New Patient Check List

Please complete each item below and initial where indicated before your first appointment.

☐ **1.** I have completed the New Patient Demographic information forms, including the HIPAA notice of privacy practices.

☐ **2.** I have reviewed the Concierge Medical Practice Sheet, distinguishing the Gold (Medicare as primary insurance) and Silver plan (private pay) and agree to pay the appropriate semi-annual retainer fee at the conclusion of my first appointment.

- ☐ I chose the Gold Concierge plan.
- ☐ I chose the Silver Concierge plan.

Concierge Fee Payment is due at the end of the first clinical appointment.

☐ **3.** I have completed the Clinical packet, titled Osteopathic Manipulative Questionnaire, to the best of my abilities and knowledge.

☐ **4.** I agree to call the office and leave a message at 707-829-5455 confirming my initial appointment 72 hours prior to my scheduled appointment time. If the office does not receive my confirmation call, I understand the office reserves the right to release my appointment time to another patient. Initial: _____

☐ **5.** I understand that since the doctor is only seeing patients twice a week, I am required to give 48 hours advance notice for cancellations. The charge for a missed or late cancellation of a first appointment is $150.00 or I may not be rescheduled; and for follow-up appointments, the late notice or missed cancellation fee is $95.00. Initial: _____

Signed: _____ **Dated:** _____

WAIT LISTING: Please complete steps 1 and 2 and return the paperwork to our office via email attachments yusuferskinedo@gmail.com or fax 707 824 9235. You will receive confirmation of registration for the wait list.

We truly thank you for taking the time to complete the paperwork and look forward to supporting your health.

New Patient Information

We are committed to the best, most comprehensive care possible. All information is confidential.

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE) | TODAY'S DATE | DATE OF BIRTH | SEX ☐ M ☐ F | AGE

PARENT IF PATIENT IS A MINOR

PATIENT'S SOCIAL SECURITY NUMBER | CALIFORNIA DRIVER'S LICENSE #

HOME ADDRESS | CITY | STATE | 9-DIGIT ZIP

MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | 9-DIGIT ZIP

E-MAIL ADDRESS

HOME TELEPHONE | WORK TELEPHONE | CELL PHONE

OCCUPATION | EMPLOYER'S NAME

SPOUSE'S NAME | EMPLOYER

PRIMARY CARE PHYSICIAN'S NAME | PCP'S TELEPHONE NUMBER

HOW DID YOU HEAR ABOUT US?

☐ Family ☐ Friend ☐ Dr. ☐ Other

PERSON / INSURANCE RESPONSIBLE FOR FEES (ATTACH INSURANCE CARD COPIES)

FOR PRIVATE PAY — PERSON TO BE BILLED:

RELATIONSHIP: ☐ Self ☐ Spouse ☐ Child ☐ Other SOC. SEC. #:

BILLING ADDRESS | CITY | STATE | ZIP | PHONE

FOR INSURANCE RESPONSIBILITY

WERE YOU INJURED ON THE JOB? ☐ Yes ☐ No HAVE YOU INFORMED YOUR EMPLOYER? ☐ Yes ☐ No

WORKER'S COMP CARRIER NAME | ADDRESS | CLAIM # / DATE OF ORIGINAL INJURY

WERE YOU INJURED IN A MOTOR VEHICLE ACCIDENT? ☐ Yes ☐ No

MVA CARRIER NAME | CLAIM # | DATE OF ACCIDENT | STATE WHERE OCCURRED

INSURANCE #1

CLAIM ADDRESS | SUBSCRIBER NAME | * DATE OF BIRTH | SUBSCRIBER ID #

GROUP # | PATIENT'S RELATIONSHIP TO INSURED:

☐ Self ☐ Spouse ☐ Child ☐ Other

Financial Information & HIPAA Acknowledgement

NOTIFY IN CASE OF EMERGENCY

NAME

RELATIONSHIP

ADDRESS

CITY

STATE

ZIP

HOME TELEPHONE

WORK TELEPHONE

NEAREST RELATIVE (NOT LIVING WITH YOU)

RELATIONSHIP

HOME TELEPHONE

WORK TELEPHONE

OFFICE FINANCIAL POLICIES

ANNUAL ADMINISTRATION FEE

Our Practice has established an Annual Administration Fee due at your second visit and annually thereafter on July 1. By signature below, you agree to accept this fee as a condition of being accepted as a patient. It is not billable to/nor reimbursable from any insurance carrier.

