

# LOOK BETTER, FEEL BETTER, LIVE BETTER

1728 Tower Ave Superior WI 54880 (715)395-0928 twinportshealth.com



Look Better, Feel Better, Live Better



# YOUR HEALTH, OUR PRIORITY

At our health care clinic we want to provide the best care possible to our patients. We are always actively looking for ways to make our patients more comfortable, happier and live their lives to the fullest.

Our team of qualified medical providers have over 20 years of experience over a wide range of subjects. Your health is our biggest priority so we are constantly researching new methods to provide you with better care.



1728 Tower Avenue Superior, WI 54880

### PATIENT INTAKE FORM

Name	Date	Date		
Date of Birth	Ag	e	Gender	
Address				
City	State	Zip Co	de	
Email Address		Phone No		
Emergency Contact		Phone No		
How did you hear about us?				
Do you consent to receive labs and via email (unsecured, not HIPPA p		Yes	No	
ME	DICAL H	IISTOR <sup>V</sup>	(	
Are you allergic to any of the follov	ving? GLP-1	Receptor Agonists	Sodium Phosphate	
Adhesives/latex Lidocain/xy	/locain lodine/	Betadine	Benzoin	
Other allergens: 📃 No 📃 Yes:	lf yes, please list c	allergen and react	on:	
Are you currently taking blood thin Diabetes medication (i.e. Insulin or s			ene, Gatifloxacin, or any Io	
Have you ever been diagnosed wit Type(s):	th cancer?	Yes	No	
Date of last Mammogram?	Abno	rmal Findings or F	Follow up? No Yes:	
Have you had a colonoscopy?	No Yes: Date of	last colonoscopy?		
Abnormal Findings or Follow up?				
Have you had surgery in the past y	year? No Y	és: —		
Have you or a family member b Multiple Endocrine Neoplasia Syn	•		ollowing? No Yes: llary Thyroid Carcinoma	
winPortsHealth@yahoo.com	715-395-0	0927	TwinPortsHealth.cor	

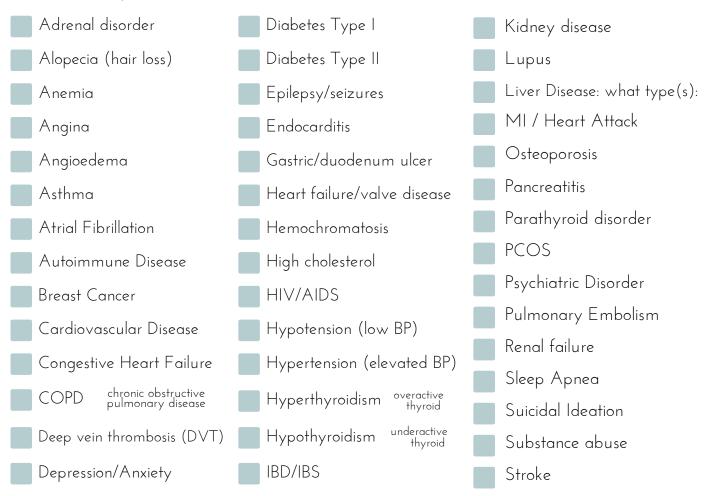
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### 1728 Tower Avenue Superior, WI 54880 PATIENT INTAKE FORM

## MEDICAL HISTORY

Please select any relevant conditions below:



#### Details or any other condition:

Τv

FEMALE MEDICAL HISTORY							
Are you currently:	Pregnant	Trying to co	nceive	Breastfeeding	Post-menopause		
Using contrace	eptives:			Other:			
Date last menses:		Pregnancies:		Live birth	S:		
winPortsHealth@vahoo	COM	715-395	.0997		TwinPortsHealth com		

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### CLIENT INTAKE FORM

HEALTH HABITS							
Do you smoke? No Yes How many per day? How long?							
Do you drink alcohol on a regular basis? No Yes Weekly units:							
Activity level? Sedentary Lightly active Moderately active Very active							
Do you drink caffeine? Yes No How much per day?:							
Date of last physical: Primary Care Provider:							
Relevant results:							
GENERAL MOOD AND FEELINGS							
Check the answer that best describes your feeling:							
I have little interest or take little prleasure in doing things.							
Always Freqently Occassionally Rarely Never							
I feel down, depressed, and hopeless.							
Always Freqently Occassionally Rarely Never							
I have trouble falling or staying asleep.							
Always Freqently Occassionally Rarely Never							
Family medical history:							
Heart Disease Osteoporosis Breast Cancer							
Diabetes Alzheimer's/dementia Other:							
Activity Level:							
low moderate average high							
Marital Status:							
Married Divorced Widow Single Living with Partner							
Sexual Health:							
I'm sexually active My sex life has suffered. I want to be sexually active.							
I have difficulty achieving organism							

