THRIVE HEALTH SOLUTIONS – Sermorelin Evaluation
88 Inverness Circle East, Ste A204, Englewood, CO 80112 (303) 790-8446 Fax: (303) 799-8175

Name:_____ Date: _____/____/____

Address: Street_____

City_____

State:____Zip:_____Cell Phone: (_____)_____

Home Phone: (_____) Email: _____

HOW DID YOU FIND OUT ABOUT US? (Circle) : Internet Search | Magazine | Print Ad Sign | fax | Referral
| business card | other_____

referred by _____

Date of Birth: ____/_____/____ Gender: M F Marital Status: S M D W

Age: _____ Height: _____' _____" Weight: _____lbs.

Emergency Contact: Name: _____Phone:_____

ALLERGIES: (please list any foods, drugs, or medications you are hypersensitive or allergic to. Please include reaction.

_____

MEDICATIONS: _____

MEDICAL AILMENTS THAT YOU HAVE SEEN A PHYSICIAN FOR: _____

SYMPTOMS OR COMPLAINTS YOU CURRENTLY HAVE:_____

HOW CAN WE HELP YOU?_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding
of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Please complete all information and indicate areas of confusion with a question mark. Thank You.

1. Skin Assessment:

Do you have any of the following concerns (check ALL that apply):

- ☐ Fine lines
- ☐ Deep wrinkles
- ☐ Under eye circles
- ☐ Sagging skin
- ☐ Sagging cheek bones
- ☐ Dark spots
- ☐ Other (please describe)_____
- ☐ Rough skin texture
- ☐ Large pores
- ☐ Scars (acne or surgical)
- ☐ Stretch marks
- ☐ None

Please describe your skin type (check ALL that apply)

- ☐ Normal
- ☐ Combination normal-oily
- ☐ Combinations normal-dry
- ☐ Oily
- ☐ Other (please describe):_____
- ☐ Very dry
- ☐ Sensitive
- ☐ Prone to redness
- ☐ Acne prone

Have you experienced any of the following (mark ALL that apply):

- ☐ Sunbathing, using suntan beds, sunless tanner and or spray tans within past 2 weeks
- ☐ Waxing, plucking or electrolysis in treatment area within past 6 weeks
- ☐ Facial laser resurfacing
- ☐ Chemical peeling within past 3 months
- ☐ Permanent make-up or facial tattoos
- ☐ I had none of the above procedures within indicated time frame _____(Initials)

Comments: _____

2. Menstrual/Birthing History Last Menstrual Cycle:_____

Age of first Menses: _____
Of Days of Menses:_____
Length of Cycle:_____
Birth Control Type: _____

# of Pregnancies: _____
# of Miscarriages: _____
# of Abortions: _____
# of Live Births: _____

3. When and where did you last receive health care?

For what reason?

4. Is it possible you may be pregnant? Yes____No_____

If "Yes" How far along are you or may you be?

5. Do you have any infectious diseases? Yes__No_____

If "Yes" Please Identify:

6. Family History (check those that apply)

	Father	Mother	Brothers	Sisters	Children
Age (if living)					
Health (G=Good. P=Poor)					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Mental Illness Asthma/Hay					
Fever/Hives Kidney Disease					
Age (At Death)					
Cause Of Death					
7. (10 years)					

Past Max Weight: _____ Past Min Weight: _____

8. Blood Pressure: What is your most recent blood pressure reading? ___/_____Taken: ___/___/___

HAVE YOU BEEN DIAGNOSED WITH OR HAD ANY OF THE FOLLOWING CONDITIONS:

Please Circle ALL that apply: Past or Present.

- Hepatitis
- Headaches
- Scoliosis
- Brain Fog
- Neck Pain
- Fatigue
- Back
- Pain
- Fever
- Shoulder Pain
- Night Sweats
- Leg Pain
- Insomnia
- Heart Murmur
- Depression
- Epilepsy / seizures
- Spasms/Cramps
- Hot Flashes
- Tendonitis
- Rash /skin problems
- Numbness/Tingling
- Arthritis/Stiff/Painful Joints
- Sciatica/Shooting pain
- Osteoporosis
- Heart Disease
- Bladder/Kidney Disease
- Stroke
- Cancer
- Blood Clots
- Gas / Bloating
- High Blood Pressure
- Abdominal Pain
- Chest Pain
- Anxiety
- Constipation / Diarrhea
- Shortness of Breath
- Thyroid Dysfunction
- Asthma/Allergies /Hay Fever
- Diabetes
- Dizziness
- Pregnancy
- Infection
- PMS /Menstrual Problems
- High Cholesterol
- TMJ or Jaw Pain
- Gout
- Anorexia
- Bulimia

9. Digestion Issues: (Circle if yes)
Nausea | Vomiting | Diarrhea | Blood in stool | Pain | Bloating | Gas | ABD Distention | Constipation | Incomplete Evacuation | Small Round Stool | Hard Stool | Significant Residual When Wiping | ABD cramping | other digestive concerns if any_____

BM FREQUENCY: Number of times Per Day: 1 2 3 4

If don't typically have a daily BM how often do you evacuate?

