Integrative Health and Hormone Clinic

1731 Boyson Road
Hiawatha Iowa 52233
Phone 319-363-0033 | Fax: 319-363-4411

We ask that you complete each page of the enclosed comprehensive initial consultation form and return it to us so we may schedule your initial appointment. We will call the number provided to schedule once we have received and reviewed your forms. This may take up to a week to complete. If it is convenient for you, we also request the following:

1. All laboratory results for previous 2 years – Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP), Cholesterol Panel (HDL, LDL, Total Cholesterol), any thyroid and/or hormone studies, any special food sensitivity testing, saliva, and/ or stool testing.
2. For women: mammograms, PAP results, and yearly exams for previous 2 years
3. For men: prostate screening and yearly exams for previous 2 years

If you are not conveniently able to locate these items and your clinician would require them to continue care, we will have to complete an authorization to release medical records form at your first appointment to obtain them. If these tests have not been completed recently, our clinician can order what she feels is necessary for you at the time of your appointment.

We also ask that you bring the following to your initial consultation:

1.) Most recent insurance card
2.) Photo ID
3.) List of medications and supplements. Please bring in the supplements so that we may see the ingredients and please remember to also list them on your initial paperwork.

Please arrive 15 minutes prior to your appointment. If you arrive 10 minutes or more PAST your scheduled appointment time, you may be asked to reschedule to maximize your time with your clinician. If you are unable to keep your appointment, please call at least **72 hours in advance** of your scheduled appointment date to cancel or reschedule. Failure to show to the appointment or notify the office 72 hours in advance will result in a **no show/late cancellation fee of $200.** Please know that we are unable to provide supervision for young children that accompany you to our clinic and we ask that you make other arrangements.

Thank you for allowing us to be a part of your health care team. We look forward to meeting you soon!

Wellness is Waiting!

Integrative Health and Hormone Clinic Staff

IMPORTANT OFFICE POLICIES

For prescription refill requests ordered by Dr. Gray simply have your pharmacy fax the request to our office at (319) 363-4411. Please allow at least ONE WEEK for this process or any other prescriptions request.

We greatly appreciate our patients, and work hard to ensure each patient is our top priority during appointments. We make every effort to respond to questions and / or concerns presented outside of an appointment within 3-5 business days.

Supplement Discount Cards are great way to save on supplements. When you spend $200 on supplements, you will receive $20 off your NEXT PURCHASE. Supplement Discount Cards cannot be combined with any other offer.

We make every effort to see our patients in a timely manner, but we often have many on the waiting list for an appointment time. To help us, we ask that you please notify the office 72 hours in advance if you need to change or reschedule your appointment.

A **$200.00 NO SHOW** fee will be charged for initial appointments without the 72 hour notice. A **$100.00 NO SHOW** fee will be charged for follow-up appointments without the 72 hour notice.

We also ask that all patients are 15 minutes early to their appointments, so we may stay on schedule and prevent patients from waiting too long when they arrive.

All specimens collected in this office are sent to LabCorp.

If you would like us to send any medical records to your primary care physician, please allow us 3-5 business days.

Thank you!

PATIENT RIGHTS AND RESPONSIBILITIES

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his/her individual dignity and with protection of his/her need for privacy.
- A prompt and reasonable response to questions and requests. Please allow at least **72 hours** for us to respond to your non-urgent questions.
- Know what rules and regulations apply to his/her conduct.
- Be given, by his/her healthcare providers, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- Receive upon request and in advance of treatment, a reasonable estimate of charges for medical care.
- **Know, upon request and in advance of treatment, that Integrative Health and Hormone Clinic is a direct-pay practice.**
- Receive a copy of a reasonable clear and understandable itemized bill and, upon request, have the charges explained.
- Receive impartial access to medical treatment or accommodations, regardless of race, color, gender, ethnicity, national origin, religion, sexual orientation, physical handicap, or source of payment.