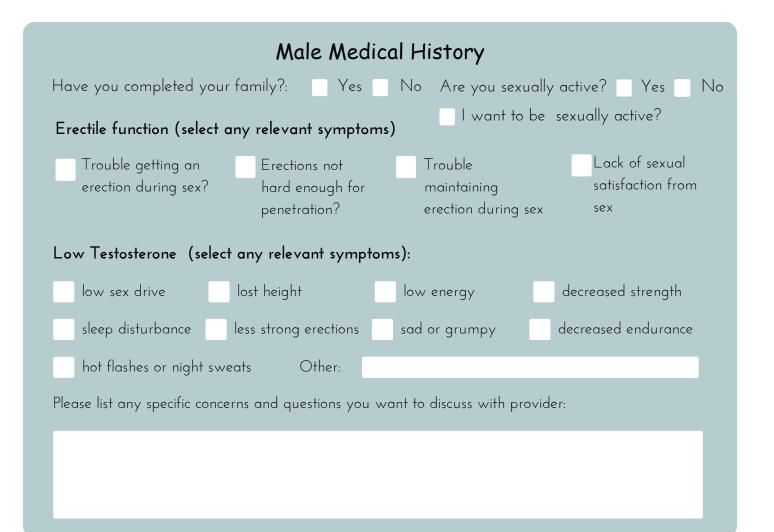
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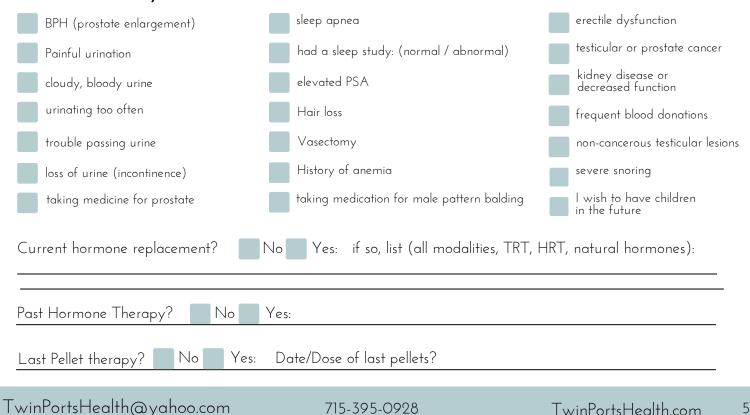
### CLIENT INTAKE FORM HORMONE REPLACEMENT

Have you completed your family?	P: Yes No	
Date last menses:	Pregnancies: Live	births:
Are you currently: Pregnant	Trying to conceive Breastfeedi	ng Post-menopause
Are you sexually active? Yes	No Do you have issues with low s	sex drive?: Yes No
Currently using contraceptives?:	Yes No Contraceptive Name:	_
Birth control method?: Check be	· · · · · · · · · · · · · · · · · · ·	
Menopause Hystered		Condoms
	,	
IUD Tubal L	igation Vasectomy	Infertility
Uterine Cancer	Hysterectomy (total) ovaries & uterus	
Uterine Cancer Uterine fibroids	Hysterectomy (total) ovaries & uterus Hysterectomy (partial)Uterus only	Loss of Scalp Hair
Uterine Cancer	<ul> <li>Hysterectomy (total) ovaries &amp; uterus</li> <li>Hysterectomy (partial)Uterus only</li> <li>Menstral Migraines</li> </ul>	Loss of Scalp Hair Hot Flashes
Uterine Cancer Uterine fibroids Endometriosis	Hysterectomy (total) ovaries & uterus Hysterectomy (partial)Uterus only	Loss of Scalp Hair
Uterine Cancer Uterine fibroids Endometriosis Irregular heavy periods	<ul> <li>Hysterectomy (total) ovaries &amp; uterus</li> <li>Hysterectomy (partial)Uterus only</li> <li>Menstral Migraines</li> <li>Ovarian Cancer</li> </ul>	Loss of Scalp Hair Hot Flashes Breast Cancer
Uterine fibroids Endometriosis Irregular heavy periods Ophorectomy (removal of ovaries only)	<ul> <li>Hysterectomy (total) ovaries &amp; uterus</li> <li>Hysterectomy (partial)Uterus only</li> <li>Menstral Migraines</li> <li>Ovarian Cancer</li> <li>Polycystic Ovaries /PCOS</li> </ul>	Loss of Scalp Hair Hot Flashes Breast Cancer Water weight
Uterine Cancer Uterine fibroids Endometriosis Irregular heavy periods Ophorectomy (removal of ovaries only) Breast Cancer History of seizure/epilepsy	<ul> <li>Hysterectomy (total) ovaries &amp; uterus</li> <li>Hysterectomy (partial)Uterus only</li> <li>Menstral Migraines</li> <li>Ovarian Cancer</li> <li>Polycystic Ovaries /PCOS</li> <li>Painful periods</li> <li>Irregular periods</li> </ul>	<ul> <li>Loss of Scalp Hair</li> <li>Hot Flashes</li> <li>Breast Cancer</li> <li>Water weight</li> <li>Fibromyalgia</li> </ul>
Uterine Cancer Uterine fibroids Endometriosis Irregular heavy periods Ophorectomy (removal of ovaries only) Breast Cancer	<ul> <li>Hysterectomy (total) ovaries &amp; uterus</li> <li>Hysterectomy (partial)Uterus only</li> <li>Menstral Migraines</li> <li>Ovarian Cancer</li> <li>Polycystic Ovaries /PCOS</li> <li>Painful periods</li> <li>Irregular periods</li> <li>No Yes: if so, list (include birth cor</li> </ul>	<ul> <li>Hot Flashes</li> <li>Breast Cancer</li> <li>Water weight</li> <li>Fibromyalgia</li> <li>Heavy Cycles</li> </ul>

