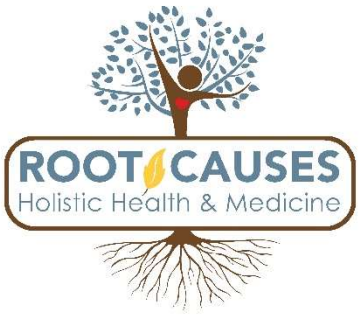

NEW PATIENT HEALTH SURVEY

Welcome to our practice. As a new patient, please answer the questions below to the best of your ability. The Initial Consult Fee is $ 375.00

Date _____ **Patient No**_____

Patient Name _____ **Birth Date** _____

Home Phone _____ **Work or Cell Phone** _____ **Email** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Describe your main complaint _____

_____

If your complaint is due to pain, complete the following:

Location _____ **Severity on a scale of 1** _____ **10**

Quality _____ **Duration** _____

Time _____ **What makes it better or worse?** _____

Do you have any other health concerns? _____

MEDICAL HISTORY: List any other doctors you've seen for this condition _____

Who is your current family physician? _____ **Specialist?** _____

Date of your last physical exam _____ **When did you have your last blood tests?** _____

List any diagnoses or treatments _____

List any surgeries or major illness with date of occurrence _____

Have you had any infectious diseases? _____

Have you been hospitalized for any condition? What?_____

Do you have any allergies? _____ **Have you ever reacted to medications?** _____

MEDICATIONS: List all prescription or over-the-counter drugs you are taking _____

_____

FAMILY HISTORY: Please indicate if your mother, father, or sibling has had any of the following conditions?

- ☐ Heart or coronary arterial disease (congestive heart failure, angina, etc.) _____
- ☐ Atherosclerosis (hardening of the arteries) _____
- ☐ High cholesterol or other form of abnormal lipids _____
- ☐ Heart attack or stroke _____
- ☐ Diabetes or any form of metabolic disease or obesity _____
- ☐ Cancer and list type(s) _____
- ☐ Osteoporosis or any form of bone disease _____
- ☐ Thyroid disease _____
- ☐ List any other diseases in your family _____

ADDITIONAL INFORMATION: Describe any other information you feel is important for your doctor to know

NUTRITION REVIEW

NUTRIONAL SUPPLEMENTS: List all vitamin, mineral, and other nutritional or herbal supplements

_____

_____

LIFE STYLE INFORMATION: Answer the following questions with YES or NO and explain if necessary

- ☐ **Do you exercise? How often? _____ What type? _____**
- ☐ **Do you use alcohol? How often? _____ What kind? _____**
- ☐ **Do you smoke? How much? _____ For how long? _____ When did you quite? _____**
- ☐ **Do you drink coffee? _____**
- ☐ **Do you drink caffeinated sodas? _____**
- ☐ **Do you follow a specific diet? _____**
- ☐ **Are you concerned about your weight? Are you following a specific diet? _____**
- ☐ **Do you overeat? How is your appetite? _____ Do you have any reactions to foods? _____**
- ☐ **Do you crave sweets? Do you have any other food cravings? _____Or aversions? _____**
- ☐ **Are you concerned about aging? Do you have a specific concern? _____**
- ☐ **Are you concerned about your appearance? Have you used any aesthetic therapies? _____**
- ☐ **Are you stressed or anxious? _____**
- ☐ **Do you or have you experienced depression? Is there any form of depression or dementia in your family? _____**
- ☐ **Do you suffer from insomnia or any other form of sleep abnormality? _____**
- ☐ **Are you concerned about memory loss? _____**
- ☐ **Do you practice any form of stress reduction such as meditation, tai chi or yoga? _____**
- ☐ **Is your relationship fulfilling? _____ How is your children's health? _____**
- ☐ **Do you experience fatigue? _____**
- ☐ **What is your form of employment?_____**

DIETARY INFORMATION: Describe your daily diet

_____

_____

BIOMARKER QUESTIONNAIRE

Age _____ Sex_____ Height _____ Weight _____ BMI _____

Have you experienced any of the following?

- ☐ Decreasing muscle mass
- ☐ Reduced strength
- ☐ Decreased joint mobility
- ☐ Increased stiffness
- ☐ Reduced capacity for work and exercise
- ☐ Decreased endurance
- ☐ Significant weight loss
- ☐ Increased body fat
- ☐ Increased waist to hip ratio (more fat deposits on the abdomen and waist)
- ☐ Reduced sexual drive and/or performance
- ☐ Muscle mass loss or flabbiness
- ☐ Changes in body temperature
- ☐ Sensitivity to cold or heat
- ☐ Hot flashes
- ☐ Dryer or thinning skin and hair
- ☐ Brown or red spots
- ☐ Spider veins on the skin
- ☐ Slow wound healing
- ☐ Frequent colds or flu
- ☐ Presence of viral infections: Herpes Zoster (shingles), Epstein Barr, HIV, HHV-6, Hepatitis
- ☐ Chronic pain or inflammation
- ☐ Poor sleep
- ☐ Waking up tired
- ☐ Fatigue
- ☐ Longer recovery time needed after exertion
- ☐ Forgetfulness
- ☐ Increasing difficulty concentrating
- ☐ Mood changes
- ☐ Unexplained depression
- ☐ Anxiety
- ☐ Increased anger or irritability
- ☐ Sensitivity to certain foods
- ☐ Craving for sugar
- ☐ Alcohol intolerance

Have you had any of the following tests in the last year?

