



# **Idaho Center for Regenerative Medicine**

***ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!***

**Eagle River IV Building | 868 East Riverside Dr., Ste. 170 | Eagle, Idaho 83616**

**208-995-2802 / 208-995-2804 (fax) / [www.icrmboise.com](http://www.icrmboise.com)**

## **An Integrative Approach to Health, Wellness & Vitality**

Welcome and thank you for your interest in the Idaho Center for Regenerative Medicine. Dr. Robert Haake is committed to support your journey to reach your unique optimal health goals. From a functional medical perspective, Dr. Haake's approach to patient care focuses on identifying underlying causes of disease using a systems-oriented approach.

### **Our approach is based on these key components:**

- Bio-identical Hormone Replacement
- Macro nutrition/Paleo Diet
- Micronutrition/Supplementation
- Weight Training/Aerobic exercise
- Restorative Sleep

To reach your goal of optimal health, it is **ESSENTIAL** for you to embrace and actively participate using these key components in your lifestyle.

Our texting service will remind you to have your LABS DRAWN IN ADEQUATE TIME; however, ultimately, IT IS THE RESPONSIBILITY OF THE PATIENT TO KEEP TRACK OF WHEN TO GET YOUR LABS DRAWN, AS WELL AS YOUR SCHEDULED APPOINTMENT. Please

Be aware that LABS ARE INTREGAL to your treatment. You will need to have LABS DRAWN 10-14 DAYS PRIOR TO EVERY FOLLOW-UP APPOINTMENT.

Dr. Haake saves an entire hour for every appointment. If you are unable to get labs drawn in time or attend your scheduled appointment, PLEASE LET US KNOW ASAP SO WE CAN ACCOMMODATE OTHER PATIENTS.

### **Effective August 1, 2024 our office visit fees:**

**Robert Haake, DO**

**New Patient Consultation           \$550.00**

**Follow Up Visits                         \$350.00**

### **Cancellation Fees:**

**Less than 48 hours existing patient \$150.00**

**Less than 72 hours new patient \$150.00**

**All cancellations with less than 12 hours notice \$200.00**



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**WE REQUIRE THIS PAPERWORK IN OUR OFFICE 2-3 DAYS PRIOR TO YOUR VISIT. PLEASE EMAIL TO FRONTDESK@ICRMBOISE.COM, FAX TO 208-995-2804 OR DROP OFF AT THE OFFICE.**

***(PLEASE NOTE: YOUR APPOINTMENT WILL NEED TO BE RE-SCHEDULED IF PAPERWORK IS NOT RECEIVED IN ADVANCE.)***

Please Print

Date \_\_\_\_\_

\_\_\_\_\_  
Last Name    First Name    Middle Initial    Marital Status

\_\_\_\_\_  
Date of Birth    Age

\_\_\_\_\_  
Address    City    State    Zip

\_\_\_\_\_  
Home Phone Number / Cell Phone Number    E-mail Address

\_\_\_\_\_  
Employed By    Work Phone Number

\_\_\_\_\_  
Name of Spouse    Employed By    Work Phone Number

\_\_\_\_\_  
Emergency Contact    Relationship to Patient    Contact Phone Number

\_\_\_\_\_  
Who may we thank for referring you?

\_\_\_\_\_  
What is your chief problem or complaint?

PLEASE COMPLETE THE FOLLOWING HEALTH ASSESSMENT AS ACCURATELY AS POSSIBLE. WE THANK YOU!  
*(If additional pages are needed for this information, please attach additional page)*

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

1. **CURRENT MEDICATIONS:** (Name/Dosage/Frequency) \_\_\_\_\_

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2. **OVER-THE-COUNTER MEDICATIONS:** (Name/Dosage/Frequency) \_\_\_\_\_

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3. **VITAMINS / SUPPLEMENTS:** (Name/Dosage/Frequency) \_\_\_\_\_

