



ENIHEALTHCARE

HORMONE & WELLNESS INTAKE QUESTIONNAIRE

MALE OR FEMALE

PERSONAL INFORMATION

Personal Information

Legal First Name: _____

Preferred First Name: _____

Middle Name: _____

Last Name: _____

Street Address: _____

Unit: _____

City: _____

State/Province: _____

Postal Code: _____

Home Phone: _____

Mobile Phone: _____

Email Address: _____

Date of Birth: _____

Gender: _____

Relationship Status: _____

Provider: _____

Practice Name: _____

BACKGROUND & OCCUPATION

Genetic Background

(Check all that apply)

- African American
 - Hispanic
 - Mediterranean
 - Asian
 - Native American
 - Caucasian
 - Northern European
 - Other: _____
-

Occupation

Current Occupation: _____

Do you work scheduled shifts?

- Yes No

If yes, select the type of shifts you work:

- Days
 - Evenings
 - Nights
 - Alternating Shifts
 - Weekends
-

How did you hear about our practice?

(Check one)

- Clinic website
 - Referral from doctor
 - Social media
 - Referral from friend/family member
 - Other: _____
-

PRIMARY CARE & EMERGENCY CONTACT

Referral Information

Name of friend or family member who referred you (if applicable):

When and from whom did you last receive medical or health care?

Primary Care Information

Primary Care Practice Name: _____

PCP Name: _____

Office Address: _____

Office Phone Number: _____

Specialty Care

In addition to your primary care provider, are you currently under the care of any specialists?

Specialist Name Specialty

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

CURRENT HEALTH CONCERNS

Current Health Concerns

Please list current or ongoing health concerns in order of priority.

Health Concern Mild Moderate Severe Prior Treatment/Approach Fair Good Excellent

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Allergies or Sensitivities

List any allergic reactions to medications, supplements, or other substances:

Substance Severity of Reaction

Reasons for Visit

(Check all that apply)

- Weight Loss
 - Hormone Evaluation
 - Thyroid Evaluation
 - B-complex Injections
-

SLEEP

Sleep Assessment

How many hours of sleep do you get each night on average?

_____ hours

Do you use or have you been prescribed a CPAP machine?

- Yes No

Do you have difficulty falling asleep?

Yes No

Do you have difficulty staying asleep?

Yes No

Do you experience insomnia?

Yes No

Do you snore?

Yes No

Do you feel rested upon awakening?

Yes No

Do you use sleep aids (prescription or over-the-counter)?

Yes No

If yes, please list: _____

EXERCISE

Exercise Habits

Current Exercise Program

(Please complete all that apply)

Activity	Type	# of Times per Week	Time/Duration (minutes)
Cardio / Aerobic	_____	_____	_____
Strength / Resistance	_____	_____	_____
Flexibility / Stretching	_____	_____	_____
Balance	_____	_____	_____
Sports / Leisure (e.g., golf)	_____	_____	_____
Other	_____	_____	_____

Do you feel motivated to exercise?

Yes A little No

Are there any physical problems that limit your ability to exercise?

Yes No

If yes, please explain:

Do you feel unusually fatigued or sore after exercise?

Yes No

NUTRITION

Dietary Patterns

Do you currently follow any of the following diets or nutrition programs?

(Check all that apply)

Vegetarian

Vegan

Elimination Diet

Allergy-based Diet

Low Fat

High Protein

Low Carb

Low Sodium

No Wheat

No Dairy

Gluten Free

Blood Type Diet

Other: _____

Do you have sensitivities to certain foods?

Yes No

Do you have an aversion to certain foods?

Yes No

Food Reactions

(Check all that apply)

- Monosodium glutamate (MSG)
- Garlic/onion
- Citrus fruit
- Alcohol
- Sulfite-containing foods (wine, dried fruit, salad bars)
- Food colorings
- Artificial sweeteners
- Cheese
- Chocolate
- Red wine
- Preservatives
- Other food substances: _____

If other, please list foods and symptoms:

Are there foods you crave or binge on?

- Yes No

Do you eat three meals per day?

- Yes No

Does skipping a meal greatly affect you?

- Yes No

NUTRITION

How many meals do you eat out per week?