- ☐ Complete Blood Count
- ☐ Chemistry Panel
- ☐ PSA (Prostate Specific Antigen) and prostate exam for men over 40
- ☐ Breast Exam and Mammography for women
- ☐ Pap Smear (for women)
- ☐ Colonoscopy
- ☐ Basal Temperature
- ☐ 3-5 hour Glucose Tolerance Test
- ☐ Fasting insulin
- ☐ Blood Lipids: total Cholesterol, triglycerides, HDL, and LDL
- ☐ Thyroid Studies (TSH, Free T3, Free T4)
- ☐ Free T3
- ☐ Homocysteine
- ☐ Blood Pressure
- ☐ Bone Density
- ☐ Treadmill Test
- ☐ Estrogen levels
- ☐ Testosterone
- ☐ Free testosterone
- ☐ IgF-1 (a marker for human growth hormone)
- ☐ DHEA-S
- ☐ Cortisol
- ☐ SHBG (sex hormone binding globulin)

FATIGUE QUESTIONNAIRE

Answer the questions below by checking each applicable box if you have ever experience any of the following:

- ☐ Exhausted feelings that are not related to stress or amount of work or exercise.
- ☐ Morning tiredness, even after a full night's sleep.
- ☐ Depression that does not respond to antidepressants, diet, or exercise.
- ☐ Unexplained anxiety and panic attacks.
- ☐ Been told that I move as if in slow motion, and take too long to responds to questions.
- ☐ A frequently low or hoarse voice (for a woman).
- ☐ Mental sluggishness and have difficulty focusing.
- ☐ Low sex drive and do not experience significant sexual arousal.
- ☐ High cholesterol that has been unresponsive to diet or medications.
- ☐ A tendency to feel cold even in warm weather.
- ☐ Chronic aches and pains not due to accidents or exercise.
- ☐ Carpal tunnel syndrome
- ☐ Problems with allergies.
- ☐ Difficulty losing weight and keeping it off.
- ☐ Very dry skin.
- ☐ I have acne or eczema.
- ☐ Diabetes
- ☐ Rheumatoid arthritis or other autoimmune condition.
- ☐ Problem with my periods, including abnormal menstrual bleeding.
- ☐ Anemia
- ☐ Infertility or a history of frequent miscarriages.
- ☐ Significant menopausal symptoms.
- ☐ A tendency to have chronic constipation even with a high fiber diet.
- ☐ Lots of hair falling out or brittle hair.
- ☐ Vitiligo or other unusual changes in skin color.
- ☐ Trembling of my hands or stumbling for no reason.
- ☐ Have a family history of thyroid disorder
- ☐ Have previously been diagnosed with a thyroid disorder

In case of emergency, notify _____ Phone No. _____Relationship _____

I understand that all fees for consultations, examinations, treatments, and supplies are to be paid for as they are received. My signature is consent for consultation and treatment.

PATIENT'S SIGNATURE: _____ Date _____

INFORMED CONSENT FOR TREATMENT

_____I understand that Root Causes Holistic Health and Medicine LLC (Herein after referred to as Root Causes) is an Integrative Medicine practice focusing on whole body health and wellness through the use of naturally occurring compounds as much as possible, and pharmacologic interventions when necessary and in the best interest of the client. Integrative Medicine is personalized care that blends conventional medicine with evidence-based complementary/integrative therapies. Recommended therapies may include, but are not limited to, traditional prescription medication, mind-body modalities such as meditation, yoga, and guided imagery, biologically based therapies such as vitamins, herbs and other supplements in oral, injectable and intravenous forms, MESO therapy, PRP treatments, injections of various prescriptive compounds for therapeutic purposes, nutritional recommendations, exercise recommendations, other systems of medicine-based therapies such as homeopathy, light therapy, and oxygen therapies including hyperbaric, ozone insufflation and intravenous ozone.

_____Individualized treatment plans are evidence-based, safe and custom-designed to meet the patient's needs and goals. Evidence base changes frequently for Integrative Medicine and recommendations are done with the evidence base currently known to the practitioner at the time of your consultation. These recommendations will very likely not be what is considered to be the medical/legal "standard of care". Your primary care practitioner is likely the person you will want to see for "standard of care" protocols. Root Causes never recommends stopping conventional medical care or treatment that is in your best interest. Please retain your medial team.

