling hopeless about the future		☐ Pain in lower abdomen	
☐ Muscle twitching		☐ Decreased interest in things		☐ Prostate problems	
☐ Legs move or jerk during sleep		☐ Lonely or bored with life		☐ Low sex drive	
☐ Joint redness		☐ Cry easily or for unknown reasons		**WOMEN ONLY**	**R**
☐ Joint stiffness		☐ Irritability or mood swings		☐ Previous abnormal pap smear	
☐ Joint swelling		☐ Excessive worry, fearful or afraid		☐ Bleeding between periods	
☐ Joint warm or hot		☐ Lose temper easily/frequently		☐ Missing or skipping periods	
☐ Injuries (where ________________)		☐ Hallucinations		☐ Periods lasting longer than 7 days	
☐ Pain in feet		☐ Short attention span/difficulty		☐ Periods lasting shorter than 3 days	
☐ Bunions		concentrating		☐ Irregular periods	
☐ Difficulty walking? Why? _________		☐ Forgetful or memory problems		☐ Period bleeding is: ☐ Light ☐ Heavy	
_____________________________		☐ Making yourself vomit		☐ Clotting ☐ Other_____________	
☐ Finger joints enlarged		☐ Substance abuse		☐ Extreme menstrual pain	
☐ Decreased joint range of motion		☐ Stress (rate on scale of 0-10) ____________		☐ Breast lump or lumps	
☐ Neck stiffness		**SLEEP PROBLEMS**	**R**	☐ Nipple discharge	
☐ Neck cracks		☐ Takes sleeping pills		☐ Painful intercourse (sex)	
ENDOCRINE	**R**	☐ Trouble falling asleep		☐ Vaginal discharge	
☐ Excessive thirst		☐ Trouble staying asleep		☐ Breast tenderness	
☐ Excessive urination (large volumes)		☐ Early morning waking		☐ Water retention before periods	
☐ Cold when others are comfortable		☐ Bad dreams/nightmares		☐ Taking hormone replacement	
☐ Hot when others are comfortable		☐ Wake up feeling not rested		☐ Sexually active	
☐ Change in hair texture		Falls asleep easy in these situations:		☐ Trouble getting pregnant	
☐ Hair loss		☐ During the day		☐ Excessive body or facial hair	
☐ Unable or trouble losing weight		☐ At stoplights		☐ Hot flashes	
☐ Excessive sweating		☐ While watching TV		☐ Low sex drive	
☐ High blood sugars		☐ In a waiting room or meeting		☐ Vaginal dryness	
☐ Low blood sugars		☐ While talking to someone			
☐ Night sweats (soaking sheets)		☐ While riding in a car			
		☐ After a lunch with no alcohol			
		☐ While reading			
		How many hours do you sleep? __________			

Women's Health

Are you or could you currently be pregnant? ☐ Yes ☐ No Date of last menstrual period: _________________

Number of pregnancies you have had: ________

Number of vaginal deliveries: _______ C-sections: ________ Live births: ________ Miscarriages/abortions: ______

Birth weight of baby or babies: ____

Age at onset of periods: _______ Year of last PAP: _______ Year of last Mammogram/Thermogram: _____________

Age at onset of menopause: __________

Previous hormone replacement use? ☐ Yes ☐ No Age when you began hormone replacement use: _________

If sexually active, what contraception do you use? ____

Men's Health

Year of last PSA (Blood test): _________ Year of last Rectal Exam: __________

Last Testosterone level:_______________ Are you using testosterone replacement? ☐ Yes ☐ No

Andrs Wellness

NEW PATIENT FORM **HEALTH INVENTORY**

FAMILY MEDICAL HISTORY – List medical problems your family members have or have had

Family Member	Medical Problems	Age at death	Cause of Death
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Grandmother (your Mom's mom)			
Grandfather (your Mom's dad)			
Grandmother (your Dad's mom)			
Grandfather (your Dad's dad)			
Your Child (son/daughter)			
Your Child (son/daughter)			
Your Child (son/daughter)			
Aunt/Uncle			
Aunt/Uncle			

SUBSTANCE USE – Fill in the blanks or cross through substances you have never used

Substance	How much?	How often?	Year you started	Year you stopped
Caffeine (any form)				
Tobacco (any form)				
Alcohol (1 serving of: Beer = 12oz., Wine = 5 oz., Liquor = 1.5 oz.)				
Illegal substances				

Do you live with a smoker? ☐ Yes ☐ No If you smoke, have you tried to quit? ☐ Yes ☐ No

