KINGWOOD WELLNESS CLINIC®
REGISTRATION FORM

(Please Print Clearly)

Today's date:				PCP:		
PATIENT INFORMATION We verify your identity with your Drivers License						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		DL #		Cell:		
P.O. box: EMAIL:	City:	State:	ZIP Code:			
Occupation:	Employer:	Pharmacy:				
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.	❑ Business Card	❑ Billboard	❑ Google	
❑ Family	❑ Friend	❑ Newspaper	❑ Internet Search	Billboard location:		
Other family members seen here:						

Advance Beneficiary Notice of Non-coverage

I hereby certify that the above information is true and correct to the best of my knowledge. I hereby authorize Kingwood Wellness clinic to release any of my patient information required for continued care to other Providers that I may utilize for my care. I understand and agree, that I am financially responsible for any balance owed for my care This is a fee for service clinic. Payment due on day of service. _____**Initial**

We will not authorize lab slips or lab testing and that the lab testing must be done outside of any insurance plan Dealing with insurance companies and HRT has been difficult and insurmountable. We, therefore, wish to advise you that your HRT treatment will not involve any use of insurance or completing insurance forms or statement of medical necessity." _____ Initial**

Your telephone number is collected to send appointment reminders as well as clinic specials. You may "opt out" of receiving texts at any time. Please sign below to indicate that you understand and consent to treatment and agree to receive our text reminders._____**Initial**

We strive to achieve optimal health & wellness through nutrition, exercise, hormone balance and optimization. Our programs, protocols and philosophy are designed to maximize your QUALITY of life. If your hormone levels are in a "normal" range but are low and you have symptoms we may start therapy to alleviate symptoms. ._____**Initial**

Patient signature (SIGN HERE) *Date*

REASON FOR VISIT TODAY

Please check the reason you are coming in today; if it is not listed please write in the reason, if doing lab-work what is the reason:

_____
_____
_____
_____

- □ New weight patient
- □ New Hormone
- □ B-complex Injection
- □ Thyroid Evaluation
- □ Botox Injections
- □ Laser Evaluation
- □ Juverderm/Fillers
- □ Fatigue

- □ Hormone Imbalance
- □ Loss of sexual desire
- □ Low Testosterone Symptoms

(Patient MUST read and sign in order to be seen)

KINGWOOD WELLNESS CLINIC®

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Current or referring doctor:		**Date of last physical exam:**	
PERSONAL HEALTH HISTORY			
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	
	☐ Hepatitis	☐ Chickenpox	
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	

List or circle any medical problems that other doctors have diagnosed

☐ Low thyroid ☐ high thyroid	☐ Cancer	☐Elevated PSA
☐ High blood pressure	☐ Depression	☐ Constipation
☐ High Cholesterol	☐ Bipolar	☐ Snoring or sleep apnea
☐ Diabetes (insulin or no-insulin)	☐ Reflux	☐ Waking at night to urinate

Surgeries ☐ **No Surgeries Please list or circle if listed**

Year	Surgery	Thyroidectomy ☐R ☐Left ☐Total
	☐ C-section How many?_____	Gastric ☐ Staple or ☐ Banding
	☐ Hysterectomy ☐ Tubal Ligation	Heart Surgery
	☐ Gallbladder removed (cholecystectomy)	Other:
	☐ Appendectomy	Other:
	☐ Tonsillectomy	Other:
	ANYTHING ELSE:	

Other hospitalizations

Year	Reason	Age if you do not remember year

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins ,inhalers and including birth control

Name the Drug	Strength	Frequency Taken

Allergies to medications ☐ **No Known Drug Allergies**

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

PLEASE ANSWER ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting ?			☐ Yes	☐ No
	Have you taken appetite suppressants in the past?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind? ☐ Beer ☐ Wine ☐ Liquor ☐Tequila ☐Vodka				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	

	☐ # of years	☐ Or year quit ☐ Do you desire to quit?_____		
Sex	Are you sexually active?		☐ Yes	☐ No
	If yes, are you trying for a pregnancy?		☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?		☐ Yes	☐ No
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No
	Do you get dizzy on standing?		☐ Yes	☐ No
Quality of Life	HOW WOULD YOU RATE YOUR HEALTH AND WELL-BEING			
	Poor **Fair** **Good** **Very Good** **Excellent** ** This helps us evaluate our treatments, please compare o the best you ever felt health-wise			

