Health*E* and Well, PC

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PATIENT REGISTRATION INFORMATION

Date:____________________

Dr.Walker provides a comprehensive evaluation of your health and wellness searching for those root causes of illness that often accompany aging or are precipitated by environmental exposures. This necessitates that this inital history be completed in advance of your office visit and faxed to him prior to the scheduled appointment at 866.415.7902 24 at least 24 hours ahead.

The first visit is one hour and consists of analysis, exam and a plan of action. Additional time, over one hour, will be added to the standard charge. We do this to be respectful of everyone's time and try hard to remain on schedule. A blood work requisition will be provided at the initial visit.

Last Name:____________________________ First Name:___________________________ MI:_______________

Address:_______________________________City:____________________ State:_______ Zip:_______________

Home #:________________________ Work #:________________________ Cell #:_________________________

Sex: Male / Female **Marital Status:** Single / Married / Separated / Divorced / Widowed

E-mail:_________________________Referred By:______________ Phone:_________________________

Release:

I ____________________________________, the undersigned, understand, acknowledge and agree that my relationship with Richard W. Walker, Jr. MD and any/or all his designees is solely a consultative relationship. I do not expect Dr. Walker or his designees to become or replace my primary care provider (PCP) or my Ob/Gyn physician. I will continue to see and consult with my PCP or Ob/Gyn physician for all and any medical problems I may experience. At my request, Dr. Walker and/or his designees will keep the physician of my choice informed of any and all treatments Dr. Walker and/or his designees may recommend. I acknowledge that I am personally responsible for payment in full at the time of service.

Signature:____ Date:_________________________________

Payment:
This office does not accept insurance or Medicare. We will supply you with a receipt that you can submit to your insurer. The fees for this practice are: In office initial visit $___395.00___, in office follow-up visits $______150.00___, telephone initial visit $______295.00___, telephone follow-up $__125.00___. Payment is due at the time of service. <u>You will be provided documents to file with your insurance company for reimbursement.</u>

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Last Name:________________ **First:**________________ **MI:**________

Allergies:________________________ **Smoker: Y N Alcohol: Y N**

Surgeries: Y N If yes, When:________________ **Type:** ________________

Female Health Assessment

Date: __________ **Weight:**__________ **Height:**__________ **Last Menstrual Period:**__________

Check all that apply

SYMPTOMS	Yes	No	Duration
Hot Flashes			
Night Sweats			
Insomnia			
Sleep Disorders			
Weight Gain			
Bloating			
Depression			
Forgetfulness			
Headaches			
Mood Swings			
Fatigue			
PMS			
Irritability			
Difficulty Concentrating			
Vaginal Dryness			
Painful Intercourse			
Decreased Sex Drive			
Breast Tenderness			
Repeat Urinary Track Infections			
Hair Thinning			
Joint pains/Tenderness			
Acne			

Check all that apply

CONDITIONS	Yes	No	Family	Self
Heart Disease				
Stroke				
Blood Clots				
Bleeding Disorders				
Digestive				
Infertility				
Osteoporosis				
Arthritis				
Psychiatric Disorders				
Cancer				
Others				

MEDICAL TESTING	Date	Normal/Abnormal
Complete Physical Exam		
Pap Smear		
Hormone Levels		
Colonoscopy		
Mammogram		
Blood work		
Bone Density		
Others		

FAMILY HISTORY	Age	Medical/Surgical Problems
Mother		
Father		
Sister		
Brother		

Female Health Assessment

Menstrual History **Name:**______________________________

Age of onset:

Date of 1st menses:

Still menstruating: Y N

Regular: Y N

Duration of menses:

No. of pregnancies:

No. of live births:

No. of abortions: Stillbirths:

Type of birth control:

1. What current medications, supplements and/or vitamins are you taking?____________________

2. Summarize your eating habits (Check which applies): Good_________, Fair________, Poor________.
Explain why you chose your answer?________________________________

3. Summarize your exercise habits (Check which applies): Good________, Fair________, Poor________.
Explain why you chose your answer?________________________________

4. When was the last time you felt well?:________________________________

5. What is/are your main complaints?:
   - ______________________________
   - ______________________________
   - ______________________________
   - ______________________________
   - ______________________________

6. What have you done to improve your health and/or symptoms?:____________________

7. What are your goals for this health evaluation?:____________________
   - ______________________________
   - ______________________________
   - ______________________________

Female Health Assessment

Name:_______________________________

Circle Any Symptoms That Have Caused You Problems

Obesity	Chronic Fatigue	Headaches
Compulsive Eating	Abdominal Bloating	Asthma
Hypersensitivity	Lethargy	Sinusitis
Dark Shadows Around Eyes	Muscle Pain	Edema
Eczema	Heart Palpitations	Diarrhea
Difficulty Concentrating	Drowsiness	Constipation
Runny Nose (Rhinitis)	Food Cravings	Muscle Cramps
Cold Hands	Sore Throat	Insomnia
Excessive Tearing	Abdominal Cramps	Labile Emotions
Difficulty Breathing	Joint Pains	Swelling Eyelids
Slurred Speech	Ringing In the Ears	Indigestion
Rashes	Unsteady Gait	Blurred Vision
Chronic Cough	Itchy Skin	Irritability
Poor Memory	Wheezing	Brain Fog
Depression	Word Search	Other:

Environmental Exposures:

1. Are you unable to tolerate: Alcohol Caffeinated Products
2. Have you become sensitive to medications, supplements, vitamins or herbs that you used to take without problems? Y N
3. Are you regularly exposed to hair dyes or sprays? Y N
4. Have you had any exposures to chemicals or toxins from school, work or your home? Y N
5. If yes, what were those exposures:____
6. Have you had any exposures to mold? Y N
7. Do you feel sick at (circle each that apply) school, work and/or home? Y N
8. Do odors of any kind make you ill (dizziness, throat tightening, sneezing, coughing, etc.)? Y N
9. Have you ever had any exposures to heavy metals: Lead (pipes and gasoline), Mercury (amalgams), Arsenic (chickens, lumber treated with CCA), Cadmium (cigarette smoke), etc? Y N