KARE
CHIROPRACTIC
"Because We Care About Your Health"

Hormone Replacement Therapy Paperwork

In order to help determine if you are a good candidate for hormone replacement therapy treatments, please fill in the information below to the best of your ability.

Today's Date:_____

Legal Name : _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Sex: ▢ Female ▢ Male

Race: ▢ White ▢ African American ▢ Hispanic ▢ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____ Height: _____ Weight: _____

*Email(*required*): _____

Email is used for secure patient portal communication, online scheduling, and electronic statements.

Employer: _____ Occupation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Do you give us permission to contact this person in the event of an emergency? ▢ Yes ▢ No

How did you hear about our office? _____

Primary Care Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact your doctor with our findings? ▢ Yes ▢ No

Medical History

Have you ever taken hormone replacement medications? ▢ Yes ▢ No If yes, when and name the medication? _____

_____

_____

Personal/Family History (check all that apply):

▢ Deep Vein Thrombosis(DVT)	▢ Uterine Cancer	▢ Pulmonary Embolism
▢ Stroke within last 6 months	▢ Heart Attack within the last 6 months	▢ Breast Cancer
▢ Prostate Cancer	▢ High Blood Pressure	▢ Heart Disease
▢ Blood Clotting Disorder	▢ Other: _____	

Do you have any children? ▢ Yes ▢ No Are you wanting any children in the future? ▢ Yes ▢ No

For Women:

Are you currently pregnant/breastfeeding? ▢ Yes ▢ No Are you taking birth control? ▢ Yes ▢ No

Do you have a regular menstrual cycle? ☐ Yes ☐ No

Symptoms

Please check all that apply:

☐ Depression	☐ Fatigue	☐ Body Aches	☐ Loss of Muscle
☐ Lack of Sexual Desire	☐ Muscle Pains	☐ Unstable Mood	☐ Hot Flashes
☐ Vaginal Dryness	☐ Urinary Incontinence		

Medications

Please list all medications you are currently taking including prescription, over-the-counter, botanicals, homeopathic, and supplements:

_____

_____

Allergies

Please list any and all allergies: _____

_____

Consultation for Regenerative and Medical Services

I understand that my initial consultation is complementary and is used to determine whether or not I am a candidate for care. There will be a one-on-one consultation with the Doctor to:

- ❖ Review my case history to determine if the practice may be able to help me;
- ❖ Review my dietary and nutritional habits, nutritional supplements, herbs, minerals, botanicals, homeopathics, ect and discuss my problems and answer questions.

The only cost I may incur is the cost of any initial screening tests the Doctor requests, that I choose, to undergo.

I am aware that after the consultation, I may not be accepted as a patient or additional testing may be recommended prior to treatment. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand and accept the terms of the complimentary consultation.

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____

I acknowledge and agree to the **Patient Health Information Consent Form**.*

I acknowledge and agree to the **Missed Appointment Policy** including the **$50** missed appointment fee.*

Policies are available on the clipboard for review.

Patient/Parent/Guardian Signature(X): _____ **Date:** _____