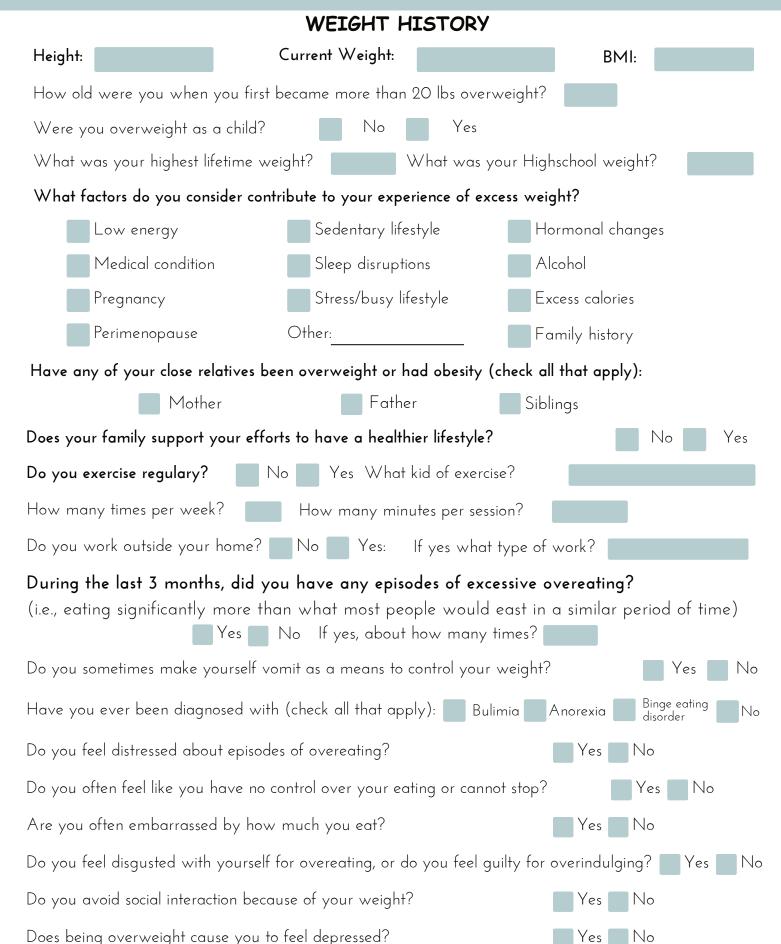
### CLIENT INTAKE FORM HORMONE REPLACEMENT



### Please select any relevant conditions below:



### CLIENT INTAKE FORM WEIGHTLOSS



TwinPortsHealth@yahoo.com

715-395-0928

## WEIGHT HISTORY

Have you ever been treated by a doctor for your weight? Yes 🗾 No
When? Successful? Yes No How much weight did you loose?
Have you participated in a weight loss program? Yes No
Please indicate which of the following weight loss programs you have tried:
Jenny Craig Weight Watchers Diet Exercise Therapy
Optavia Nutri-system Herbal Supplements Other:
Please indicate which of the following medications you have tried for weight loss:
Phentermine Belviq (lorcaserin) Contrave(naltrexone/bupropion)
Xenical (orlistat) Topamax (topiramate) Saxenda (liraglutide) for weightloss
Other: Victoza (liraglutide) for DM2
Have you ever consulted with a registered dietitian?
Have you ever had bariatric surgery?
Have you ever consulted a surgeon regarding bariatric surgery? 🛛 🔤 Yes 🔤 No
What are your main motivations and concerns for wanting to lose weight with a GLP-1 RA/GIP (Semaglutide/Tirzepatide) medication?
What is your goal Weight?     Short term:     Long term:
How do you plan to achieve your weight loss goals? (action steps or lifestyle modification):
Please list any specific concerns or questions you want to discuss with provider:

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1728 Tower Avenue Superior, WI 54880

### REVIEW OF SYSTEMS

yes		
Do you have glaucoma?	Yes	No
Do you have retinopathy? (diabetes-related eye disease)	Yes	No
Do you have blurry vision?	Yes	No
eurologic		
Do you have tingling in your hands or feet?	Yes	N
Do you have hand tremor, or does your hand shake when you hold	it out? Yes	N
Have you ever had migraine headaches?	Yes	N
Do you take medication to prevent migraine headaches?	Yes	N
Have you ever had a seizure?	Yes	N
Have you ever had a stroke or TIA (transient ischemic attack)?	Yes	N
espiratory		
Do you snore?	Yes	
Have you ever been diagnosed with sleep apnea?	Yes	N
Do you get short of breath when walking?	Yes	N
Do you wheeze?	Yes	N
ardiac		
Have you been diagnosed with angina?	Yes	N
Have you ever had a heart attack?	Yes	N
Have you ever been diagnosed with an arrhythmia (irregular hear	tbeat)? Yes	N
Have you ever been told you have a heart murmur?	Yes	
Do you get short of breath when lying down flat?	Yes	N
Do your feet swell?	Yes	N
Do you ever have palpitations? (racing heart)	Yes	N
Do you ever have chest pain?	Yes	N
Do you take medication for high cholesterol?	Yes	N
Do you take medication for high blood pressure?	Yes	N

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## REVIEW OF SYSTEMS

astrointestinal	Yes	
Have you been diagnosed with GERD (gastroesophageal reflux disease?		
Do you ever have heartburn?	Yes	
Have you had gallstones?	Yes	
Have you had your gallbladder removed (choleysystectomy)?	Yes	
Have you ever been diagnosed with pancreatitis?	Yes	
Do you have abdominal pain?	Yes	
Have you had part of your intestine removed?	Yes	
Have you been diagnosed with gastroparesis?	Yes	
Do you frequently have diarrhea?	Yes	
Do you frequently have nausea?	Yes	
Do you vomit frequently?	Yes	
phrology		
Do you have a history of kidney stones?	Yes	
Do you have trouble holding your urine?	Yes	
Do you experience excessive urination?	Yes	
At night do you wake up to urinate?	Yes	
Do you ever have blood in your urine?	Yes	
usculoskeletal		
Do you have a history of arthritis?	Yes	
Do you have pain in your knees?	Yes	
Do you have pain in your hips?	Yes	
Do you have chronic back pain?	Yes	
Do you have trouble walking or exercising due to joint pain?	Yes	
Do you take medication for joint or back pain?	Yes	
Have you had a joint replacement (ex. hip or knee surgery)?	Yes	