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father (F)			**Children** (M)male (F)female	☐ M ☐ F	
Mother (M)				☐ M ☐ F	
Diabetes	☐ M ☐ F			☐ M ☐ F	
Heart Disease	☐ M ☐ F			☐ M ☐ F	
Hypertension	☐ M ☐ F		**Grandmother** *Maternal*		
Thyroid	☐ M ☐ F		**Grandfather** *Maternal*		
Kidney	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you have problems with weight gain or losing weight?	☐ Yes	☐ No
Do you occasionally feel depressed or have depressed moods?	☐ Yes	☐ No
Is your concentration decreased?	☐ Yes	☐ No
Do you have problems with occasional constipation?	☐ Yes	☐ No
How often are bowel movements?		
Do you get cold easily or have cold hands or feet?	☐ Yes	☐ No
Have you noticed excessive hair loss?	☐ Yes	☐ No
Is your skin dry?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Poor energy or fatigue?	☐ Yes	☐ No
Bone / Joint Pain	☐ Yes	☐ No

WOMEN ONLY

DO NOT WRITE N/A, EVERYTHING IS APPLICABLE

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days Length of periods_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____ Miscarriage_____Abortions_____		
Are you pregnant or breastfeeding?	☐ **Yes**	☐ **No**
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ **Yes**	☐ **No**
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Date of last pap and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)		

Date of last mammogram?_____Results: ☐ Normal ☐ Abnormal (Please list any findings)

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)	☐ Yes	☐ No

OTHER PROBLEMS

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Hormonal symptoms

I hereby certify that the above information is true and correct to the best of my knowledge._____

Notice of Privacy Practices Acknowledgment

KINGWOOD WELLNESS

2316 TIMBER SHADOWS DRIVE, #100
KINGWOOD, TX 77339
PHONE: 281-852-1800

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (**"HIPPA"**), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to so as documented below:

Date: Initials: Reason:

CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

Background:

You have been diagnosed with or have an increased risk of having a hormone deficiency (ies) and your Provider has recommended treatment with bio-identical hormone replacement therapy (HRT). Some of the bio-identical hormone preparations that may be prescribed for you are regulated by pharmacy compounding laws, which follow the Pharmacy Compounding Accreditation Board (PCAB) guidelines. The use of this therapy as it relates to your diagnosis, while common in alternative practices, may be debated in the traditional medical community.

You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so you make an informed decision whether or not to undergo the procedures after knowing the risks involved. This disclosure is not meant to scare or alarm you, but to simply inform you so you have the information needed to give or withhold your consent to the procedure or treatment.

NOTICE: Refusal to consent to the innovative, integrative, complementary or non-standard procedure shall not affect your right to future care or treatment.

Therapeutic Basis:

Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or inability to lose weight may also benefit from these therapies. Bio-identical HRT can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident.

Estrogen therapy can maintain vaginal and urethral function and slow the progression of osteoporosis. It may also improve sleep, decrease hot flashes and night sweats, decrease pain and perhaps cognitive function, and improve libido and overall well-being. This therapy may contain one or any combinations of the following medications: estriol, estradiol, and/or estrone.

Progesterone hormone replacement therapy can offer protection from endometrial cancers, treatment of irregular menstruation, and other low progesterone conditions. It also can improve sleep quality and decrease anxiety.

Testosterone replacement therapy is used to treat symptoms or lab tests suggesting suboptimal hormone levels as determined by your Provider. Low testosterone is associated with elevated cholesterols, high blood pressure and diabetes. Other low testosterone symptoms include excessive fatigue, abdominal weight gain, irritability and decreased sexual drive and function.

CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

Objectives:

Bio-identical HRT is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones.

Potential Risks:

Safety of any of these hormones during pregnancy cannot be guaranteed. Notify your Provider if you are pregnant, suspect that you are pregnant, or are planning to become pregnant during this therapy.

Estrogen Therapy: Bio-identical estrogens are available in various forms including oral capsules, troches, patches, pellets and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, mood swings, [liver cysts, death (e.g.-from blood clots or cancer) associated with conjugated hormones]. High potency conjugated estrogens (e.g. Premarin) have been associated with an increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole area of estrogen replacement is undergoing further evaluation. Do not take estrogen if you have breast cancer.

Progesterone Therapy: Bio-identical progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

Testosterone Therapy: Bio-identical testosterone therapy is available in various forms including sublingual drops, troches, topical creams, pellets and injection. Side effects include acne, change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur.

Although the use of bio-identical hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with the use of bio-identical hormones.

Statement of Patient:

I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I acknowledge that my family physician, OB-GYN or other health care providers may not agree with hormone replacement therapy.