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**4. HABITS:**

a) Smoking History: \_\_\_\_\_ Number of packs/day \_\_\_\_\_ Number of years \_\_\_\_\_ Quit \_\_\_\_\_

b) Alcohol: Number of alcoholic beverages per day/week \_\_\_\_\_

Type of alcohol: Wine \_\_\_\_\_ Beer \_\_\_\_\_ Liquor \_\_\_\_\_

c) Other Recreational Drugs: \_\_\_\_\_

d) Cell phone use (hours per day): \_\_\_\_\_

e) Antibiotic use (yearly / monthly, etc.): \_\_\_\_\_

f) Mercury fillings: Yes / No

5. **SOCIAL HISTORY:** a) Married \_\_\_ / Single \_\_\_ / Divorced \_\_\_ b) Number of Children \_\_\_\_\_

c) Job/Profession \_\_\_\_\_

d) Religion / Spirituality: \_\_\_\_\_ e) Primary Care Physician: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**6. FAMILY HISTORY:**

Is your father living? (Age \_\_\_\_\_) Died at age \_\_\_\_\_

Cause of death \_\_\_\_\_

Is your mother living? (Age \_\_\_\_\_) Died at age \_\_\_\_\_

Cause of death \_\_\_\_\_

Number of brothers living \_\_\_\_\_

Number of brothers deceased \_\_\_\_\_ Cause \_\_\_\_\_

Number of sisters living \_\_\_\_\_

Number of sisters deceased \_\_\_\_\_ Cause \_\_\_\_\_

Age of spouse (if living) \_\_\_\_\_

If living, is spouse in good health?    Yes                      No

Has anyone related to you had:                      *Relative with  
this disease:*

Diabetes \_\_\_\_\_

Cancer \_\_\_\_\_

High blood pressure \_\_\_\_\_

Heart disease \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Glaucoma \_\_\_\_\_

Cataracts \_\_\_\_\_

Kidney disease \_\_\_\_\_

**7. ALLERGIES:** a) Drugs: \_\_\_\_\_

b) Other: \_\_\_\_\_

**8. SURGICAL HISTORY:**

List and date of any operations; if none, please check \_\_\_\_\_

Type: \_\_\_\_\_ Date \_\_\_\_\_

Type: \_\_\_\_\_ Date \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**9. TRAUMATIC HISTORY: (Fractures, etc.)**

\_\_\_\_\_  
\_\_\_\_\_

**10. (Circle where appropriate):**

- Diabetes mellitus
- Thyroid disease (hypothyroid)
- Hypertension
- Obesity
- Arthritis
- Hyperlipidemia (high cholesterol)
- Coronary heart disease
- Angina
- Previous MI (heart attack)
- COPD (emphysema) or chronic bronchitis
- Obstructive sleep apnea
- Peptic ulcer disease
- Cancer (type) \_\_\_\_\_
- Other

**WHAT ARE YOUR HEALTH CONCERNS AT THIS TIME:** \_\_\_\_\_

**GENERAL:**

Do you usually have difficulty falling asleep?	Yes	No
Do you usually have difficulty staying asleep?	Yes	No
Do you often have severe fatigue?	Yes	No
Do you have loss of strength?	Yes	No
Do you have loss of muscle mass?	Yes	No
Have you gained body fat?	Yes	No
Do you have low energy levels?	Yes	No
Are you frequently ill?	Yes	No
Fever, chills or night sweats recently?	Yes	No
Do you have any chronic disease?	Yes	No
Do you have recurrent anxiety?	Yes	No
Have you had recurrent depression?	Yes	No
Have you ever been diagnosed with any other mental illness?	Yes	No
How often do you engage in exercise – <b>days per week</b> ?	1 / 2 / 3 / 4 / 5 / 6 / 7	
What type of exercise do you do: walking, biking, weight lifting, running, yoga?	_____	

When is the last time that you engaged in vigorous exercise? \_\_\_\_\_

**NEUROLOGICAL:** *Have you ever had?*

Frequent or severe headaches?	Yes	No
Fainting, loss of consciousness?	Yes	No
Clumsiness, incoordination?	Yes	No
Have you ever had seizures?	Yes	No
Dizziness?            Yes    No	Numbness?            Yes	No
Weakness?            Yes    No	Stroke?                Yes	No
Double vision?      Yes    No	Falling Episodes?    Yes	No

Other problems: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEMORY SCREENING:**

The following statements describe everyday life situations. Please rate how common each situation is for you by selecting one of the following: Daily, Regularly, Occasionally, Rarely, Never. Circle the corresponding number for each rating:

	Daily	Regularly	Occasionally	Rarely	Never
1. Forgetting where you have put something. Losing things around the house. ....	1	2	3	4	5
2. Failing to recognize places that you have been before.....	1	2	3	4	5
3. Finding a television story difficult to follow.....	1	2	3	4	5
4. Not remembering a change in your daily routine, such as a change in the place where something is kept, or a change in the time something happens. Following your old routine instead.....	1	2	3	4	5
5. Having to go back and check whether you have done something that you that You meant to do. ....	1	2	3	4	5
6. Completely forgetting to take things with you, or leaving things behind and having to go back and fetch them. ....	1	2	3	4	5
7. Forgetting that you were told something yesterday or a few days ago, and having to be reminded about it. ....	1	2	3	4	5
8. Starting to read something (book, newspaper, magazine) without realizing you have already read it before. ....	1	2	3	4	5
9. Having difficulty picking up a new skill. For example, finding it hard to learn a new game or to work a new gadget after practice. ....	1	2	3	4	5
10. Finding that a word is "on the tip of your tongue." You know what it is but just cannot find it. ....	1	2	3	4	5
11. Forgetting details of what you did or what happened to you the day before. ...	1	2	3	4	5
12. When talking to someone, forgetting what you have just said. Maybe saying "What was I just talking about?" .....	1	2	3	4	5
13. When reading a newspaper or magazine, being unable to follow the thread of a story, losing track of what it is about. ....	1	2	3	4	5
14. Getting details of what someone has told you mixed up and confused. ....	1	2	3	4	5
15. Telling someone a story or joke that you have told them already. ....	1	2	3	4	5
16. Forgetting details of things you do regularly, whether at home or work, for example, forgetting details of what to do or what time it is. ....	1	2	3	4	5
17. Forgetting where things are normally kept, or looking for them in the wrong place. ....	1	2	3	4	5
18. Getting lost or turning in the wrong direction on a journey, a walk or in a building that you are familiar with. ....	1	2	3	4	5
19. Repeating to someone what you have just told them or asking a question twice. ....	1	2	3	4	5
20. Doing some routine thing twice by mistake. For example, putting two bags of tea in the teapot, going to brush/comb your hair when you have already done so. ....	1	2	3	4	5

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**EYES:**

Has there been a change in vision recently?

Yes No

Do you wear glasses?	Yes	No
Do you have glaucoma?	Yes	No
Have you ever had cataracts?	Yes	No
Have you ever had macular degeneration?	Yes	No

Other problems: \_\_\_\_\_

**EARS:**

Do you have deafness?	Yes	No
Have you had ringing in your ears (tinnitus)?	Yes	No
Do you have recurrent ear infections?	Yes	No

Other problems: \_\_\_\_\_

**NOSE AND THROAT:**

Do you have a history of sinus problems?	Yes	No
Do you have hay fever?	Yes	No
Have you had hoarseness or a change in your voice?	Yes	No
Do you have trouble swallowing?	Yes	No
Do you have pain with swallowing?	Yes	No
Do you see a dentist regularly?	Yes	No

Other problems: \_\_\_\_\_

**NECK:**

Have you had any thyroid trouble?	Yes	No
Do you have swollen glands in your neck?	Yes	No
Are there any masses in your neck?	Yes	No

Other problems: \_\_\_\_\_

**LUNGS:**

Have you had a recent chest x-ray and was it normal?	Yes	No
Do you have a history of asthma, cough?	Yes	No
Have you had recent fever, chills, chest pain?	Yes	No
Do you cough up mucous or pus?	Yes	No
Have you ever coughed up blood?	Yes	No

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Do you have a history of pneumonia?	Yes	No
Do you have a history of COPD or emphysema?	Yes	No
Do you have a history of sarcoidosis?	Yes	No

Do you have a history of lung cancer? Yes No

Other problems: \_\_\_\_\_

**HEART:**

Have you had chest pain? Yes No

Do you have chest pain with exertion? Yes No

Do you have chest pain with rest? Yes No

Do you have shortness of breath at rest? Yes No

Do you have shortness of breath with exertion? Yes No

Do you need to sleep on more than one pillow at night? Yes No

How many pillows do you use for sleep? \_\_\_\_\_

Do you have swelling in your feet? Yes No

Do you have palpitations? Yes No

Has your blood pressure been elevated or so low that it has given you symptoms? Yes No