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## REVIEW OF SYSTEMS

Have you been told that you have prediabetes?       Yes       N         Do you have dry mouth?       Yes       N         Do you have excessive thirst?       Yes       N         Are you planning to have children within the next year?       Yes       N         Have you been diagnosed with infertility or been told you're infertile?       Yes       N         Do you have low sex drive?       Yes       N         Do you have increased facial hair?       Yes       N         Do you have breast pain or have fibrocystic breast disease?       Yes       N         Do you have breast pain or have fibrocystic breast disease?       Yes       N         Have you been diagnosed with low testosterone (low-T)?       Yes       N         Have you been diagnosed with anxiety?       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Do you have trouble sleeping?       Yes       N         Do you drink more than 2 alcoholic beverages per day?       Yes       N         Do you take pain medication or opiates on a regular b	docrine					
Do you have dry mouth?       Yes       N         Do you have excessive thirst?       Yes       N         Are you planning to have children within the next year?       Yes       N         Have you been diagnosed with infertility or been told you're infertile?       Yes       N         Do you have low sex drive?       Yes       N         oman       Yes       Yes       N         Do you have acne?       Yes       N         Do you have increased facial hair?       Yes       N         Do you have breast pain or have fibrocystic breast disease?       Yes       N         Po you have breast pain or have fibrocystic breast disease?       Yes       N         Have you been diagnosed with low testosterone (low-T)?       Yes       N         Have you been diagnosed with anxiety?       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you been diagnosed with ADD/ADHD?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Do you have trouble sleeping?       Yes       N         Do you drink more than 2 alcoholic beverages per day?       Yes       N         Do you have memory problems?       Yes       N         Do you have		prediabetes?		Yes		Nc
Are you planning to have children within the next year?       Yes       N         Have you been diagnosed with infertility or been told you're infertile?       Yes       N         Do you have low sex drive?       Yes       N         oman       Yes       Yes       N         Do you have acne?       Yes       Yes       N         Do you have increased facial hair?       Yes       Yes       N         Do you have increased facial hair?       Yes       Yes       N         Do you have breast pain or have fibrocystic breast disease?       Yes       N         Have you been diagnosed with low testosterone (low-T)?       Yes       N         Have you been diagnosed with erectile dysfunction?       Yes       N         vchiatric       Yes       N       N         Have you been diagnosed with anxiety?       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you ever been diagnosed with ADD/ADHD?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Do you have trouble sleeping?       Yes       N         Do you drink more than 2 alcoholic beverages per da	Do you have dry mouth?			Yes		No
Have you been diagnosed with infertility or been told you're infertile?       Yes         Do you have low sex drive?       Yes         oman         Do you have acne?       Yes         Do you have increased facial hair?       Yes         Do you have irregular periods?       Yes         Do you have breast pain or have fibrocystic breast disease?       Yes         Have you been diagnosed with low testosterone (low-T)?       Yes         Have you been diagnosed with erectile dysfunction?       Yes         vchiatric       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you been diagnosed with ADD/ADHD?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Do you drink more than 2 alcoholic beverages per day?       Yes       N         Do you take pain medication or opiates on a regular basis?       Yes       N         Do you take medication for depression or anxiety?       Yes       N	Do you have excessive thirst?			Yes		No
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oman       Yes       Yes         Do you have increased facial hair?       Yes       Yes         Do you have increased facial hair?       Yes       Yes         Do you have inregular periods?       Yes       Yes         Do you have breast pain or have fibrocystic breast disease?       Yes       Yes         Have you been diagnosed with low testosterone (low-T)?       Yes       Yes         Have you been diagnosed with erectile dysfunction?       Yes       N         ychiatric       Yes       Yes       N         Have you been diagnosed with anxiety?       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you ever been diagnosed with ADD/ADHD?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Do you have trouble sleeping?       Yes       N         Do you drink more than 2 alcoholic beverages per day?       Yes       N         Do you take pain medication or opiates on a regular basis?       Yes       N         Do you have memory problems?       Yes       N         Do you take medication for depression or anxiety?       Yes       N	Have you been diagnosed with infe	ertility or been told you're infertile?		Yes		Na
Do you have acne?       Yes       Yes         Do you have increased facial hair?       Yes       Yes         Do you have irregular periods?       Yes       Yes         Do you have breast pain or have fibrocystic breast disease?       Yes       Yes         Have you been diagnosed with low testosterone (low-T)?       Yes       Yes         Have you been diagnosed with erectile dysfunction?       Yes       N         ychiatric       Yes       Yes       N         Have you been diagnosed with anxiety?       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you ever been diagnosed with ADD/ADHD?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Do you have trouble sleeping?       Yes       N         Do you drink more than 2 alcoholic beverages per day?       Yes       N         Do you take pain medication or opiates on a regular basis?       Yes       N         Do you have memory problems?       Yes       N         Do you take medication for depression or anxiety?       Yes       N	Do you have low sex drive?			Yes		No
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Do you have breast pain or have fibrocystic breast disease? Have you been diagnosed with low testosterone (low-T)? Have you been diagnosed with erectile dysfunction? Yes N Yes N Yes N Have you been diagnosed with anxiety? Have you been diagnosed with depression? Have you ever been diagnosed with ADD/ADHD? Have you ever been diagnosed with bipolar disorder? Do you have trouble sleeping? Do you drink more than 2 alcoholic beverages per day? Do you take pain medication or opiates on a regular basis? Do you have memory problems? Do you take medication for depression or anxiety? Yes N	Do you have increased facial hair?			Yes		Ν
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Have you been diagnosed with low testosterone (low-T)?YesNHave you been diagnosed with erectile dysfunction?YesNychiatricYesYesNHave you been diagnosed with anxiety?YesNHave you been diagnosed with depression?YesNHave you ever been diagnosed with ADD/ADHD?YesNHave you ever been diagnosed with bipolar disorder?YesNDo you have trouble sleeping?YesNDo you drink more than 2 alcoholic beverages per day?YesNDo you have memory problems?YesNDo you take medication for depression or anxiety?YesN	Do you have breast pain or have f	brocystic breast disease?		Yes		$\land$
Have you been diagnosed with erectile dysfunction?       Yes       N         ychiatric       Yes       Yes       N         Have you been diagnosed with anxiety?       Yes       N         Have you been diagnosed with depression?       Yes       N         Have you ever been diagnosed with ADD/ADHD?       Yes       N         Have you ever been diagnosed with bipolar disorder?       Yes       N         Do you have trouble sleeping?       Yes       N         Do you drink more than 2 alcoholic beverages per day?       Yes       N         Do you have memory problems?       Yes       N         Do you take medication for depression or anxiety?       Yes       N	en					
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Have you been diagnosed with depression?YesHave you ever been diagnosed with ADD/ADHD?YesHave you ever been diagnosed with bipolar disorder?YesDo you have trouble sleeping?YesDo you drink more than 2 alcoholic beverages per day?YesDo you take pain medication or opiates on a regular basis?YesDo you have memory problems?YesDo you take medication for depression or anxiety?Yes	ychiatric					
Have you ever been diagnosed with ADD/ADHD?YesHave you ever been diagnosed with bipolar disorder?YesDo you have trouble sleeping?YesDo you drink more than 2 alcoholic beverages per day?YesDo you take pain medication or opiates on a regular basis?YesDo you have memory problems?YesDo you take medication for depression or anxiety?Yes	Have you been diagnosed with an	xiety?		Yes		$\square$
Have you ever been diagnosed with bipolar disorder?YesDo you have trouble sleeping?YesDo you drink more than 2 alcoholic beverages per day?YesDo you take pain medication or opiates on a regular basis?YesDo you have memory problems?YesDo you take medication for depression or anxiety?Yes	Have you been diagnosed with de	oression?		Yes		$\wedge$
Do you have trouble sleeping?       Yes         Do you drink more than 2 alcoholic beverages per day?       Yes         Do you take pain medication or opiates on a regular basis?       Yes         Do you have memory problems?       Yes         Do you take medication for depression or anxiety?       Yes	Have you ever been diagnosed wi	h ADD/ADHD?		Yes		
Do you drink more than 2 alcoholic beverages per day?       Yes         Do you take pain medication or opiates on a regular basis?       Yes         Do you have memory problems?       Yes         Do you take medication for depression or anxiety?       Yes	Have you ever been diagnosed wi	h bipolar disorder?		Yes		
Do you take pain medication or opiates on a regular basis? Do you have memory problems? Do you take medication for depression or anxiety? Yes	Do you have trouble sleeping?			Yes		$\land$
Do you have memory problems?       Yes         Do you take medication for depression or anxiety?       Yes	Do you drink more than 2 alcoholic	e beverages per day?		Yes		$\land$
Do you take medication for depression or anxiety?	Do you take pain medication or opi	ates on a regular basis?		Yes		$\land$
Do you take medication for depression or anxiety?	Do you have memory problems?			Yes		
nPortsHealth@yahoo.com 715-395-0927 TwinPortsHealth.co	, , , ,	sion or anxiety?		Yes		Ν
	nPortsHealth@yahoo.com	715-395-0927	Т	winPorts	Healt	h.cor

