We take your symptoms and an evaluation of your entire endocrine system to determine how to treat you, as an individual. Please take the time to fill out the following forms and questionnaires before your visit. and bring them completed along with your insurance card. The questionnaires, although lengthy, help us identify the cause of your problems so that we can get you feeling better quicker.

6811 N. Knoxville Ave., Ste. A | Peoria, IL 61614 309.439.9400
2309 E. Empire St., Ste. 200 | Bloomington, IL 61704 309.740.7970

www.LifePlusMD.com

WOMEN'S INTAKE FORM

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

SSN#: _____ Date of Birth: _____ / _____ / _____ Age: _____

Height: _____ Weight: _____

Occupation: _____ Marital Status: _____

Primary Insurance Information

Employer: _____

Company: _____

Primary Address: _____

Primary ID Number: _____

Primary Group ID: _____

Primary Cardholder Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN#: _____ Date of Birth: _____ / _____ / _____ Age: _____

Secondary Insurance Information

Secondary Address: _____

Secondary ID Number: _____

Secondary Group ID: _____

ASSIGNMENT AND RELEASE

I, the undersigned verify that. to the best of my knowledge. the information above is correct. I assign directly to (Inspirit Health PC / LifePlus MD) all insurance benefits. If any. otherwise payable services are rendered. I understand that I am financially responsible for changes whether or not paid by insurance. **By signing this form I fully understand that (Inspirit Health PC / LifePlus MD) Is not a participant of Medicaid or Medicare and will not provide services to Medicaid or Medicare patients at this time.** I hereby authorize release of information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

_____

Signature *Relationship* *Date*

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MESSAGE AUTHORIZATION

Patient Name: _____ Date of Birth: _____ / _____ / _____

Please Circle Yes or No for the following questions:

Do you give the staff at LifePlus MD permission to leave messages on your voice mail?

YES NO

If Yes, please specify phone number(s) we we can leave voice mail: _____

Do you give the staff at LifePlus MD permission to send appointment reminders via text and email?

YES NO

Do you give the staff at LifePlus MD permission to discuss your healthcare needs with your spouse or other designated person?

YES NO

If yes, please list spouse/designated individuals and phone contacts:

_____

_____

_____

_____

Signature *Date*

Primary Care and Specialty Doctors:

Doctor's Name: _____

Location: _____

Doctor's Name: _____

Location: _____

Doctor's Name: _____

Location: _____

Allergies: Pleae list all allergies to medications (if any) and what reactions have occurred (if any):

_____

_____

Medications: Pleae list all prescription medications you currently take, including samples.

	Medication Name	Dose	Number of times per day	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Herbal/Supplements: Pleae list all vitamins, herbs, enzymes, protein supplements, pro-hormones or any other supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Past Medical History and Current Medical Conditions: Pleae check all that apply to you.

- ❑ Heart Disease
- ❑ Diabetes
- ❑ Cancer
- ❑ Epilepsy
- ❑ Hormone Related Issues
- ❑ Bladder Infections
- ❑ Blood Clots
- ❑ Diagnosed Obesity
- ❑ Lung Disease
- ❑ High Blood Pressure
- ❑ Depression
- ❑ Thyroid Disease
- ❑ Headaches
- ❑ Fatigue
- ❑ Abnormal PAP
- ❑ High Cholesterol
- ❑ Arthritis
- ❑ Ulcers
- ❑ Head Trauma
- ❑ Kidney Stones
- ❑ Insomnia
- ❑ Prader-Willi Syndrome

List any other medical conditions that you currently receive treatment for (medical, chiropractor, physical therapist, etc.). _____

_____

_____

_____

Surgical History: _____

_____

_____

_____

Family History: Pleae list any illness that any of the following members of your family have had.

Mother: _____ Deceased ❑ Yes ❑ No

Father: _____ Deceased ❑ Yes ❑ No

Siblings: _____ Deceased ❑ Yes ❑ No

Siblings: _____ Deceased ❑ Yes ❑ No

Children: _____ Deceased ❑ Yes ❑ No

Children: _____ Deceased ❑ Yes ❑ No

Gynecological History:

Age of first period: _____ Age of last period: _____

Date of last PAP: _____ Doctor/Location: _____

Have you ever had an abnormal PAP? ❑ Yes ❑ No

If yes, please elaborate? _____

Are you sexually active? ❑ Yes ❑ No Are you trying to get pregnant? ❑ Yes ❑ No

Please list any birth control methods._____

_____

Are your periods regular? ❑ Yes ❑ No How many days do your periods last? _____

Any abnormality with flow? ❑ Yes ❑ No Any cramps? ❑ Yes ❑ No

Any premenstrual symptoms? ❑ Yes ❑ No Any fluctuations in timing of periods? ❑ Yes ❑ No

Starting and ending when? _____ Any bleeding between periods? ❑ Yes ❑ No

Any pelvic pressure or fullness? ❑ Yes ❑ No When was your last period? _____

Any unusual vaginal discharge or itching or recurrent urinary tract infections? ❑ Yes ❑ No

Please describe: _____

_____

Number of pregnancies: _____ Number of children: _____

Lifestyle Information:

	Do you use?	If Yes, how often and how much?
Tobacco (Chew, Smoke, Snuff)	❑ Yes ❑ No	_____
Alcohol	❑ Yes ❑ No	_____
Caffeine (Soda, Tea, Coffee)	❑ Yes ❑ No	_____
Artificial Sweeteners	❑ Yes ❑ No	_____

Do you snore or stop breathing when sleeping? ❑ Yes ❑ No

Insomnia ❑ Yes ❑ No Sleep Apnea ❑ Yes ❑ No

Diet:

Do you have an eating plan that you follow? ❑ Yes ❑ No

If Yes, please describe _____

_____

Exercise:

Do you exercise regularly? ❑ Yes ❑ No

If Yes, how often and how much? _____

_____

Stress Management:

Do you practice any stress management techniques? ❑ Yes ❑ No

If Yes, how often and how much? _____

_____

Body Image:

Are you comfortable with your current weight and size? ❑ Yes ❑ No

Do you struggle to lose weight? ❑ Yes ❑ No

General Health:

Do you think your health is good? ❑ Yes ❑ No

If No, please explain _____

_____

Goals:

What do you hope to accomplish at LifePlus MD?

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

Symptoms Report: Pleae indicate if the following symptions apply to you.

Headaches	❑ Yes	❑ No	Painful Intercourse	❑ Yes	❑ No
Decreased Libido	❑ Yes	❑ No	Irritability	❑ Yes	❑ No
Anxiety/Panic Attacks	❑ Yes	❑ No	Weight Gain	❑ Yes	❑ No
Breast Swelling	❑ Yes	❑ No	Concentration Problems	❑ Yes	❑ No
Breast Tenderness	❑ Yes	❑ No	Shortness of breath	❑ Yes	❑ No
Moodiness	❑ Yes	❑ No	Night Sweats	❑ Yes	❑ No
Foggy or Fuzzy Thoughts	❑ Yes	❑ No	Inability to have orgasms	❑ Yes	❑ No
Sleep Disturbances	❑ Yes	❑ No	Fluid Retention	❑ Yes	❑ No
Vaginal Dryness	❑ Yes	❑ No	Breast Lumps or Fibroids	❑ Yes	❑ No
Dry Hair/Skin	❑ Yes	❑ No	Loss of sex drive	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Bleeding Abnormalities	❑ Yes	❑ No
Hair Loss	❑ Yes	❑ No	Heat or Cold Intolerance	❑ Yes	❑ No
Heart Palpitations	❑ Yes	❑ No	Excessive Sweating	❑ Yes	❑ No
Flushing or Hot Flashes	❑ Yes	❑ No	Nervousness	❑ Yes	❑ No
Frequent Yeast Infections	❑ Yes	❑ No	Burned Out/Past Peak	❑ Yes	❑ No

Adrenal Function and Evaluation: Pleae indicate if the following statements apply to you.