Have you had a previous heart attack? Yes No

Do you have a history of valvular disease? Yes No

Have you had rheumatic fever? Yes No

Have you ever had bypass surgery? Yes No How many vessels bypassed? \_\_\_\_\_

Have you ever had an angioplasty and stent in your heart? Yes No

Have you had a pacemaker or defibrillator placed? Yes No

Do you have a history of hypertension? Yes No

**GASTROINTESTINAL:**

What is the most you have ever weighed? \_\_\_\_\_

Have you lost weight recently? Yes No

Have you had any change in appetite? Yes No

Do you have a history of peptic ulcer disease? Yes No

Do you have a history of gastritis? Yes No

Have you ever had gallbladder disease? Yes No

Have you ever had liver disease? Yes No

Have you had a history of abdominal pain, nausea, vomiting, diarrhea or constipation? Yes No

Have you ever been jaundiced? Yes No

Do you have recurrent heartburn? Yes No

Do you have recurrent vomiting? Yes No

Have you ever vomited up blood? Yes No

Do you have any history of bloody or black stools? Yes No

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Do you have recurrent diarrhea or constipation? Yes No

Do you use laxatives? Yes No

Do you require laxatives? Yes No

Have you ever had hemorrhoids? Yes No



Have you ever had diverticulosis?	Yes	No
Have you ever had intestinal polyps?	Yes	No
Have you ever had colon cancer?	Yes	No
Date of last colonoscopy? _____ Any other gastrointestinal problems? _____		

**GENITOURINARY:**

Do you urinate frequently?	Yes	No
Do you get up at night do you get up to urinate?	Yes	No
How often do you get up at night to urinate? _____		
Do you ever have burning with urination?	Yes	No
Do you have urgency or frequency of urination?	Yes	No
Have you ever passed blood in your urine?	Yes	No
Is your urine frequently dark?	Yes	No
Have you had previous kidney stones?	Yes	No
Have you had bladder infections or urinary tract infections?	Yes	No
Do you sometimes lose control of your bladder?	Yes	No
Have you had a venereal disease?	Yes	No
Do you have erectile dysfunction?	Yes	No
Have you had any sexual dysfunction?	Yes	No
Is sex painful?	Yes	No
Do you have chronic kidney disease (CKD)?	Yes	No
Have you had acute renal failure?	Yes	No
Have you had glomerulonephritis?	Yes	No
Do you have hereditary kidney disease?	Yes	No
Other problems: _____		

**BONES AND JOINTS:**

Have your joints ever been painful or swollen?	Yes	No
Do you get muscle cramps?	Yes	No
Do you have severe back or neck pain?	Yes	No
Do you have limitation with range of motion?	Yes	No
Do you have morning stiffness?	Yes	No
Are your smaller joints ever painful or swollen?	Yes	No
Have you had trauma to your joints?	Yes	No
Have you ever been diagnosed as having rheumatoid arthritis?	Yes	No
Have you ever been diagnosed as having osteoarthritis?	Yes	No
Other problems: _____		

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**SKIN:**

Have you had skin rashes or itching?	Yes	No
Have you detected any lumps or growths on your skin?	Yes	No
Have you had any moles that have changed size or color or appearance?	Yes	No
Have you had any areas of bruising?	Yes	No
Do you bruise easily?	Yes	No

Other problems: \_\_\_\_\_

**ENDOCRINOLOGIC:**

Do you have any history of hyperthyroidism, hypothyroidism, adrenal problems, diabetes mellitus?	Yes	No
Do you have any history of pituitary problems?	Yes	No
Problems with conception?	Yes	No
Problems with erectile function?	Yes	No
Have you had any problems with any of the other endocrine systems?	Yes	No

Other problems: \_\_\_\_\_

Date of your last immunization for influenza: \_\_\_\_\_ Other: \_\_\_\_\_

Most recent overseas travel: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**Do you have any of the following signs or symptoms? Please identify as none, mild, moderate or severe:**

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue / low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint / muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinning hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to sweat with exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy menstrual flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hair on outer eyebrow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worsening hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of polycystic ovarian syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of slow heart rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling around the eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Profound fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty recovering from exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability or agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