PAYMENT POLICY

Professional fees are due in full at the time of service for patients without insurance. Co-payments and deductibles are due at the time of service for insured patients.

MISSED APPOINTMENTS

There is a charge for appointments missed or cancelled without 24 hours notice.

FOR PATIENTS WITH INSURANCE

As a courtesy we will bill insurance carriers for you. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from the patient.

MEDICARE

We are a Non-Participating Medicare provider. We do not accept assignment. You are required to pay the Medicare Limiting Charge at the time of your visit. We will submit your claim to Medicare.

NON-COVERED SERVICES

Any care or services known to be non-covered by your insurance will require payment in full at the time of service or immediately upon denial by your insurance carrier.

AGREEMENT TO FINANCIAL POLICIES

I have read, understand and agree to the above financial policies for the payment of an Annual Administration Fee, and for the payment of professional fees for services rendered.

PATIENT OR AUTHORIZED PERSON:

DATE:

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF INSURANCE BENEFITS

I authorize the release of any medical or other information necessary to process my claims, in compliance with the Family Wellness Medical Center's Notice of Privacy Practices, a copy of which has been provided to me. I hereby authorize payment of medical and/or surgical benefits to J. Yusuf Q. Erskine D.O. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

PATIENT OR AUTHORIZED PERSON:

DATE:

MEDICARE PATIENTS: SIGNATURE ON FILE

I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine payment of benefits payable to related services. I understand that my signature requests that payment be made to the party accepting assignment and authorizes release of medical information necessary to pay the claim. This authorization will remain in effect until revoked by me in writing.

PATIENT'S NAME (PLEASE PRINT):

PATIENT'S SIGNATURE:

PATIENT'S MEDICARE #:

DATE:

HIPAA — Patient Record of Disclosures & Contact Preferences

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided with the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone:**

- ☐ OK to leave message with detailed information with spouse, family member, domestic partner, caregiver, or on answering machine
- ☐ Leave message with call back number only

☐ **Work Telephone:**

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication — Mail to my home address

☐ Written Communication — Mail to my work/office address:

☐ OK to fax to this number:

Please note, it is the patient's responsibility to inform our office of any change of information.

My signature below also acknowledges that I have received the HIPAA Notice of Privacy Practices for Family Wellness Medical Center.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN/PERSONAL REPRESENTATIVE (PLEASE CIRCLE):

PRINT PATIENT'S NAME:

PRINT YOUR NAME:

DATE:

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

DATE	DISCLOSED TO (ADDRESS OR FAX)	AUTHORIZED IN WRITING	DESCRIPTION OF DISCLOSURE	DISCLOSED BY WHOM	REASON	HOW DISCLOSED*

** Fax, Telephone, E-Mail, Mail, or Other*

Concierge Medical Practice Fee Schedule — July–December 2026

OSTEOPATHIC NEUROMUSCULOSKELETAL MEDICINE: O.N.M – O.M.T.

I. CONCIERGE GOLD (MEDICARE)

A. Semi-Annual Retainer Fee is due by 7-15-2026: $475.00

B. Primarily for patients with Medicare insurance. We will bill Medicare; you are responsible for your co-pays, deductibles, and any other charges that Medicare deems you are responsible for.