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### CLIENT INTAKE FORM

MEDICATION OR SUPPLEMENTS	DOSE	FREQUENCY	COMMENTS

### Please provide a list of all medications or supplements you take:

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the practitioner of any changes to my medical history or skincare routine. I agree to waive all liabilities of the practitioner or employer for any injury or damages incurred due to misrepresentation of my health history.

Please note that if you contact our provider it may take up to 7-10 business days for her to get back to you for non emergency.



### WEIGHTLOSS AND HORMONE REPLACEMENT THERAPY



# POLICY FORM Cancellation

At Twin Ports Wellness and Aesthetics, we strive to provide an exceptional standard of care. We request your cooperation in adhering to our cancellation policy to achieve this.

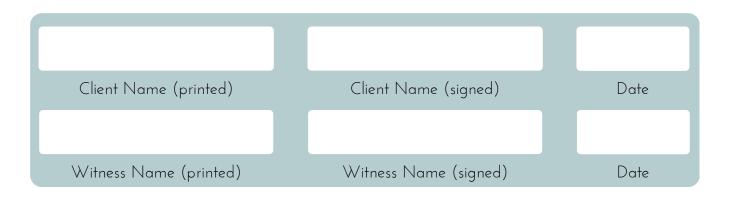
We understand that life can be unpredictable, and unexpected circumstances may arise. However, please provide us with at least 24 hours' notice if you need to cancel or reschedule your appointment. Your deposit will be refunded or applied to a new appointment.

Cancellations made within 24 hours of the scheduled appointment time are subject to a \$50 cancellation fee.

While we understand that unforeseen circumstances can occur, a missed appointment where no notice is given affects our ability to serve other clients and results in lost time and resources. The total cost of the service is charged for these appointments.

We value your time as well as the time of our other clients. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your session or shorten the treatment duration. The total price of the initially scheduled appointment will still apply.

We truly appreciate your understanding and cooperation in honoring our cancellation policy to ensure each client receives the attention and quality service they deserve.





#### FEMALE PELLET INSERTION CONSENT FORM

My physician/practitioner has recommended bioidentical hormone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low hormone levels. The following information has been explained to me prior to receiving the recommended therapy.