- 0-1
- 1-3

- 3-5
 - More than 5
-

Lifestyle & Eating Habits

(Check all that apply)

- Fast eater
 - Eat too much
 - Late-night eating
 - Dislike healthy foods
 - Time constraints
 - Travel frequently
 - Eat more than 50% of meals away from home
 - Healthy foods not readily available
 - Poor snack choices
 - Significant other/family dislikes healthy foods
 - Family members have special dietary needs

 - Love to eat
 - Eat because I have to
 - Negative relationship with food
 - Struggle with eating issues
 - Emotional eater (sad, lonely, bored, stressed)
 - Eat too much under stress
 - Eat too little under stress
 - Don't like to cook
 - Confused by nutrition advice
-

DIET & CAFFEINE

Average Weekly Intake

How many servings per week do you typically eat?

Fruits (not juice): _____

Vegetables (not including white potatoes): _____

Legumes (beans, peas, etc.): _____

Fish: _____

Nuts & Seeds: _____

Red meat: _____

Dairy / Alternatives: _____

Fats & Oils: _____

Sweets (candy, cookies, ice cream, etc.): _____

Cans of soda (regular or diet) per week: _____

Caffeine

Do you drink caffeinated beverages?

Yes No

If yes, how many per day?

Beverage **1** **2-4** **More than 4**

Coffee

Tea

Caffeinated sodas

Do you have adverse reactions to caffeine?

Yes No

If yes, check all that apply:

Irritability

Nervousness or anxiety

GI upset (nausea, diarrhea)

Aches or pains

Increased heart rate

Headaches

TOBACCO & ALCOHOL

Smoking / Tobacco Use

Do you currently smoke or use tobacco products?

Yes No

If yes:

Type: Cigarettes Cigars Pipe E-cigarette/Vape Smokeless

Packs per day (if applicable): _____

Number of years used: _____

Have you attempted to quit?

Yes No

If you smoked in the past:

Number of years: _____

Are you regularly exposed to second-hand smoke?

Yes No

Alcohol Use

How many alcoholic beverages do you drink per week?

(1 drink = 5 oz wine, 12 oz beer, or 1.5 oz spirits)

None

1-3

4-6

7-10

More than 10

ALCOHOL & OTHER SUBSTANCES

Previous Alcohol Intake

(Check one)

- None
- Mild
- Moderate
- High

Have you ever had a problem with alcohol?

- Yes No

Have you ever thought about getting help to control or stop drinking?

- Yes No
-

Other Substances

Are you currently using any recreational drugs?

- Yes No

Have you ever used IV or inhaled recreational drugs?

- Yes No

If yes to any above, please explain:

STRESS & MENTAL HEALTH

Stress Assessment

Do you feel you have an excessive amount of stress in your life?

- Yes No

Do you feel you can handle the stress in your life?

- Yes No
-

Daily Stress Rating

(Rate each item on a scale of **0–10**

0 = Not applicable, 10 = Extreme stress)

Area **0 1 2 3 4 5 6 7 8 9 10**

Work

Family

Social

Finances

Health

Other

Stress Management

Do you use relaxation techniques?

Yes No

If yes, which do you use? (Check all that apply)

Meditation

Breathing exercises

Prayer

Yoga

Tai Chi

Other: _____

Have you ever sought counseling?

Yes No

Are you currently in therapy?

Yes No

Have you ever experienced abuse, been a victim of a crime, or experienced significant trauma?

Yes No

LIFESTYLE & LEISURE

Hobbies and Leisure Activities

Please list hobbies, activities, or interests you regularly enjoy:

RELATIONSHIPS & SUPPORT

Relationship Status

(Check one)

- Single
- Married
- Divorced
- Long-term partner
- Widowed

With whom do you currently live?
(Include children, parents, relatives, pets)

Emotional Support

Do you have resources for emotional support?

- Yes No

If yes, check all that apply:

- Spouse/Partner
- Family
- Friends
- Pets
- Religious/Spiritual Community
- Other: _____

Do you have a religious or spiritual practice?