	None	Mild	Moderate	Severe
Salt cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased libido or other sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint or muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other allergies like hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty recovering from sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent nausea or abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances / waking at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylactic reactions to drugs or bee stings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure with standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

↓ **T – Decrease in Testosterone:** \_\_\_\_\_ **(MEN AND WOMEN)**

	None	Mild	Moderate	Severe
Decreased energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased cognitive function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased stamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased body fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased muscle mass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**ADULT GROWTH HORMONE DEFICIENCY (AGHD):**

**Please identify as none, mild, moderate or severe:**

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Thin skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sagging skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrinkles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Graying Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased short-term memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty learning new information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worsening presbyopia (near vision)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor or nonrestorative sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased belly fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased visceral fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of muscle mass and strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased kidney function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased immune function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**DIETARY HISTORY:**

How often do you eat breakfast? \_\_\_\_\_

What generally does breakfast consist of for you? \_\_\_\_\_

How often do you eat lunch? \_\_\_\_\_

What generally does lunch consist of for you? \_\_\_\_\_

How often do you eat dinner? \_\_\_\_\_

What generally does dinner consist of for you? \_\_\_\_\_

**F -FREQUENTLY**

**S -SOMETIMES**

**R -RARELY**

**N -NEVER**

Refined carbohydrates: F / S / R / N  
*(high glycemic index carbohydrates)*

Fatty Food F / S / R / N

Trans fats F / S / R / N

Fried foods F / S / R / N

High fructose corn syrup F / S / R / N

Desserts/sweets F / S / R / N

Sugar F / S / R / N

Grains F / S / R / N

Gluten-free grains F / S / R / N

Complex carbohydrates F / S / R / N

Protein:

-- Fish F / S / R / N

-- Beef F / S / R / N

-- Turkey F / S / R / N

-- Chicken F / S / R / N

-- Other \_\_\_\_\_ F / S / R / N

Fat

--Omega 3 (EPA—DHA): F / S / R / N

--Omega 9 (monounsaturated fat): F / S / R / N

Alcohol:

--Beer F / S / R / N

--Wine F / S / R / N

--Liquor F / S / R / N

-- Coffee F / S / R / N

-- Soda F / S / R / N

--Energy drinks F / S / R / N

***I hereby certify that the above information is true and accurate to the best of my knowledge.***

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

# Idaho Center for Regenerative Medicine

*ICRM ~ Defy Age! Live the Optimal Healthy Life You Deserve!*

**Eagle River IV Building | 868 East Riverside Dr., Ste. 170 | Eagle, Idaho 83616**

208-995-2802 / 208-995-2804 (fax) / [www.icrmboise.com](http://www.icrmboise.com)

Thank you for choosing the Idaho Center for Regenerative Medicine for your healthcare. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. Please feel free to call our office if you have any questions concerning our policies.

## **OFFICE HOURS**

ICRM office is open Monday through Thursday, 9:00 a.m. to 5:00 p.m.\* The Clinic may be reached at (208) 995-2802. If we are with patients or not available, please leave a message on our voice mail and we will return your call as soon as possible or on the next business day. \*Office hours above except for holiday office closures.

## **APPOINTMENTS/CANCELLATIONS**

To ensure quality care, ICRM's team of physicians do not treat patients they have not seen (i.e. will not call in prescriptions or offer medical advice for patients prior to an initial office visit). Follow up visits are scheduled after all testing/labs have been completed so that results may be reviewed together and an effective and appropriate plan for your healthcare can be determined. **Please note that test results will not be given over the phone.**

*YOUR APPOINTMENT TIME IS SET ASIDE JUST FOR YOU! WE DO NOT DOUBLE OR TRIPLE BOOK. THEREFORE, IF YOU ARRIVE MORE THAN 15 MINUTES AFTER YOUR SCHEDULED APPOINTMENT, YOU WILL NOT BE SEEN BY YOUR PROVIDER AND WILL NEED TO RESCHEDULE YOUR APPOINTMENT. YOU WILL BE CHARGED A \$50.00 CANCELLATION FEE WHICH IS NOT REIMBURSABLE BY INSURANCE.*