If yes, what methods have you tried? ______________________________

Do you or others feel you should reduce your alcohol consumption? ☐ Yes ☐ No

SOCIAL SUPPORT – Place an "X" in each row in the column that is closest to your situation

	As much as I would like	Almost as much as I would like	Some, but would like more	Less than I would like	Much less than I would like
I have people who care what happens to me					
I get love and affection					
I get chances to talk to someone about problems at work or home					
I get invitations to go out and do things with other people					
I get useful advice about important things in life					
I get help when I am sick in bed					
I feel like I have spiritual support					

Living situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parent(s) ☐ Children

Pets: ☐ Yes ☐ No If yes, please list: ______________________________

What do you do to relax? ______________________________

What are your hobbies/sports/pursuits? ______________________________

Education: What is your highest level of education? ______________________________

Employment Status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Disabled ☐ Never worked outside home

Current or most recent occupation or job: ______________________________

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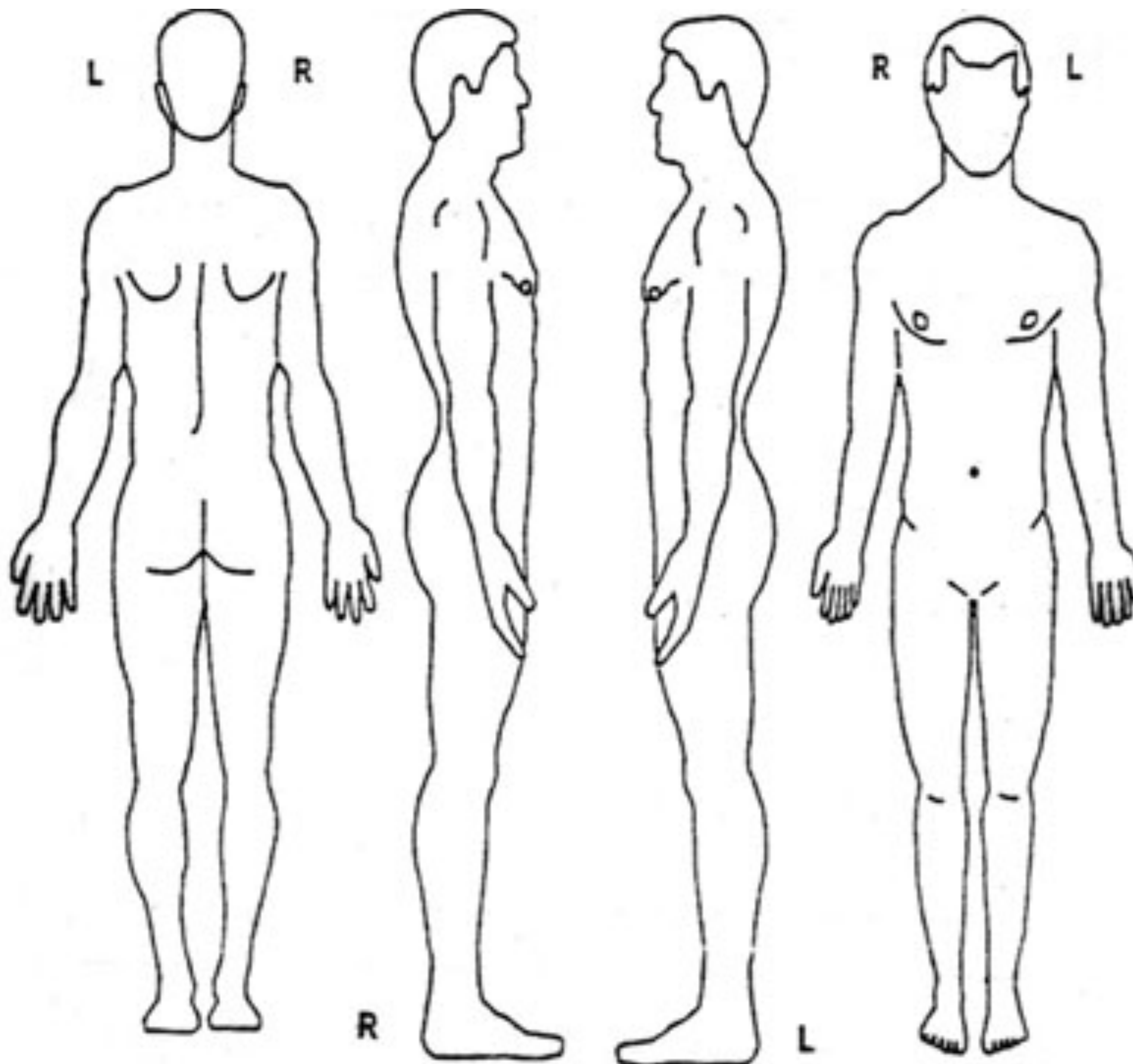
Pain

Do you have any pain(s)? ☐ Yes ☐ No

Please indicate painful or distressed areas with an "X".