A patient has the responsibility to:

- Provide accurate and complete health information concerning his/her illness, hospitalization, medications, supplements, allergies, and all other pertinent items. The patient should bring any information relating to his/her health to Integrative Health and Hormone Clinic at the time of the visit.
- **Understand that Integrative Health and Hormone Clinic is a specialty care provider and the services it provides are not meant to take the place of a primary care provider. Patient understands that he/she must notify his primary care provider, and any other health care provider of any and all supplements and hormones (including pellets) that Integrative Health and Hormone Clinic has prescribed, ordered, or inserted.**
- **Understand that as a specialty care provider, Integrative Health and Hormone Clinic does not offer emergency or urgent care. These services must be accessed at an urgent care facility or emergency room.**

- Participate in the development of his/her care plan, and comply with Integrative Health and Hormone Clinic policies and procedures governing his/her care. The patient understands he/she may be discharged from services from non-adherence to this plan of care.
- Voice concerns or problems to Integrative Health and Hormone Clinic staff, and to request further information concerning anything he/she does not understand.
- Be respectful of other people of Integrative Health and Hormone Clinic property. This implies that no patients will be seen under the influence of drugs or alcohol.
- Realized the consequences of his/her actions if he/she refuses treatment or does not follow medical instructions.
- Remain under medical supervision as warranted by his/her condition.
- Abide by Integrative Health and Hormone Clinic rules and regulations, and ensure that those who accompany him/her do likewise.
- Provide truthful information about insurance status, notifying Integrative Health and Hormone Clinic of changes.
- Verify coverage of his/her insurance payer for annual physical examination coverage if requesting this be provided by Integrative Health and Hormone Clinic.
- Be considerate and cooperative with Integrative Health and Hormone Clinic staff and not discriminate against health care providers because of race, color, gender, ethnicity, nation origin, religion or sexual orientation.
- Arrive for appointments on time. If you are unable to arrive on time, it may be necessary to reschedule your appointment.
- Notify Integrative Health and Hormone 72 hours in advance if he/she is unable to keep a scheduled appointment. Integrative Health and Hormone Clinic will apply a $100 fee for all follow-up visits that are not rescheduled or cancelled 72 hours in advance.
- Permitted 1 Emergency Rescheduling: He/She will be able to reschedule 1 appointment due to an emergency within the 72 hour timeframe. He/She must reschedule in order to have the fee waived due to the emergency. Simply cancelling the appointment without the rescheduling will result in a $100 fee.
- Fulfill personal financial obligations of his/her healthcare are promptly as possible.

By signing this document, I acknowledge that I have read and agree to all of the above statements.

Print Legal Name of Patient/Authorized Representative_____

Signature of Patient/Authorized Representative_____

Date_____

Reason why patient cannot sign (if applicable): _____

INFORMED CONSENT

Regarding Treatment and Care

I have elected to seek functional and integrative medicine treatment. _____ (initial)

I understand that in the practice of functional medicine some treatments are considered "alternative" by the conventional medical community and that there are some risks to treatment. I understand that some of the recommended treatments may not be approved by the FDA. _____ (initial)

I understand it is recommended that I see my primary care physician if I desire only FDA-approved treatments for my conditions. _____ (initial)

I understand that it is important that I provide accurate and complete health information concerning my illness, hospitalizations, medications, supplements, allergies, and other pertinent items. _____ (initial)

I understand that Integrative Health and Hormone Clinic is a specialty care provider and the services the Clinic provides are not meant to take the place of my primary care provider. _____ (initial)

I further understand that I must notify my primary care provider, and any other health care provider, of any and all supplements and hormones (including pellets) that IHHC has prescribed, ordered, or inserted. _____ (initial)

IHHC has explained the risks and benefits concerning functional and integrative medicine and I have had a chance to have my questions answered. _____ (initial)

Regarding Diet Recommendations and Nutritional/Herbal Supplements

I hereby request nutritional consultation and supplement suggestions. _____ (initial)

We may make diet recommendations and recommendations regarding use of nutritional and herbal supplements in order to supply nutrition to support the physiological and biomechanical processes of the human body. Although these foods and products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. _____ (initial)

Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking. _____ (initial)

As a service to you, we make nutritional supplements available in our office. We purchase only top quality products and only from manufacturers who have gained our confidence through considerable research and experience. You are under no obligation to purchase these in our office but we cannot guarantee a similar quality from an outside source. _____ (initial)

Refunds will be given to any supplement that is unopened and returned within 14 days of purchase. _____ (initial)

ANY QUESTIONS I HAVE HAD REGARDING THE CARE IHHC PROVIDES HAS BEEN ANSWERED TO MY SATISFACTION PRIOR TO MY SIGNING THIS CONSENT FORM. I HAVE MADE MY DECISION VOLUNTARILY AND FREELY. BY SIGNING THIS DOCUMENT BELOW, AND INITIALING THE ABOVE STATEMENTS, I ACKNOWLEDGE I HAVE READ AND AGREE TO ALL OF THE ABOVE STATEMENTS.