1-2 per week | 3-4 per week | 5-6 per week | less than once a week

Do you feel like you don't completely evacuate after having bowel movement? yes / no

Do you have a diet low in fiber: yes / no

Does your diet include a lot of meat/cheese or processed foods: yes / no

Incontinence: yes / no | Pain upon defecation: yes / no | Blood in Stool: yes / no | Hemorrhoids: yes / no |

10. Other :

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

11. Childhood Illness: (circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. Immunizations: (circle any that you have had):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria HiB Hepatitis-B Chicken Pox

Pneumonia Flu Other_____

13. Hospitalizations and Surgeries:

Reason	When	Reason

14. X-Rays / CAT Scans / MRIs / NMRs / Special Studies:

Reason	When	Reason

For the following questions:
(circle any that you experience now and underline any you have experienced in the past)

15. Emotional/Psychiatric :

Mood Swings Nervousness Mental Tension Irritability Depression Grief Obsessive Thinking issues:

16. Energy and Immunity :

Fatigue Slow Wound Healing Chronic Infections Lyme Disease Chronic Fatigue

Candida / Yeast Infections

17. Head, Eye, Ear, Nose, Throat :

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing

Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds Frequent Sore Throats

Teeth Grinding TMJ/Jaw Problems Hay Fever

18. Respiratory :

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy

Asthma Tuberculosis Shortness of Breath Other Respiratory_____

19. Cardiovascular :

Heart Disease Chest Pain Swelling of Ankles High BP Palpitations/Fluttering Stroke Bruising

Heart Murmurs Rheumatic Fever Varicose Veins Abnormal Bleeding Pain in Calves

20. Gastrointestinal :

Ulcers Changes In Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching

Gallbladder Disease Liver Disease Hepatitis A, B or C Hemorrhoids Abdominal Pain

Diverticulosis Diverticulitis IBS

21. Genito-Urinary Tract :

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. Female Reproductive / Breasts :

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge

Premenstrual Problems Clotting Bleeding Between Cycles Menopausal Symptoms

Difficulty Conceiving Painful Periods

23. Male Reproductive :

Erectile Dysfunction Prostrate Problems Testicular Pain/Swelling Penile Discharge

24. Musculoskeletal :

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Lower Back Pain Leg Pain Joint Pain

25. Neurologic :

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

26. Endocrine :

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

27. Lifestyle:

a. Do you typically eat at least three meals per day? Y N

If no, why not? _____

b. Exercise routine: Y N

c. How many hours per night do you sleep? _____ Do you wake rested? Y N

d. Level of education completed: High School Bachelors Masters Doctorate Other

e. Occupation: _____ Employer: _____

Hours/Week: _____ Do you enjoy work?

f. Nicotine Use (what form):_____(past or present)

Amount:_____Frequency:_____

g. Alcohol Use (what form):_____(past or present)

Amount:_____Frequency:_____

h. Recreational Drugs(what form):_____(past or present)

Amount:_____Frequency:_____

j. Have you experienced any major traumas? Y N

Explain: _____

j. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

k. Interests and Hobbies:_____

l. Have You Been Able To Follow Prescribed Medications/Treatments? yes/no If "no" why not?

_____

Family Physician_____

I _____(patient name) acknowledge and understand that:

1) Neither THRIVE HEALTH SOLUTIONS, LLC nor its practitioners are my primary Medical Doctor;
2) All medical decisions regarding any current or future health conditions should be addressed with my primary care physician;
3) THRIVE HEALTH SOLUTIONS, LLC and its practitioners serve as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness;
4) All supplied information is accurate and forthcoming;
5) I have informed my primary care physician about services I am to receive at THRIVE HEALTH SOLUTIONS, LLC and he/she has no objections to such services.
6) I have not been rushed into making any decisions and I have had ample opportunity to ask THRIVE HEALTH SOLUTIONS, LLC, its practitioners and my primary care physician questions prior to receiving any treatment.
7) I acknowledge that THRIVE HEALTH SOLUTIONS, LLC does not provide any promises or guarantees that the treatments I am to received will be effective in helping to improve my current health conditions and that in coming to THRIVE HEALTH SOLUTIONS, LLC I had previously made a decision independent of THRIVE HEALTH SOLUTIONS, LLC to try the services offered at THRIVE HEALTH SOLUTIONS, LLC
8) I understand that there are NO REFUNDS and that I can afford the services for which I am seeking and I have not been made any promises as to the results or effectiveness of such services/ treatments.

X _____ _____
Patient Signature Date

X _____ _____
Signature of Health Care Provider Date