C. If credit or debit card is used for payment, a 3.5% service charge by Square will be applied.

II. CONCIERGE SILVER (PRIVATE PAY)

A. For patients who do not have Medicare, we will provide you with a super-bill and supporting documentation for you to submit for reimbursement from your insurance company and to consider for federal tax filing individual health cost deductions if you itemize.

B. Semi-Annual Retainer Fee due by 7-15-2026: $200.00

C. Payment is expected at the time of visit. Please note, if a service charge is applied to your payment method, such as Square, for credit or debit card, that will be your responsibility.

D. Fee for appointments are based on length and complexity of visit and # of body regions treated.
Established follow up visit: $309–$359
New patient first visit: $459–$499

HOMEOPATHIC MEDICAL CARE

A. The Fee schedule is based on whether appointment type is ACUTE, RETURNING, or CONSTITUTIONAL and the length of visit.

B. Payment is expected at the time of visit. Not billed to insurances.

C. Follow up visits are $325. There is an additional charge for remedies.

PLEASE INDICATE YOUR CONCIERGE PLAN CHOICE:

☐ I chose the Gold Concierge plan (Medicare)

☐ I chose the Silver Concierge plan (Private Pay)

Osteopathic Manipulative Medicine Questionnaire

To be completed by patient — please print clearly.

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE QUESTIONNAIRE COMPLETED | DATE OF FIRST APPOINTMENT

AGE | SEX ☐ Female ☐ Male ☐ Transgender

PRIMARY CARE PHYSICIAN

NAME | PHONE

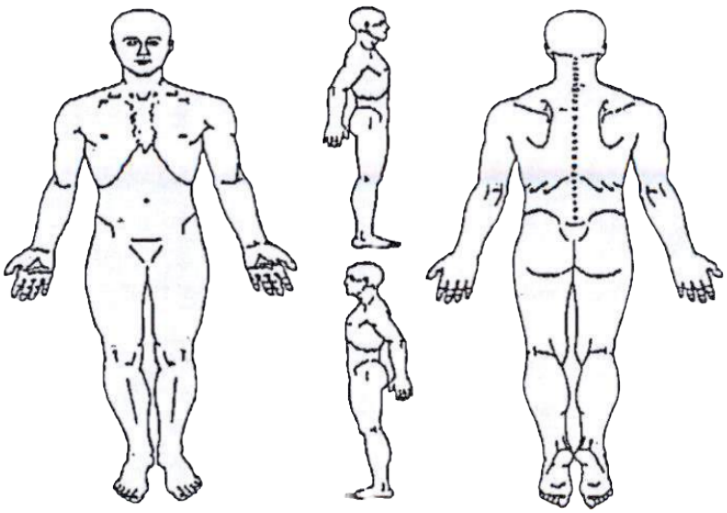
ADDRESS

WHEN WAS YOUR LAST COMPLETE CHECK-UP / PHYSICAL?

PAIN LOCATION & CHARACTER

Mark the areas on your body where you now feel pain. Include all affected areas and use the codes below:

ACHE >>>> **BURNING xxxx** **NUMBNESS ....** **PINS & NEEDLES oooo** **STABBING ////**



HOW BAD IS YOUR PAIN? (0 = NO PAIN, 10 = WORST IMAGINABLE)

No pain **10 (Worst)**

0 1 2 3 4 5 6 7 8 9 10

MY CURRENT PAIN LEVEL (circle or mark on scale above):

History of Onset

WHY WOULD YOU LIKE TO BE SEEN?

DO YOU HAVE PAIN? ☐ No ☐ Yes

IF YES, WHAT TYPE OF PAIN?

WHEN DID THIS EPISODE OF PAIN BEGIN?

HOW DID THE CURRENT EPISODE OF PAIN OCCUR?