- Yes No
-

Quality of Life Rating

(Rate 1–10; 1 = Poor, 10 = Excellent; N/A if not applicable)

Area	N/A	1	2	3	4	5	6	7	8	9	10
Overall life	<input type="checkbox"/>										
Job	<input type="checkbox"/>										
Spouse/Partner	<input type="checkbox"/>										
Sexual relationship	<input type="checkbox"/>										
Children	<input type="checkbox"/>										
Close friends	<input type="checkbox"/>										

ADDITIONAL RELATIONSHIP CONTEXT

Please rate the following (if applicable):

Area	N/A	1	2	3	4	5	6	7	8	9	10
Attitude/outlook	<input type="checkbox"/>										
School	<input type="checkbox"/>										
Parents	<input type="checkbox"/>										

ENVIRONMENTAL & TOXIN EXPOSURE

Environmental / Detoxification History

Do any of the following significantly affect you?
(Check all that apply)

- Cigarette smoke
- Auto exhaust fumes
- Perfumes / colognes
- Other: _____

If "Other," please explain:

Home & Work Environment

In your home or work environment, are you regularly exposed to:

(Check all that apply)

- Mold
- Renovations
- Electromagnetic radiation
- Carpets or rugs
- Stagnant or stuffy air
- Pesticides
- Herbicides
- Harsh chemicals (solvents, glues, gas, acids, etc.)
- Heavy metals (lead, mercury, etc.)
- Cleaning chemicals
- Paints
- Old paint
- Damp environments
- Water leaks
- Smokers
- Airplane travel
- Other: _____

If "Other," please explain:

Have you had significant exposure to harmful chemicals?

- Yes No

Do you have any pets or farm animals?

- Yes No

If yes, where do they live?

- Inside
 Outside
 Both inside and outside

WOMEN'S HEALTH HISTORY

(Complete this section if applicable)

Obstetric History

(Check and provide number if applicable)

History	Number
Pregnancies	_____
Miscarriages	_____
Abortions	_____
Living children	_____
Vaginal deliveries	_____
Cesarean deliveries	_____
Term births	_____
Premature births	_____

Did you develop any problems during or after pregnancy?

(Check all that apply)

- Toxemia / high blood pressure
- Gestational diabetes
- Postpartum depression
- Issues with breastfeeding
- Other: _____

If other, please explain:

Menstrual History

Age at first period: _____

Date of last menstrual period: _____

Average length of cycle: _____ days

Time between cycles: _____ days

Cramping?

Yes No

Pain?

Yes No

Have you experienced premenstrual symptoms (bloating, breast tenderness, irritability, etc.)?

Yes No

CONTRACEPTION, MENOPAUSE & HORMONES

Do you have other menstrual problems (heavy bleeding, irregular cycles, spotting, skipped periods)?

Yes No

If yes, please describe:

Hormonal Birth Control (Past or Present)

(Check all that apply and list duration)

Birth control pill — Years used: _____

Patch — Years used: _____

Implant — Years used: _____

NuvaRing — Years used: _____

Hormonal IUD (e.g., Mirena) — Years used: _____

Other: _____ Years used: _____

Any problems with hormonal birth control?

Yes No

Other Contraception Methods

- Condoms
 - Copper IUD
 - Natural family planning
 - Diaphragm
 - Partner vasectomy
 - Withdrawal method
-

Menopause

Are you in menopause?

Yes No

Was menopause surgical (ovaries removed)?

Yes No

Do you currently have menopausal symptoms?

(Check all that apply)

- Hot flashes
- Night sweats
- Mood swings
- Headaches
- Joint pain
- Weight gain
- Vaginal dryness
- Decreased libido
- Palpitations
- Urinary symptoms
- Concentration or memory problems

Are you currently on hormone replacement therapy (HRT)?