#### OVERVIEW

Bioidentical hormones are hormones that are biologically identical to those made in my own body. The levels of active estradiol and/or testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced hormones. The pellets are a delivery mechanism for estradiol and/or testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930s. There are other formulations of estradiol and testosterone replacement available, and different methods can be used to deliver the therapy. There are no commercially available forms of testosterone, however, that are formulated specifically for use in women. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

#### PELLET ACTIVE INGREDIENTS

I understand that (please initial by the appropriate statement):

- I am receiving pellets today that contain testosterone only.
- I am receiving pellets today that contain estradiol and testosterone.
- I am receiving pellets today that contain testosterone and anastrozole.

#### **RISKS/COMPLICATIONS OF TESTOSTERONE**

Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion, which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.

Some individuals may experience one or more of the following complications with testosterone: acne, abnormal bleeding or a change in menstrual cycle (if patient has a uterus), anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid, and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or female pattern baldness, hypersexuality (overactive libido) or decreased libido, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

If you are planning to start or expand your family soon, please talk to your provider about other options.

#### RISKS/COMPLICATIONS OF ESTRADIOL

#### (ONLY APPLICABLE IF RECEIVING ESTRADIOL IN THE PELLETS)

The side-effects of estradiol are similar to those listed above for testosterone. Additionally, there is some risk, even when using bioidentical hormones, that estrogens may cause existing cases of some breast cancers to grow more rapidly. This risk may also apply to some undiagnosed forms of breast cancer. Using estrogen alone (without progesterone) may increase the chance of getting cancer of the uterus. Endometrial sampling (biopsy) or surgery may be required if abnormal bleeding occurs.

Please initial if you are postmenopausal, have a uterus, and are getting estradiol.

I understand that I have a uterus and am receiving postmenopausal dosing of estradiol. I agree to take progesterone as directed by my healthcare provider while receiving estradiol.

### RISKS/COMPLICATIONS OF ANASTROZOLE (ONLY APPLICABLE IF RECEIVING ANASTROZOLE IN THE PELLETS)

Anastrozole is a type of medication called an aromatase inhibitor. Aromatase inhibitors limit or prevent the conversion of testosterone into estrogen. Aromatase inhibitors can be used for a variety of conditions but are most commonly used in patients with a history of estrogen receptor positive breast cancer.

Anastrozole should not be used in pregnant women and should be used with caution in women with pre-existing ischemic heart disease. Anastrozole in pellets should not be given to premenopausal women nor to women taking oral aromatase inhibitors (anastrozole or letrozole) or selective estrogen receptor modulators (tamoxifen or raloxifene).

The amount of anastrozole used in pellets is very low. The most common side-effects for women taking anastrozole are hot flashes, joint pain, and muscle pain. Because of the low dose in the pellet, these effects are not usually seen with this type of therapy, however.

#### CONSENT FOR TREATMENT:

I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits.

I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered. I understand that follow-up blood testing will be necessary four (4) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.

I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets.

I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

I have read or have had this form read to me.

Client Name (printed) Client Name (signed) Date Witness Name (printed) Witness Name (signed) Date TwinPortsHealth@yahoo.com 715-395-0928 TwinPortsHealth.com



### **HIPAA** Information and Consent Form

Name:

\_\_\_\_\_Date of Birth\_\_\_\_\_

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

The following policies are what we have adopted here at our office:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

#### I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print Name

Signature\_\_\_\_ Date

TwinPortsHealth@yahoo.com

TwinPortsHealth.com



### Hormone Replacement acknowledgment and Insurance Disclaimer

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, injections, Laser or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New patient initial pellet insertion fee	\$800.00
Female hormone re-pellet insertion fee	\$500.00





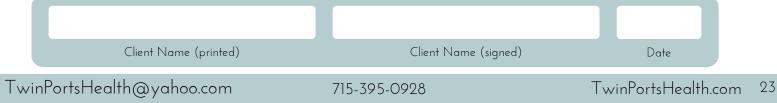
### Post Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It must be removed as soon as it gets wet. The inner layer (usually a steri-strip) should be removed in 3 days.
- Do not take tub baths or get into a hot tub or swimming pool for 3-4 days. You may shower, but do not remove the bandage or steri-strips for 4 days.
- No heavy lifting or major exercises for the incision area for the next 3-4 days, which includes running, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief (25 to 50 mg orally every 6 hours). Caution: this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks. If the redness worsens after the first 2-3 days, please contact the office.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.
- We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.

### **REMINDERS**:

- Remember to have your post-insertion blood work done 6 weeks after your FIRST insertion. If you are not feeling any better by 4 weeks, however, please call the office to have your labs drawn early.
- Most women will need re-insertion of their pellets 3-4 months after their initial insertion. If you experience symptoms prior to this, please call the office.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

#### I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM





### What Might Occur After A Pellet Insertion (Female)

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

#### • INFECTION:

Is possible with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.