Area of pain	Description (sharp, dull, aching, burning, cramping, poking, etc.)	Rate level (1 - 10)	When did it start?	How often do you have it?

Andrs Wellness

Priorities for your Wellness

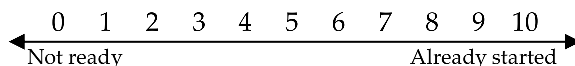
What area(s) of your life or health (overall) are you hoping to improve over the next 6-12 months? ____________________

____

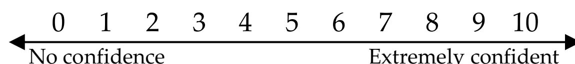
What are you hoping to accomplish at today's visit? ____

____

Your **readiness** to make changes or improvements in the above areas:



How **confident** you are that you can make these improvements:



Stress and Emotional Health

Emotional Issues – During the past 4 weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional issues, such as feeling depressed or anxious?

- ☐ Extremely
- ☐ Quite a bit
- ☐ Moderately
- ☐ Slightly
- ☐ None at all

Social Activities – During the past 4 weeks, to what extent has your physical health or emotional issues interfered with your normal social activities with family, friends, neighbors, or groups?

- ☐ Extremely
- ☐ Quite a bit
- ☐ Moderately
- ☐ Slightly
- ☐ None at all

Coping – How well do you feel you are coping with your current stress load?

- ☐ Feeling unable to cope any more
- ☐ Often have trouble coping
- ☐ Have trouble coping at times
- ☐ Coping fairly well
- ☐ Coping very well

Personal Loss – Have you suffered a personal loss or misfortune in the past year? (For example, a job loss, disability, divorce, separation, or the death of someone close to you.)

- ☐ No
- ☐ Yes - one loss
- ☐ Yes - two or more losses

What do you consider to be major stressors in your life (how do you feel they contribute to body tension or illness)?

____

____

How satisfied are you with your life in general? ____

Where do you derive your strength during difficult times? ______________________________________

____

What gives your life purpose and meaning? ____

____

Do you have any religious affiliations and/or ways you express your spirituality?____________ If yes, what or how?

____

What do others say they find most wonderful about you? ______________________________________

____

Do you experience joy? ____________ If yes, from what? ______________________________________

Andrs Wellness

NEW PATIENT FORM **HEALTH INVENTORY**

List prior experiences with complementary/alternative medicine – please include reason and effectiveness.

____

____

____

Your height: ______ft. ______in. Your current weight: ____________ lbs. Your ideal weight: ____________ lbs.

Your weight this time last year: ___________ lbs. Your weight at 18 years old: __________ lbs.

Trying to lose weight? ☐ Yes ☐ No What type of exercises/activities? ______________________________

How often do you exercise and how long? ____

Diet

How often do you eat out? __________________________ How often do you eat fast food? _________________

How many times a day do you snack? _____ How often do you eat desserts? __________________________

List what you drink with and between meals & how much: ____________________________________

Do you crave foods? ☐ Yes ☐ No If yes, what do you crave & when? _____________________________

List any cooking oils/fats you use: ____

How do you feel about your diet? ____

Do you feel in control of your eating habits? _________ Do you obsess about food, weight, or body image? ________

Do you have religious concerns related to your diet? ☐ Yes ☐ No

List usual food & drink for each meal or what you ate yesterday.

Breakfast ____

Lunch ____

Dinner ____

Snacks or dessert ____

Preventative Screening Inventory (Bring copy of results if possible)

When was your most recent screening tests below?	Date (or approx.)	Results if known
Physical exam with other provider		
Blood work (labs)		
Mammogram/Thermogram and last Self-Breast Exam		
Colonoscopy		
Dental exam		
Eye exam		
Cardiac stress test or EKG		
Carotid Ultrasound/Dopplers		
Rectal and/or Prostate exam		
PAP and/or pelvic exam		
Skin cancer screen (dermatologist)		
DEXA/bone density		

Do you take vaccines? ☐ Yes ☐ No If yes, please provide the year (if known) of the last vaccine taken for:

Chickenpox or Shingles __________ Hepatitis B _________ Pneumonia _________ Flu ________ Tetanus _______