I have low blood pressure.	❑ Yes	❑ No
I get dizzy or see spots when standing up rapidly from a sitting or lying position.	❑ Yes	❑ No
I feel as though I might faint or black out.	❑ Yes	❑ No
I have acute of chronic fatigue (lack of energy).	❑ Yes	❑ No
I have low energy before lunch or dinner.	❑ Yes	❑ No
I usually feel better after 6pm.	❑ Yes	❑ No
I often feel the best late at night because I get a “second wind”.	❑ Yes	❑ No
I have trouble getting asleep.	❑ Yes	❑ No
I tend to wake early (approx. 3am - 5am) and have trouble getting back to sleep.	❑ Yes	❑ No
I need to rest after times of mental, physical, or emotional stress.	❑ Yes	❑ No
I feel more tired after excercise or physical exertion, either soon after or the next day.	❑ Yes	❑ No
I have chronic tenderness in my back near the bottom of my rib cage.	❑ Yes	❑ No
I have a back pain / joint pain / chronic inflammation.	❑ Yes	❑ No
I am allergic to many things, such as food, animals, and pollens.	❑ Yes	❑ No
My allergies are getting worse.	❑ Yes	❑ No
I become hungry, confused, or shaky if I miss a meal.	❑ Yes	❑ No
I crave sugar, sweets, or desserts.	❑ Yes	❑ No
I use stimulants, such as tea or coffee, to get started in the morning.	❑ Yes	❑ No
I need caffeine (chocolate, tea, coffee, sodas) to get me through the day.	❑ Yes	❑ No
I often crave salt and/or foods high in salt, such as potato chips.	❑ Yes	❑ No
I do not eat regular meals.	❑ Yes	❑ No
I have taken steroid medications for a long term or at high doses.	❑ Yes	❑ No
I have symptoms that improve after I eat.	❑ Yes	❑ No
I get more than 2 colds or flus per year.	❑ Yes	❑ No
I do not exercise regularly.	❑ Yes	❑ No
I am emotionally stressed.	❑ Yes	❑ No
I tend to be a perfectionist.	❑ Yes	❑ No
I tend to avoid stressful situations for the sake of my health.	❑ Yes	❑ No
I am less productive at work than I used to be.	❑ Yes	❑ No
My ability to focus mentally is generally impaired.	❑ Yes	❑ No
Stress causes me to become overly anxious.	❑ Yes	❑ No
My sex drive is very low or non-existent.	❑ Yes	❑ No
My relationships at work and/or home tend to be strained.	❑ Yes	❑ No
My life contains insufficient time for fun and enjoyable activities.	❑ Yes	❑ No
I have little control over my life and I feel “stuck”.	❑ Yes	❑ No
I tend to get addicted easily to drugs, alcohol, or food.	❑ Yes	❑ No

Adult Growth Hormone Deficiency Assessment: Pleae indicate if the following statements apply to you.

I struggle to finish jobs.	❑ Yes	❑ No
I feel a strong need to sleep during the day.	❑ Yes	❑ No
I often feel lonely even when I am with other people.	❑ Yes	❑ No
I have to read things several times before they sink in.	❑ Yes	❑ No
It is difficult for me to make friends and/or hard for me to mix with people.	❑ Yes	❑ No
It takes a lot of effort for me to do simple tasks.	❑ Yes	❑ No
I have difficulty controlling my emotions.	❑ Yes	❑ No
I often lose track of what I want to say, or forget what people say to me.	❑ Yes	❑ No
I lack confidence.	❑ Yes	❑ No
I have to push myself to do things.	❑ Yes	❑ No
I often feel very tense.	❑ Yes	❑ No
I feel as if I let people down.	❑ Yes	❑ No
I feel worn out even when I'm not doing anything.	❑ Yes	❑ No
There are times I feel very low.	❑ Yes	❑ No
I avoid responsibility if possible.	❑ Yes	❑ No
I avoid mixing with people I don't know well.	❑ Yes	❑ No
I feel as if I am a burden to people.	❑ Yes	❑ No
I find it difficult to plan ahead.	❑ Yes	❑ No
I have to force myself to do things that need doing.	❑ Yes	❑ No
My memory lets me down.	❑ Yes	❑ No

Thyroid Function and Evaluation Tool: Pleae indicate if the following statements apply to you.

Do you feel exhausted from morning to night?	❑ Yes	❑ No
Do you have trouble getting up in the morning?	❑ Yes	❑ No
Do you have morning stiffness?	❑ Yes	❑ No
Do you have trouble working under pressure?	❑ Yes	❑ No
Do you have trouble losing weight no matter what you do?	❑ Yes	❑ No
Are you constipated?	❑ Yes	❑ No
Do your muscles feel weak as if they can't generate energy?	❑ Yes	❑ No
Is your cholesterol over 200?	❑ Yes	❑ No
Do you have or did you have PMS or menstrual difficulty?	❑ Yes	❑ No
Have you ever had trouble with fertility?	❑ Yes	❑ No
Do you have low body temperature?	❑ Yes	❑ No
Do you use any sort of thyroid supplementation?	❑ Yes	❑ No
Do you have a history of anemia or bruise easily?	❑ Yes	❑ No