_____
Patient Name

_____ _____
Signed Date

DEMOGRAPHIC PROFILE

Please complete to the best of your knowledge and return to our clinic so that we can schedule your initial appointment.

Today's date:_____

Legal Name:_____ Preferred Name:_____

Date of birth:_____ Sex:_____ Ht:_____ Wt: _____

Address:_____ City: _____ State:_____ Zip: _____

I wish to be contacted in the following manner (check all that is acceptable):

☐ Cell Phone: _____ ☐ Check if we may leave a detailed message (test, results, billing, etc.)

☐ Home Phone: _____ ☐ Check if we may leave a detailed message (test, results, billing, etc.)

☐ Work Phone: _____ ☐ Check if we may leave a detailed message (test, results, billing, etc.)

My Email Address: _____

(By providing your e-mail address, you are giving your consent for future email communication from Integrative Health and Hormone Clinic. They may use this email through Constant Contact to send you email newsletters, promotions and discounts, and for marketing their events. You may request to have your email address removed from this list at any time.)

Legal Guardian (if applicable):_____ Relationship to patient: _____

Address:_____ City: _____ State: _____ Zip: _____

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

Name of Insurance: _____

Policy Holders Name: _____ Insurance Policy / Card #_____

Primary Care Provider:_____ Phone: _____Fax: _____

Alternative Providers (i.e. Chiropractor):_____ Phone:_____

Preferred Pharmacy:_____ Phone:_____

Please list your race: ☐White ☐Asian ☐Black or African American ☐American Indian or Alaska Native
☐Native Hawaiian or Other Pacific Islander ☐Other ☐Unreported/Refused to Report

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Language Preference: ☐English ☐Other_____
Employment Status: ☐Employed ☐Not Employed ☐Retired Occupation:_____

COMPREHENSIVE HEALTH INFORMATION

Referring Provider (if applicable):_____ Phone:_____ Fax:_____

How did you hear about us? _____

(If recommended by a current patient, please state who so we can send them a token of our appreciation.)

History of Present Illness (HPI)

When listing your history below, please prioritize and score their severity on a scale of 0-10 with 0 being non-bothersome and 10 being the worst imaginable. We may not have time to discuss everything in the first visit so prioritizing will assist us in addressing your most important issues during your initial visit.

	Description	Score	When did this start?
	Example: Hot Flashes	5	4 Months ago in May of 2010
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Is there anything that makes these problems better or worse?

_____

_____

_____

_____

_____

Past Medical History:

☐Alzheimer's	☐Anemia	☐Anxiety	☐Arthritis	☐Asthma
☐Back Injury	☐Bladder tumor	☐Bleeding problems	☐BPH	☐Bronchitis
☐Cancer	☐Cataracts	☐Celiac	☐Chest Pain	☐Constipation
☐COPD	☐Cysts (ovarian)	☐Depression	☐Diabetes	☐Diverticulitis
☐Dysmenorrhea	☐Endometriosis	☐Falls	☐Fertility problems	☐Fibroids
☐Fractures	☐Glaucoma	☐Headaches	☐Head Injury	☐Heart attack
☐Heart disease	☐Hemorrhoid	☐HIV/AIDS	☐Hypertension	☐Thyroid Disease
☐Incontinence	☐Irritable bowel	☐Kidney stones	☐Liver disease	☐Mental health
☐Multiple sclerosis	☐Osteoporosis	☐Parkinson's	☐PCOS	☐Pneumonia
☐Prolapse vaginal	☐Prostate issues	☐Pulmonary emboli	☐Renal disease	☐Sinusitis
☐Skin sensitivities	☐Spinal cord injury	☐STDs	☐Stroke	☐Seizures
☐Vascular problems	☐Heart murmur	☐Urinary Infection	☐Other_____	