- ☐ Gradual onset
- ☐ Twisting
- ☐ Pushing/Pulling
- ☐ Bending
- ☐ Direct blow
- ☐ Lifting
- ☐ Vehicle accident
- ☐ Recreational accident
- ☐ Fall
- ☐ On-the-job injury
- ☐ No known cause
- ☐ Other
- ☐ Non-work related incident

IF YOUR PAIN IS THE RESULT OF AN INJURY, PLEASE DESCRIBE THE INCIDENT AND DATE:

HAVE YOU HAD PREVIOUS EPISODES OF THIS PAIN? ☐ No ☐ Yes

IF YES, HOW LONG AGO WAS YOUR FIRST EPISODE OF THIS PAIN?

HOW MANY PREVIOUS EPISODES IN THE LAST TWO YEARS?

HAVE YOU PREVIOUSLY BEEN OFF WORK DUE TO PAIN? ☐ No ☐ Yes

IF YES, HOW MANY DAYS MISSED DUE TO PAIN IN LAST TWO YEARS?

ARE YOU STILL WORKING? ☐ No ☐ Yes IF YES, OCCUPATION:

DO YOU PLAN TO BE AT YOUR REGULAR JOB IN SIX MONTHS? ☐ No ☐ Yes

DO YOU EXPERIENCE POSITIVE JOB SATISFACTION? ☐ No ☐ Yes

IF OFF WORK, IS YOUR EMPLOYER SUPPORTIVE OF YOUR RETURNING? ☐ No ☐ Yes

PLEASE INDICATE LAST GRADE COMPLETED IN SCHOOL:

Pain Detail & Accident History

ACCIDENTS — PLEASE LIST ANY CAR ACCIDENTS, BAD FALLS, OR WORK/SPORTS INJURIES (SORE 5+ DAYS)

1.
2.
3.
4.
5.

HOW MUCH OF A PROBLEM ARE THESE? (0 = NONE, 10 = SEVERE)

ANXIETY		(0 = None → 10 = Severe)
DEPRESSION		(0 = None → 10 = Severe)
IRRITABILITY		(0 = None → 10 = Severe)
POOR SLEEP		(0 = None → 10 = Severe)

WORST AND BEST TIMES OF DAY FOR PAIN

WORST	BEST
☐ First awakening	☐ First awakening
☐ Morning	☐ Morning
☐ Mid-day	☐ Mid-day
☐ Afternoon	☐ Afternoon
☐ Evening	☐ Evening
☐ Nighttime	☐ Nighttime

WHEN IS PAIN MOST SEVERE?

☐ When sitting	☐ At night	☐ Makes no difference	☐ Bending
☐ When walking	☐ Other	☐ Coughing / sneezing	☐ In the morning

FREQUENCY OF STOPPING ACTIVITIES DUE TO PAIN

- ☐ Occasionally
- ☐ Several times per day
- ☐ Approximately once per day
- ☐ I spend almost all day lying or sitting to control my pain

HOW MUCH OF AN AVERAGE DAY ARE YOU IN PAIN?

- ☐ Less than one hour per day
- ☐ Between 1 and 4 hours per day
- ☐ Between 4 and 8 hours per day
- ☐ Almost any time that I am not lying down
- ☐ Almost 24 hours per day

Pain Severity & Impact on Daily Life

OVERALL PAIN SEVERITY

- ☐ Mild nuisance pain
- ☐ Mild to moderate, but I can live with it
- ☐ Moderate — I am having difficulty dealing with it
- ☐ Severe — it is ruining my quality of life
- ☐ None — I have no pain

SINCE THE PAIN, WHAT DO YOU WORRY ABOUT? (CHECK ALL THAT APPLY)

- ☐ Finances
- ☐ Ability to earn income
- ☐ The pain lasting forever
- ☐ Ability to get to sleep, stay asleep, or tired during day
- ☐ Loss of social & recreational activities
- ☐ Family and children
- ☐ Yet to be identified medical problems
- ☐ Other
- ☐ Sexual desire, interest, or ability
- ☐ Memory and concentration

OTHER WORRIES:

DO YOU HAVE A HOME EXERCISE PROGRAM? ☐ No ☐ Yes

DO YOU EXERCISE DAILY? ☐ No ☐ Yes

RECREATIONAL ACTIVITIES — MARK (X) THOSE YOU CAN NO LONGER DO DUE TO PAIN

☐	☐
☐	☐
☐	☐

PAIN RANKING

a) How would you rank your LEAST pain? (0=None, 10=Severe)

b) How would you rank your WORST pain? (0=None, 10=Severe)

c) What is your pain like TODAY? (0=None, 10=Severe)

ACTIVITIES THAT INCREASE PAIN

1. **2.**

3. **4.**

METHODS OR ACTIVITIES THAT RELIEVE PAIN

1. **2.**

3. **4.**

General Health History

DESCRIBE IN YOUR OWN WORDS ANY PROBLEMS YOU FEEL YOU MAY HAVE BECAUSE OF INJURY OR IMPORTANT INFORMATION TO EXPLAIN YOUR PROBLEM:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

Stomach / intestinal problems	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Weakness in arms / legs	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Difficulty controlling bowel / bladder function	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Sweats at night	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Loss of appetite / change in taste of food	☐ Yes	☐ No

OTHER:

ADDITIONAL MEDICAL QUESTIONS

1. Are you in good health?	☐ Yes	☐ No
2. Have you been losing weight for no reason?	☐ Yes	☐ No
3. Do you worry about your health?	☐ Yes	☐ No
4. Are you on a special diet?	☐ Yes	☐ No
5. Are you afraid to be alone?	☐ Yes	☐ No
6. Do you feel hopeless?	☐ Yes	☐ No
7. Do you get angry easily?	☐ Yes	☐ No
8. In your opinion, have you experienced physical, sexual, verbal, or mental/emotional abuse?	☐ Yes	☐ No

IF YES, COMMENT (OPTIONAL):

MEDICATION ALLERGIES

DO YOU HAVE ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No

IF YES, PLEASE LIST:

DO YOU HAVE ENVIRONMENTAL OR FOOD ALLERGIES? ☐ Yes ☐ No

IF YES, PLEASE LIST:

Current Medications & Personal Habits

CURRENT MEDICATIONS (PRESCRIPTION & NON-PRESCRIPTION) — STAR (*) THOSE TAKEN FOR PAIN

NAME OF MEDICATION	DOSAGE	HOW LONG HAVE YOU TAKEN THIS?

PERSONAL HABITS

DID / DO YOU SMOKE? ☐ Yes ☐ No

HOW MANY PACKS/DAY AND FOR HOW LONG?

IF QUIT — PACKS/DAY: HOW LONG SMOKED: QUIT HOW LONG AGO:

DID / DO YOU DRINK ALCOHOL? ☐ Yes ☐ No

IF YES, HOW MUCH PER DAY?

DO YOU DRINK ALCOHOL TO CONTROL PAIN? ☐ Yes ☐ No

IF QUIT — HOW MUCH/DAY: QUIT HOW LONG AGO:

HOW MANY CUPS OF COFFEE PER DAY?

WHAT TYPE OF DRUGS DO YOU CURRENTLY USE OR HAVE USED IN THE PAST (Marijuana, etc.)?

Functional Abilities, Surgeries & Women's Health

FUNCTION INDEX

Do you require help lifting 30–40 pounds (heavy suitcases or a 3-4 year old child)? ☐ Yes ☐ No

Is your sitting generally limited to less than one-half hour? ☐ Yes ☐ No

Is traveling in a car or bus generally limited to one-half hour? ☐ Yes ☐ No

Is standing in one place generally limited to one-half hour? ☐ Yes ☐ No

Is your walking generally limited to less than one-half hour? ☐ Yes ☐ No

Do you regularly curtail or miss social activities because of your pain? ☐ Yes ☐ No

Does pain interfere with your sexual activity? ☐ Yes ☐ No

Do you often need help with footwear because of pain? ☐ Yes ☐ No

Are you able to do all of your activities of daily living yourself (bathing, dressing, etc.)? ☐ Yes ☐ No

PLEASE LIST THOSE YOU CANNOT PERFORM:

DO YOU PARTICIPATE IN HOUSEWORK (LAUNDRY, COOKING, CLEANING, ETC.)? ☐ Yes ☐ No

IF SO, WHAT CHORES?