Yes No

If yes, how many years? _____

GYNECOLOGIC HISTORY & SCREENING**Other Gynecologic Conditions**

(Check all that apply)

- Endometriosis
- Fibrocystic breasts
- Fibroids
- Pelvic inflammatory disease
- Vaginal infections
- Ovarian cysts
- Infertility
- Sexually transmitted disease
- Reproductive cancer

If STD selected, please specify:

Gynecologic Screening & Procedures

Screening	Date	Normal	Abnormal
Last Pap smear	_____	<input type="checkbox"/>	<input type="checkbox"/>
Last mammogram	_____	<input type="checkbox"/>	<input type="checkbox"/>
Last bone density test	_____	<input type="checkbox"/>	<input type="checkbox"/>

If bone density abnormal, result:

- High Low Within normal range

Other gynecologic tests or procedures (list type and date):

FAMILY HISTORY**Family Member Information**

(List ages or age at death if applicable)

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Child(ren): _____

Maternal Grandmother (MGM): _____

Maternal Grandfather (MGF): _____

Paternal Grandmother (PGM): _____

Paternal Grandfather (PGF): _____

Family Medical History

(Check conditions present in immediate family)

- Cancer
- Heart disease
- Hypertension
- Obesity
- Diabetes
- Stroke
- Kidney disease
- Autoimmune disease
- Arthritis
- Thyroid disorders
- Seizures / epilepsy
- Psychiatric disorders
- Anxiety
- Depression
- Asthma
- Allergies
- Eczema

If any condition checked, please specify which family member and condition:

NEURODEVELOPMENTAL & GI HISTORY

Neurodevelopmental / Behavioral Conditions

(Check all that apply and indicate family history if known)

- ADHD / ADD
- Autism spectrum disorder
- Dementia / Alzheimer's disease
- Substance abuse disorder
- Genetic disorders
- Other: _____

If yes, please specify condition and affected family member(s):

Gastrointestinal Conditions

(Check all that apply)

Condition	Current Past	
Irritable bowel syndrome (IBS)	<input type="checkbox"/>	<input type="checkbox"/>
GERD / acid reflux	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease / ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY, URINARY & ENDOCRINE

Respiratory Conditions

Condition	Current Past	
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic syndrome / insulin resistance	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNE, MUSCULOSKELETAL & SKIN

Inflammatory / Immune Conditions

Condition	Current Past	
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
Multiple chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal Conditions

Condition	Current Past	
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>

Skin Conditions

Condition	Current Past	
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Eczema	<input type="checkbox"/>	<input type="checkbox"/>
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Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
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Acne	<input type="checkbox"/>	<input type="checkbox"/>
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Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
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CARDIOVASCULAR, NEUROLOGIC & CANCER

Cardiovascular Conditions

Condition	Current Past	
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Angina	<input type="checkbox"/>	<input type="checkbox"/>
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Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
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Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
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Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
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Stroke	<input type="checkbox"/>	<input type="checkbox"/>
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High cholesterol / triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
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Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
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Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
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Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
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Neurologic / Emotional Conditions

Condition	Current Past	
Epilepsy / seizures	<input type="checkbox"/>	<input type="checkbox"/>
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Autism spectrum disorder	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>

Cancer History

(Check all that apply)

- Lung
- Breast
- Colon
- Ovarian
- Prostate
- Skin
- Other: _____

If cancer history present, please list type, year diagnosed, and treatment:

DIAGNOSTICS, SURGERIES & INJURIES

Diagnostic Studies

(Check all that apply and list dates if known)

- Bone density
- CT scan
- Colonoscopy
- Cardiac stress test
- EKG
- MRI
- Upper endoscopy
- Upper GI series
- Chest X-ray
- Barium enema

Injuries

Injury	Date	Comments
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Broken bone(s)	_____	_____
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Back injury	_____	_____
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Neck injury	_____	_____
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Head injury	_____	_____
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Surgeries

(Check all that apply and list dates)

- Appendectomy
- Dental surgery
- Gallbladder surgery
- Hernia repair
- Tonsillectomy
- Joint replacement
- Heart surgery
- Other: _____

Dates / Comments:

Hospitalizations

Date Reason

SYMPTOM REVIEW (GENERAL & SLEEP)

Symptom Review

Please check if these symptoms occur currently or within the last 6 months.