## **Cancellation Fees:**

**Less than 48 hours existing patient \$150.00**

**Less than 72 hours new patient \$150.00**

**All cancellations with less than 12 hours notice \$200.00**

Please let us know if you are unable to make your appointment and we will be happy to reschedule for you at your convenience. If you do not call and cancel your appointment a \$150.00 fee will be charged. These charges are patient's responsibility and are not reimbursable by insurance. **After the second late cancellation and/or no show we will ask you to seek care elsewhere.**

\_\_\_\_\_ **Patient Initials**

## **\*\*PRESCRIPTION REFILLS & PHARMACY INFORMATION\*\***

PLEASE DO NOT CONTACT THE OFFICE FOR PRESCRIPTION REFILLS. We MUST receive the information via fax directly from your pharmacy. *If a prescription refill is needed, please call your pharmacy and have them fax the request to our office at (208) 995-2804. Requests will be processed within 24 to 48 business hours. If received on a Friday or over the weekend, the following Monday.*

Please note that prescriptions and refills will not be given to patients we are not able to monitor. If you do not have a follow up appointment and labs in the appropriate time frame we will, unfortunately, not be able to fill your prescriptions.

\_\_\_\_\_ **Patient Initials**

**INSURANCE**

ICRM is a pay-for-fee clinic. As a courtesy to our patients, ICRM will provide you with forms and billing codes that you can use to file claims to your insurance carrier.

Please be advised that ICRM does not participate with Medicare or private insurance.

**PAYMENTS**

ICRM accepts cash, personal checks, MasterCard, Visa, Discover and American Express. Payment is due at the time of service.

**FORMS/LETTERS**

We understand that, at times, various forms or letters may be required to assist you with your healthcare needs. The staff at ICRM will be happy to complete forms and provide medical letters as necessary upon your request. However, because this can be time-consuming, fees for this service will apply. While these charges vary, they generally range from \$50.00-\$100.00 per form. Costs will be discussed in advance, and prepayment is required. Please allow 10-14 business days for completion of requested forms/letters.

**MEDICAL RECORDS**

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a Release of Medical Information must be completed and signed prior to receipt of these materials. Payment is required at the time of pickup/delivery. ICRM will put forth every effort to respond to these requests promptly.

**RECEIPT ACKNOWLEDGMENT FORM**

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Idaho Center for Regenerative Medicine OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNED NAME

\_\_\_\_\_  
DATE



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Bio-identical Hormone Replacement Therapy is the use of human bio-identical hormones (hormones which are identical to the hormones in your body) to augment levels of these hormones in the body which decline with the aging process. The goal is to bring these hormones to more youthful and balanced levels, and thereby, improve quality of life. Medical evidence suggests that many of the consequences of aging are secondary to the declining level of these hormones and that restoring levels into a youthful range greatly improves functionality, energy and helps to alleviate signs and symptoms of age related diseases. While orthodox medicine may not officially endorse this approach, the medical literature certainly supports it with a plethora of studies and data rendering.

**BHRT is medically evidence based treatment.**

As with any therapy, there are numbers of contra-indications, cautions and caveats prior to treatment, as well as serum level determination and dosage adjustments after treatment is initiated. Your provider will work closely with you to reach the optimal level for you!

I understand the foregoing and consent to therapy.

---

NAME

---

DATE

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**ACKNOWLEDGEMENT OF PRIVACY NOTICE**

As of April 1, 2003, our office is implementing the requirements of the Health Insurance Portability and Accountability Act (HIPPA) which was passed by the federal legislature.

Your signature is necessary so that we may treat you.

Please review the 'Privacy Notice' and indicate that you have reviewed this document by signing below.

***"My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice."***

---

Print Name

---

Date

---

Signature

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**AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Is there someone you wish to authorize us to share and/or discuss your records with? A spouse, child or relative or additional provider?  
If so, complete below.

I hereby request and authorize:      **6001 W. State Street, Suite B, Boise, ID 83703**

To Release/Receive Information to/from: \_\_\_\_\_

Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Information to be disclosed include copies    \_\_\_\_\_ Labs    \_\_\_\_\_ Chart Notes    \_\_\_\_\_ Entire Record

*I hereby authorize the use or release/disclosure of protected health information regarding the above-named individual as described herein. I understand that this authorization is voluntary and made at my direction with no expiration unless revoked in writing by me.*

*I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.*

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*