PRIOR SURGERIES

PROCEDURE	DATE

FRACTURES / BROKEN BONES: ☐ Yes ☐ No

IF YES, WHICH BONES AND DATES OF INJURY:

WOMEN ONLY — MENSTRUAL CYCLE & REPRODUCTIVE HEALTH

AGE AT ONSET: REGULAR: ☐ Yes ☐ No ☐ Rarely

CYCLE (START TO START): DURATION: days

PAIN OR CRAMPS: ☐ Yes ☐ No DATE OF LAST PERIOD:

NUMBER OF PREGNANCIES: COMPLICATIONS? ☐ Yes ☐ No

IF YES, WHAT?

DID YOU HAVE BACK PAIN WITH PREGNANCY? ☐ Yes ☐ No

DOES IT HURT TO HAVE INTERCOURSE? ☐ Yes ☐ No

DO YOU ENJOY YOUR SEX LIFE? ☐ Yes ☐ No

Family Health History & Prior Treatment

FAMILY HEALTH HISTORY — NOTE RELATIONSHIP TO YOU

CONDITION		CONDITION	
Obesity (overweight)		Seizures (fits, Epilepsy)	
High Blood Pressure		Anemia (low blood)	
Heart Trouble		Bleeding Problems	
Stroke		Rheumatic Fever	
Asthma or Hayfever		Alcoholism	
Allergies		Mental Illness	
Diabetes (sugar)		Physical Deformity	
Ulcers		Blind / Deaf	
Stomach/Bowel Problems		Mental Retardation	
Gout		Hereditary Problem	
Kidney Disease		Death by Accident	
Arthritis		Other (not mentioned)	

TREATMENT HISTORY — PHYSICIANS AND/OR CHIROPRACTORS SEEN FOR PAIN

TYPE OF DOCTOR	DOCTOR'S NAME	LOCATION	APPROXIMATE DATE(S)

HAVE YOU BEEN SATISFIED WITH PREVIOUS MEDICAL CARE? ☐ Yes ☐ No

IF NO, COMMENT (OPTIONAL):

Prior Treatment Effectiveness

A. Put a check next to each type of treatment you have had for your back/neck or pain problem in the past.
B. Check the column that best describes the effect of the treatment. Circle the time to improvement.

TREATMENT	CHECK IF HAD THIS	HELPED	MADE THINGS WORSE	DIDN'T DO MUCH	TIME TO IMPROVEMENT (MONTHS)
Stretching Exercises	☐	☐	☐	☐	
Hot Packs	☐	☐	☐	☐	
Ultrasound	☐	☐	☐	☐	
Ice	☐	☐	☐	☐	
Massage	☐	☐	☐	☐	
Electrical stimulation during physical therapy	☐	☐	☐	☐	
TENS unit for home use	☐	☐	☐	☐	
Body mechanics training	☐	☐	☐	☐	
Strengthening exercises	☐	☐	☐	☐	
Aerobics (e.g., exercise bike)	☐	☐	☐	☐	
Gravity inversion	☐	☐	☐	☐	
Traction	☐	☐	☐	☐	
Bed rest	☐	☐	☐	☐	
Chiropractic treatment	☐	☐	☐	☐	
Osteopathic manipulation	☐	☐	☐	☐	
Biofeedback	☐	☐	☐	☐	
Local (trigger point) injections	☐	☐	☐	☐	
Epidural injections	☐	☐	☐	☐	
Facet joint injections	☐	☐	☐	☐	
Soft back brace	☐	☐	☐	☐	
Rigid back brace	☐	☐	☐	☐	
Acupuncture	☐	☐	☐	☐	
Anti-inflammatory medication	☐	☐	☐	☐	
Narcotic pain medication	☐	☐	☐	☐	
Muscle relaxant medication	☐	☐	☐	☐	
Anti-depressant medication	☐	☐	☐	☐	
Surgery	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