Past Surgical History:

☐Bladder suspension	☐Pacemaker	☐C-section	☐Cataracts	☐Cardiac related
☐Polyps	☐Hemorrhoids	☐Joint replacement	☐Hysterectomy	☐Ovaries removed
☐Other_____				

Immunization History:

☐Polio	☐Tetanus, Year ____	☐MMR	☐Pertussis	☐Diphtheria
☐Meningitis	☐Influenza, Year____	☐Gardisil	☐BCG for TB	☐Hepatitis B
☐Pneumonia, Year_____	☐I prefer to not be vaccinated			

Environmental Allergies: _____

Food Allergies: _____

Drug Allergies_____

Please list an example of what you eat:

Breakfast_____

Lunch_____

Dinner_____

Current Medications:

Medication	Dosage	Frequency	Who prescribed it?

Current Nutritional / Herbal Supplements: *Please bring supplements or a copy of the Ingredients to your visit*

Supplement	Dosage	Frequency	Who prescribed it?

Social History:

☐Smoke – Packs per day? _____

☐History of smoking, date quit:_____

☐Marijuana

☐Other drugs

☐Caffeine – Times per day?____

☐Alcohol

☐Live alone

☐Married

☐Sleep – Hours per night? ____

☐Exercise__x/week

☐Dental filling removed in last 12 months?

☐Amalgam, silver, or gold fillings

☐Employed

☐Unemployed

☐Occupational exposures

☐Disabled

How were you delivered as a baby? ☐ Vaginal Delivery ☐ Cesarean Delivery

Were you breastfed as a child for over 6 months? ☐ Yes ☐ No

Have you taken numerous rounds of antibiotics in your life? ☐ Yes ☐ No

If so, for what? _____

For how long? _____

Health Promotion/Screenings:

Have you had any of these in the past year?

☐ Vision check ☐ Dental Visit ☐ Yearly Exams ☐ Pap ☐ Mammogram

In the past 10 years?

☐Bone Density Scan, Year_____ ☐Colonoscopy, Year _____ ☐EKG, Year _____

☐Last lab work, Year_____ ☐Perform breast self-exams ☐Perform testicular self-exams

REVIEW OF SYSTEMS

Check all that apply.

Constitutional Fevers

☐Hot flashes ☐Fevers ☐Night sweats ☐Chills ☐Fatigue

☐Problems falling asleep ☐Problems staying asleep ☐Weight loss ☐Weight gain

☐Appetite change

Head/Eyes

☐Contact lenses ☐Glasses ☐Vision loss ☐Excessive tears ☐Dry eyes

☐Irritation ☐Itching ☐Blurring ☐Double vision ☐Discharge

☐Light sensitivity

Ears, Nose, Throat

☐Otalgia-ear pain ☐Otorrhea-drainage ☐Hearing loss ☐Ringing in ears ☐Nasal polyps

☐Nose bleed ☐Sinus tenderness ☐Congestion ☐Postnasal drip ☐Neck stiffness

☐Hoarseness ☐Sore throat ☐Issues swallowing ☐Dentures ☐Mouth sores

☐Bleeding gums

Cardiac

☐Chest pain ☐Palpitations ☐Irregular beat ☐Murmur ☐Fainting

☐History of Rheumatic Fever ☐Edema (swelling) ☐Shortness of breath with activity

Vascular

☐Varicose Veins ☐Claudication ☐Raynaud's

Respiratory

☐Cough ☐Cough produces mucous ☐Color of mucous_____ ☐Amount of mucous_____

☐Wheezing ☐Shortness of Breath ☐Wear oxygen ☐Wear BI/CPAP

Gastrointestinal

☐Constipation ☐Hemorrhoids ☐Diarrhea ☐Nausea ☐Vomiting

☐Changes in bowel pattern ☐Epigastric pain ☐Abdominal pain ☐Blood in stool ☐Flatulence

