

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 2309 E. Empire St., Ste. 200 | Bloomington, IL 61704 309.439.9400 309.740.7970



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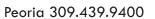
WOMEN'S INTAKE FORM

Name:							
Address:							
City:				State:			Zip:
Home Phone:	Work	Phone	:			_ Cell Phon	e:
Email:							
SSN#:	Date	of B	irth:		/	_ /	Age:
Height:				We	ight:		
Occupation:				Mari	tal 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 B	irth:		/	_ /	Age:
Secondary Insurance Information	n						
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





MESSAGE AUTHORIZATION

Patient N	lame:	Date of Birth: / /
Please C	ircle Yes or No for the following questions:	
Do you g	ive the staff at LifePlus MD permission to leave	messages on your voice mail?
YES	NO	
If Yes, ple	ease specify phone number(s) we we can leave	voice mail:
Do you g	ive the staff at LifePlus MD permission to send o	appointment reminders via text and email?
YES	NO	
-	ive the staff at LifePlus MD permission to discus	s your healthcare needs with your spouse or other
YES	NO	
lf yes, ple	ease list spouse/designated individuals and pho	one contacts:
Signature		Date





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Primary Care and Speci	alty [Doctors:				
Doctor's Name:						
Location:						
Doctor's Name:						
Location:						
Doctor's Name:						
Location:						
Allergies: Pleae list all alle	ergies	to medications (if any)	and v	vhat reactions have	occuri	red (if any):
Medications: Pleae list al	l preso			ntly take, including s	ampl	es. Doctor
1						
2						
3						
4						
5						
6						
7						
	any c	other supplements.	zymes	, protein supplemen	ts, pro	o-hormones
1						
2						
3						
4						
5 6						
7						
Past Medical History an				Pleae check all th	nat ap	oply 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





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List any other medical conditions that you currently receive treat	ment for (medical, chiropractor, physical
therapist, etc.).	
Surgical History:	
Family History: Pleae list any illness that any of the following	a members of your family have had
Mother:	
Father:	
Siblings:	
Siblings: Children:	
Children:	Deceased 🖬 Fes 🖫 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?	
	ig to get pregnant? 🔲 Yes 🔲 No
Please list any birth control methods.	
Are your periods regular?	days do your periods last?
Any abnormality with flow?	
	tions in timing of periods? Yes No
, , , , , , , , , , , , , , , , , , , ,	ng between periods?
,	your last period?
Any unusual vaginal discharge or itching or recurrent urinary tra	
Please describe:	
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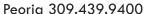




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Lifestyle Information: Tobacco (Chew, Smoke, Snuff) Alcohol Caffeine (Soda, Tea, Coffee) Artificial Sweeteners	Do you use? Yes No Yes No Yes No Yes No		If Yes, how often and how much?
Do you snore or stop breathing when Insomnia ☐ Yes ☐ No	sleeping?		
Diet: Do you have an eating plan the lif Yes, please describe	-		
Exercise: Do you exercise regularl If Yes, how often and how much?	•		
Stress Management: Do you pro	· ·	-	•
Body Image:			
Are you comfortable with your curren	nt 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			



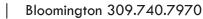




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Symptoms Report: Plea	ae indicate	e if the following symptions	apply to you.		
Headaches	☐ Yes	□ No	Painful Intercourse	☐ Yes	☐ No
Decreased Libido	☐ Yes	□ No	Irritability	☐ Yes	☐ No
Anxiety/Panic Attacks	☐ Yes	□ No	Weight Gain	☐ Yes	☐ No
Breast Swelling	☐ 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



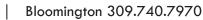




Adrenal Function and Evaluation: Pleae indicate if the following statements apply to you.

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
l 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 statement	its apply t	o 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	/OU.	
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