Diagnostic Tests & Case Information

DIAGNOSTIC TESTS — BACK / NECK (CHECK IF DONE, INCLUDE APPROXIMATE DATE)

Regular Spine X-rays	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	
CT Scan	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	
Myelogram	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	
MRI Scan	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	
Discogram	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	
Bone Scan	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	
EMG	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	
Nerve Block	☐ Yes	☐ No	APPROX. DATE:		RESULTS:	

TO ENSURE PAPERWORK IS FILLED OUT CORRECTLY, PLEASE CHECK IF APPROPRIATE

- ☐ Motor vehicle accident
- ☐ Worker's compensation case
- ☐ Receiving disability income
- ☐ Legal proceeding pending
- ☐ Report should be sent to referring physician or family physician
- ☐ Report should be sent to another party:

NAME:

ADDRESS:

PHONE:

Underlying Metabolic Screening Questionnaire

SYMPTOMS — MEN AND WOMEN

- Dry/Coarse skin ☐ Y ☐ N
- Hair loss ☐ Y ☐ N
- Constipation ☐ Y ☐ N
- Muscle cramps ☐ Y ☐ N
- Cold extremities or intolerance to cold ☐ Y ☐ N
- Fatigue or decreased energy ☐ Y ☐ N
- Easy bruising ☐ Y ☐ N

WOMEN ONLY:

- Irregular periods ☐ Y ☐ N
- Weight gain ☐ Y ☐ N

SEXUAL HEALTH & HORMONAL SYMPTOMS

MEN:

- Decreased sense of well being ☐ Y ☐ N
- Decreased libido (sex drive) ☐ Y ☐ N
- Fatigue/low energy (chronic fatigue) ☐ Y ☐ N
- Decreased firmness of erection or trouble maintaining an erection ☐ Y ☐ N
- Decreased frequency of erection ☐ Y ☐ N

WOMEN:

- Decreased sensitivity of sex organs ☐ Y ☐ N
- Decreased intensity of orgasm ☐ Y ☐ N
- Loss of muscle strength/muscle mass ☐ Y ☐ N
- Increased fat around the waist ☐ Y ☐ N
- Decreased mental sharpness/indecisive ☐ Y ☐ N
- Decreased concentration ☐ Y ☐ N
- Heart palpitations ☐ Y ☐ N
- Excess day/night sweats ☐ Y ☐ N
- Decreased facial/body hair growth ☐ Y ☐ N

WOMEN ONLY — HORMONAL SYMPTOMS

- Headaches during menstrual flow ☐ Y ☐ N
- Loss of sexual desire ☐ Y ☐ N
- Depressed or negative attitude ☐ Y ☐ N
- Anxiety ☐ Y ☐ N
- Loss of memory/forgetfulness ☐ Y ☐ N
- Decreased energy ☐ Y ☐ N
- Loss of scalp hair ☐ Y ☐ N
- Shrunken or drooping breasts ☐ Y ☐ N
- Heart racing or pounding around ovulation or at time period starts ☐ Y ☐ N
- Insomnia ☐ Y ☐ N
- Irritable ☐ Y ☐ N

WOMEN ONLY — REPRODUCTIVE SYMPTOMS

- Bloating/Fluid retention ☐ Y ☐ N
- Headaches prior to menstrual period ☐ Y ☐ N
- Low fertility/difficulty getting pregnant ☐ Y ☐ N
- Heavy menstrual periods ☐ Y ☐ N
- Breast lumps ☐ Y ☐ N
- History of spontaneous abortions ☐ Y ☐ N