☐Pain right upper ☐Pain right lower ☐Pain left upper ☐Pain left lower ☐Ulcers

☐Belching ☐Food intolerances ☐Reflux ☐Hernia

Genitourinary

☐Hesitancy ☐Frequency ☐Urgency ☐Painful Urination ☐Blood in Urine

☐Excessive Urination ☐#Urinations overnight, _____ ☐Leakage of urine

Musculoskeletal

☐Back Pain ☐Joint pain ☐Joint Swelling ☐Muscle weakness ☐Cramping

☐Muscle Stiffness ☐Muscle Pain ☐Gout ☐Limited ROM

Dermatology

☐Acne ☐Birthmarks ☐Rashes ☐Itching ☐Dryness

☐Scars ☐Ulcers ☐Suspicious lesions ☐Mole Changes

Neurological

☐Headache ☐Dizziness ☐Lightheadedness ☐Weakness ☐Head Spinning

☐Nerve Pain ☐Seizures ☐Tremor ☐Memory loss

Endocrine

☐Heat Intolerance ☐Cold intolerance ☐Excessive urination ☐Hair changes ☐Nail changes

☐Goiter

Hematology

☐Bruise easily ☐Swollen lymph nodes

Psych: How would you describe your mood?

☐Pleasant ☐Depressed ☐Anxious ☐Panic easily ☐PTSD

Pain

If you have pain, what is the location of your pain? _____

On a scale of 0-10 with 10 being the worst pain imaginable and 0 being no pain, rank your pain: _____

What is the frequency of your pain?

☐No pain ☐Sometimes ☐ 50% of the time ☐Frequently ☐Constant

Female

☐Breast lumps ☐Breast tenderness ☐Nipple discharge ☐Decreased libido

☐Vaginal dryness ☐Vaginal discharge ☐Vaginal bleeding ☐Vaginal sores

☐Painful cycles ☐Pelvic pain ☐Abnormal PAP ☐Abnormal mammogram

☐Pregnancy #____ ☐Miscarriage#___ ☐On birth control ☐PMS symptoms in second half of cycle

☐STDs

If currently taking birth control, which kind and how long have you been on it? _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, were your ovaries removed? _____

Have you taken hormone replacement therapy (HRT)? ☐ Yes ☐ No If yes, which kind? _____

Please check the routes that you have taken of HRT: ☐ Oral pills ☐ Patch ☐ Gel/cream ☐ Sublingual troche ☐ Vaginal ring

Your age when you began menopause_____ Year you began menopause _____

Any other information we should know? _____

_____

_____

Male

☐Testicular mass ☐Testicular pain ☐Erectile dysfunction ☐Decreased libido

☐Penile sores ☐Change in urine stream ☐Prostate problems ☐STDs

☐Penile discharge

Any other information we should know?_____

_____

_____

FAMILY MEDICAL HISTORY

List any family relations that have had a history of the diseases below. For example, if your grandmother on your mother's side had diabetes, find diabetes in the Disease list and write "Maternal Grandmother".

Here is the list of the relatives that we need to know if they had any of these health problems:

Father	Paternal Grandfather	Paternal Grandmother
Great Paternal Grandfather	Great Paternal Grandmother	Paternal Uncle
Paternal Aunt	Paternal Male Cousin	Mother
Maternal Grandfather	Maternal Grandmother	Great Maternal Grandfather
Great Maternal Grandmother	Maternal Uncle	Maternal Aunt
Maternal Male Cousin	Brother	Sister
Child		

Diseases (write relative in the blank if they had the disease)

Alzheimer's _____

Anemia _____

Osteoarthritis _____

Asthma _____

Celiac Disease _____

Depression _____

Diabetes _____

Epilepsy _____

Glaucoma _____

Heart Disease _____

High Blood Pressure _____

Infertility _____

Liver Disease _____

Mental Illness _____

Osteoporosis _____

Stroke _____

Tuberculosis _____

Autoimmune Disease _____

Hypothyroid _____

Multiple Sclerosis _____

Cancer _____

Rheumatoid Arthritis _____

Breast Cancer _____

PCOS (Polycystic Ovary Syndrome) _____

Colon Cancer _____

Psoriasis _____

Ovarian Cancer _____

Prostate Cancer _____

Thank you for taking the time to fill out this form. Please return it to us at your earliest convenience so that we can schedule your initial appointment with one of our clinicians.