_____I understand that Doreen DeStefano is an Advanced Practice Registered Nurse with a **Doctorate in natural health. She is not Medical Doctor.** The Medical Director for Root Causes Barry Butler MD.

_____An integrative medicine consultation may include, but is not limited to: Individualized consultation that may include evaluation of lifestyle, nutrition and supplements/ vitamins/herbs, bio-identical hormone, individualized treatment protocols for your specific concerns, lab testing of blood, sputum, stool or urine, a physical examination and referral to other therapeutic providers for care not provided by Root Causes. Many modalities are not "standard of care" as legally defined.

_____ I understand that services at Root Causes are not covered by insurance. I understand that Root Causes does not accept insurance nor does Root Causes provide billing codes to submit claims to insurance. I am responsible for payment at the time of service. Payment accepted is in the form of cash, check, or credit card.

_____I understand that lab studies conducted on my behalf confer a professional responsibility to the practitioner, and therefore require interpretation and follow up. Lab slips require diagnostic codes and interpretation. Therefore, lab slips are not given without an appointment to determine a medical diagnosis/necessity, and a lab review appointment to review and interpret results.

_____I understand that I have the right to choose which recommendations to incorporate into my treatment plan and that I should always communicate any new treatments, including vitamins, herbs, and supplements to my entire healthcare team.

_____I understand that Root Causes implies no guarantee of the outcomes/results intended from any treatment and/or recommendations provided to me, and that I have the right to choose my treatment plan and that I may refuse any or all treatment suggestions at any time. There are no guarantees that your condition will improve or resolve and none have been given to me by Doreen DeStefano or any of her personnel regarding cure or improvement of my condition.

_____ I understand that not following the entire protocol recommended to me may affect the results of my treat plan and that I may not achieve the stated goals if the protocol is not followed.

_____I acknowledge that I have not been asked to stop/discontinue care provided by my specialty or primary care medical teams.

_____ I understand that this is a fee for service practice and that consultation fees **may be up to** $675.00. Payment is expected at the time of service.

I understand and hereby agree that neither Root Causes nor it's employees, officers, directors, shareholders, successors and assigns (the "released parties") may be held liable or responsible in any way for any injury, death, or other damages to me or my family, heirs or assigns that may occur as a result of my Health care at Root Causes, or as a result of product liability or the negligence of any party, including the Released parties, whether passive or active.

I agree not to be under the influence of alcohol or any drugs while under care at Root Causes.

I hereby personally assume all risks in connection with my health care for any harm, injury, or damage that may befall me while as a result, including all risks connected therewith, whether foreseen or unforeseen.

I further save and hold harmless said activity and Released Parties from any claim or lawsuit for personal injury, property damage, or wrongful death by me, my family estate heirs or assigns arising out of my

I further declare that I am of lawful age and legally competent to sign this liability release, or that I have acquired the written consent of my parent or guardian.

I understand the terms herein are contractual and not mere recital, that this instrument is legally binding document and that I have signed this document of my own free act.

I, _____, by this instrument do hereby exempt and release Integrated Skin Care LLC, Inc, and all related parties and defined above, from all liability or responsibilities whatsoever for personal injury, property damage, or wrongful death, however caused, including but not limited to product liability or the negligence of the released parties, whether passive of active.

_____ _____

Participants name Date

Address/zip code_____ Phone_____

_____ _____

Signature of parent (where applicable) Date

_____I understand all the facts given to me in this form. I give my consent to Doreen DeStefano and Root Causes provide Integrative Medicine initial consultation and follow up services. I attest with my signature below that Doreen DeStefano has discussed all the information on this form, that I have had the chance to ask questions and that all of my questions have been answered.

_____ I hereby acknowledge that I understand that my Insurance coverage, including Medicare, will not pay for this Non-covered service, and that all services ancillary to this treatment may also be Non-covered services and Non-reimbursable. I agree to be responsible for payment at the time of service for all services, including Non-covered services.

_____ I acknowledge that Root Causes has a 24 hour cancellation policy. If it is necessary to cancel my appointment, I will do so with more than 24 hours' notice. I acknowledge and give my permission that on the third time I cancel within 24 hours, or do not show up for my appointment, Root Causes will charge my credit/debit card the full amount of the scheduled visit.

_____ I understand that all goods and services purchases are final. In case of a dispute of charges, I authorize all medical information to be released to all credit card companies. I agree to pay Root Causes for service fees and costs for processing any disputes.

Patient's Name (Please print)_____

Signature of patient:_____ Date:_____

Signature of Provider:_____ Date:_____