General Symptoms

Symptom	Mild	Moderate	Severe
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep Symptoms

Symptom	Mild	Moderate	Severe
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom	Mild	Moderate	Severe
Night waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYMPTOM REVIEW (EATING & METABOLIC)

Eating & Metabolic Symptoms

Symptom	Mild	Moderate	Severe
Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYMPTOM REVIEW (FEMALE REPRODUCTIVE)

(Complete if applicable)

Female Reproductive Symptoms

Symptom	Mild	Moderate	Severe
Breast cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Premenstrual Symptoms

Symptom	Mild	Moderate	Severe
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom	Mild	Moderate	Severe
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Menstrual Symptoms

Symptom	Mild	Moderate	Severe
Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scanty periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting between periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

Medications

(Include prescription and over-the-counter medications)

Medication Name Dosage Start Date (mo/yr) Reason for Use Past?

Nutritional Supplements

(Vitamins, minerals, herbs, etc.)

Supplement Name / Brand Dosage Start Date (mo/yr) Reason for Use

- 1.
- 2.
- 3.
- 4.
- 5.

Have medications or supplements ever caused unusual side effects or problems?

Yes No

If yes, please explain:

MEDICATION HISTORY & STEROIDS

Long-Term Medication Use

Have you used any of the following regularly for long periods of time?

- NSAIDs (ibuprofen, naproxen, aspirin)
- Acetaminophen (Tylenol)
- Acid-blocking drugs / PPIs (omeprazole, esomeprazole, famotidine, etc.)

Oral Steroid Use

(e.g., prednisone, cortisone)

How often have you taken oral steroids?

- Less than 5 times
- More than 5 times

During which life stage(s)?

- Infancy / childhood
- Teen years
- Adulthood

Reason for use:

READINESS ASSESSMENT AND HEALTH GOALS

In order to improve your health, how ready are you to:

Rate on scale from 1 (not willing) to 5 (very willing)

- | | 1 | 2 | 3 | 4 | 5 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Significantly modify your diet | <input type="checkbox"/> |
| Keep a record of everything you eat | <input type="checkbox"/> |
| Modify lifestyle habits (sleep, work, stress) | <input type="checkbox"/> |

Practice relaxation techniques

Engage in regular exercise

Follow-Through Confidence

How confident are you in your ability to organize and follow through on the above activities?
(1 = Not confident at all 5 = Very confident)

1 2 3 4 5

If you are not confident, what factors make follow-through difficult?

Household Support

At the present time, how supportive do you believe the people in your household will be of these changes?

1 (Very unsupportive)

2

3

4

5 (Very supportive)

SUPPORT NEEDS & GOALS

Ongoing Support

How much ongoing support from ENI Health Care (phone calls, portal messages, visits) would be helpful as you implement your health plan?

1 (Very infrequent contact)

2

3

4

5 (Very frequent contact)

Health Goals

What do you hope to achieve from your visit with ENI Health Care?

When was the last time you felt well?

Did something trigger changes in your health?

PATIENT PERSPECTIVE

Patient Insight

What makes you feel better?

What makes you feel worse?

How does your current health condition affect your daily life?

What do you think is happening with your health, and why?

What do you feel needs to happen for you to get better?

TEXAS PATIENT ACKNOWLEDGMENT

I understand that ENI Health Care provides care in accordance with Texas state law.
I acknowledge that this intake form is part of my medical record and that complete and accurate information is required for appropriate medical evaluation and treatment.

Patient Signature: _____

Date: _____

FINAL PATIENT ATTESTATION – TEXAS

I attest that the information provided in this intake questionnaire is true, complete, and accurate to the best of my knowledge.

I understand that incomplete or inaccurate information may affect medical decision-making.

I understand that ENI Health Care provides medical services in accordance with Texas law, and that this form becomes part of my permanent medical record.

Patient Name (print): _____

Patient Signature: _____

Date: _____

HIPAA ACKNOWLEDGMENT – TEXAS

I acknowledge that I have been informed of ENI Health Care's **Notice of Privacy Practices**, in accordance with the **Health Insurance Portability and Accountability Act (HIPAA)** and **Texas state law**.

I understand that my health information may be used and disclosed for purposes of **treatment, payment, and healthcare operations**, and as otherwise permitted or required by law.

I understand that:

- I have the right to access and request amendments to my medical records

- I may request restrictions on certain uses or disclosures
- I may revoke authorization in writing, except where action has already been taken

Patient Name (print): _____

Patient Signature: _____

Date: _____