I agree to proceed with treatment and to comply with recommended dosages. I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a KHWC Provider, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, etc. at least on a yearly basis.

I agree to immediately report to my Provider any adverse reaction or problem that might be related to my therapy. Risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other hormone treatments, and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

OFF-LABEL USE

The use of Bio-identical hormones for symptom relief is considered an off label use. Off label drug use means prescribing a drug for a condition for which it has not officially received FDA approval.

Signature of Patient _____ Date_____

Name (PRINT) _____

Statement of Provider: I have explained the risks and benefits of the therapy as detailed above. The patient has verbalized to me his/her understanding of those risks and benefits and gives verbal consent to initiate this therapy. I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed the patient has no further questions and wishes to initiate bio-identical hormone replacement therapy.

Name of PROVIDER Explaining Procedures: _____

PROVIDER Signature_____

BHRT Certified

KINGWOOD
HEALTH & WELLNESS
281-852-1800

BHRT CHECKLIST FOR WOMEN

Name: _____ Date: _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you: _____

THYROID CONSENT

Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffer symptoms of hypothyroidism or an underactive thyroid. We are/may be prescribing these medications off label. They are being used in a manner or reason that they may not be necessarily marketed for. **Your blood levels may be in the normal range but are on the low side and not optimal to maintain your health. We are prescribing you thyroid medication to alleviate SYMPTOMS.** Although weight gain may be a result of low thyroid, increasing your thyroid level will not guarantee weight loss. **We are NOT giving thyroid for weight loss.**

Statement of Patient: I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications most commonly seen are **palpitations, headaches, anxious, irritability or insomnia** have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages. I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a KHWC Provider.

TSH SUPPRESSION: Will probably occur with treatment, It is not the same as the autoimmune disease known as hyperthyroid (Grave's Disease). As recommended by the manufacture, we follow the T4 and T3 levels, not the TSH.

Secondary or Tertiary Hypothyroidism
Start SYNTHROID at the full replacement dose in otherwise healthy, non-elderly individuals. Start with a lower dose in elderly patients, patients with underlying cardiovascular disease or patients with severe longstanding hypothyroidism as described above. Serum TSH is not a reliable measure of SYNTHROID dose adequacy in patients with secondary or tertiary hypothyroidism and should not be used to monitor therapy. Use the serum free-T4 level to monitor adequacy of therapy in this patient population. Titrate SYNTHROID dosing per above instructions until the patient is clinically euthyroid and the serum free-T4 level is restored to the upper half of the normal range.

I agree to immediately report to my Provider any adverse reaction or problem that might be related to my therapy. Risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of thyroid hormone treatments, and have had all my questions answered.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with thyroid hormone replacement therapy. I acknowledge that I am NOT being given thyroid for weight loss.

Name (PRINT) _____

Signature of Patient _____ Date_____

Statement of Provider: I have explained the risks and benefits of the therapy as detailed above. The patient has verbalized to me his/her understanding of those risks and benefits and gives verbal consent to initiate this therapy. I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed the patient has no further questions and wishes to initiate thyroid hormone replacement therapy.

Signature of PROVIDER Explaining Procedures: _____

PATIENTS BEHAVIOR TOWARDS STAFF MEMBERS

Dear Patient,

Your treatment at Kingwood Wellness is founded on our set of core values and principles which we hold paramount. Our staff works diligently to maintain and adhere closely to these values throughout your health journey with us.

OUR CORE VALUES AND PRINCIPLES

-We love our patients and building trusting relationships

-We are humble, life-long learners pursing optimal wellness.

-We prioritize productivity and work-life balance and boundaries.

-We provide personalized, hands-on care for patients.

-We empower our patients and cultivate an authentic community.

In our best effort to uphold these values as top priority, our staff have been throughly trained to provide our patients with the utmost care and respect.

Likewise, we expect patients behave appropriately and respectfully towards our staff. Verbal disrespect, abuse, or mistreatment of any kind will not be tolerated.

A patient's first offense will result in a warning letter, stating the incident and requesting appropriate and respectful behavior going forward. The second offense will result in complete dismissal from our practice. However, the severity of the first offense may require immediate dismissal from the practice. Examples of offenses that may result in immediate termination include but are not limited to name-calling, yelling/screaming, swearing/cursing, or threatening.

Please contact our office if you have any concern about the behavior of a staff member, and we will connect you to the appropriate supervisor related to your concern.

We are so grateful to be a part of your healthcare team and look forward to working with you on your wellness journey.

Kindest regards,

The Team at Kingwood Wellness

Signature _____ **Date** _____