#### • PELLET EXTRUSION:

Pellet extrusion is uncommon and occurs in <5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.

#### • ITCHING or REDNESS:

Itching or redness in the area of the incision and pellet placement is common. If you have a reaction to the tape, please apply hydrocortisone 2-3 times per day to the rash. If redness becomes firm or starts to spread after the first few days, you will need to contact the office.

#### • FLUID RETENTION/WEIGHT GAIN:

Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

#### • SWELLING of the HANDS & FEET:

This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, or by taking a mild diuretic, which the office can prescribe.

#### BREAST TENDERNESS or SWELLING:

This usually occurs most commonly in the first round of pellets but does not usually continue thereafter. DIM 1 capsule daily is helpful in preventing this, but the dose may be increased to 2-3 daily, if needed. Evening primrose oil (available in our office) is helpful as is lodine+ if this occurs.

#### • MOOD SWINGS/IRRITABILITY/ANXIETY:

These may occur if you were quite deficient in hormones. These symptoms usually improve as hormone levels improve. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

#### • ELEVATED RED CELL COUNT (most common in men):

Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition is called erythrocytosis. Erythrocytosis may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased.

#### • HAIR LOSS:

Is rarely due to pellets but can occur in some patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases. Workup for other causes may also be needed.

#### • FACIAL BREAKOUT:

Some pimples may arise if the testosterone levels are either too low or rise rapidly. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

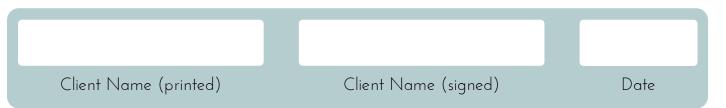
#### • UTERINE SPOTTING/BLEEDING/ IRREGULAR PERIODS:

This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem.

#### • HAIR GROWTH:

Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. Fine, vellous hairs or "peach fuzz" often occurs but is not thick nor coarse. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem

#### I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM



TwinPortsHealth@yahoo.com



### Female Letter of Necessity

Name	Date		
Date of Birth	Diagnosis: ICD10		

To whom it may concern:

Pellets are derived from natural plant-based ingredients. They are formulated in specialized 503B compounding pharmacies and possess the exact hormonal structure of the human hormone testosterone. These pellets, once implanted, secrete hormones in tiny amounts into the bloodstream constantly. No other form of testosterone delivery, whether injections, gels, sprays, creams, or patches can produce the consistent blood level of testosterone that pellets can. Pellet therapy is the only method of testosterone therapy that gives sustained and consistent testosterone levels throughout the day, for 4 to 6 months, without a "roller coaster" effect. Other forms of testosterone therapy simply cannot deliver such steady hormone levels.

The dosages are individualized by the physician or practitioner for the patient taking into consideration her current and past medical history as well as prior experience with other forms of therapy, current medications, etc. No other form of therapy has unique dosages which can be tailored to each individual patient to suit her special needs.

The above patient was seen in my office and was diagnosed with:

Testosterone deficiency syndrome and/or

His lab values and symptoms are consistent with this diagnosis. Prior to pellet therapy, the patient experienced symptoms such as:

Menopause

Decreased li	bido 🚺 L	_ack of menta	clarity	Joint pain	Lethargy	Decre	eased energy	Mood swings
Anxiety	Poor me	emory	Other:					

Pellet therapy helps to alleviate these symptoms and helps improve his quality of life both physically and mentally and has benefited his overall well-being. Please honor her request for reimbursment.

Sincerely,

Gina Luna, CNP, NP-C, AANP

### WEIGHT LOSS AND HORMONE REPLACEMENT THERAPY



# R E L E A S E F O R M Photo & Video

grant and authorize

the right to take, edit, alter, use and publish photographs and/or videos of me for the purpose of promotional materials, including but not limited to:

- Print advertisements
- Online marketing (websites, social media, blogs)
- Educational materials (brochures, flyers, presentations)

I acknowledge that all photographs and/or videos taken are the property of Twin Ports Wellness and Aesthetics and will be used solely for the purposes stated above.

I understand that by signing this release form, I grant Twin Ports Wellness and Aesthetics permission to take, edit, alter, use and publish my photographs and/or videos without any further compensation or consideration. I waive any rights to compensation, financial or otherwise, for the use of these photographs and/or videos.

i release Twin Ports Wellness and Aesthetics, its representatives, and employees from any claims, damages or liabilities that may arise from the use of the photographs and/or videos, including any claims for compensation, defamation, or invasion of privacy.

By signing below, I acknowledge that I have read this release form, understand its content, and voluntarily agree to its terms.



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TwinPortsHealth@yahoo.com