Crossroads Healing Arts
Medicine Naturally

1004 Parkway Avenue, Suite C
Elkhart, IN 46516
Phone: 574-294-1883
Fax: 574-295-1749
www.crossroadshealingarts.com

Hello and Welcome to Crossroads Healing Arts!

Enclosed you will find all of your paperwork for your first visit. Please complete the forms in full, sign and bring with you to your appointment. Please also bring your insurance cards.

It is very important that we have correct information on the medications that you are currently taking. Please bring with you all of your current medications and supplements to your appointment.

If you have had any recent lab work done (past 12 months), it would be helpful for you to bring these copies with you so that we do not duplicate any testing.

If you are female and your visit is regarding possible hormone related issues, we ask for a copy of your recent pap and mammogram prior to prescribing hormone therapy.

Please contact the ordering physician to obtain copies of your previous lab and test results prior to your visit, this would most certainly expedite your treatment. Please bring these with you or ask that they are faxed to us at 574-295-1749 prior to your appointment.

Please note; we do not file any insurance. However, we will give you all the necessary information for you to submit an insurance claim on your behalf.

Finally, if you could arrive here 10-15 minutes early prior to your appointment, that will give our staff a little extra time to get all of your paper work processed.

We look forward to meeting you very soon!

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Patient Registration

Patient: _____ _____ _____
Legal First Name | Middle Initial | Last Name

Nick Name: _____ **Birthdate:** _____ **Sex: Male Female**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell:** _____ **SS#:** _____

Preferred # to contact you (please circle one): Home Cell Other: _____

Preferred way for appointment reminders (please circle one): Voicemail Text Email

Marital Status: S M D W **Email Address:** _____
(To receive notice of upcoming seminars from our office)

Employer: _____ **Address:** _____ **Phone:** _____

Spouse/Parent: _____ **Living in Household? Yes No**

Employer: _____ **Address:** _____ **Phone:** _____

Responsible Party: _____ **Address:** _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Office Policy

Crossroads Healing Arts does not file any insurance claims. A copy of your itemized bill will be given at the time of service so that you can file with your insurance company if you so desire. We are not a member of any PPO or HMO network, insurance program, Medicare or Medicaid. If you have any questions about coverage, please contact your insurance company for specific details. Payment is expected at the time of service regardless of your insurance coverage. We do accept Discover, MasterCard and VISA, check or cash.

I understand and agree to the above office policies and the above information I have provided is correct and true to the best of my knowledge. I authorize the release of medical information to my insurance carrier should I decide to file charges incurred.

Patient Signature: _____ **Date:** _____

Parent Signature (If Patient is a Minor): _____ **Date:** _____

How did you hear about our clinic? TV Radio Referral Friend Other: _____

Patient Name: _____ **DATE OF BIRTH:** _____

Allergies (to medications, latex, testing dyes, state "none" if none are known):

_____

Concern (Please rank by priority)	**Onset**	**Frequency**	**Severity**
Example: Headaches			
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

What do you hope to achieve with Integrative and Functional Medicine?

_____

_____

Past Medical History:

Examples: High blood pressure, high cholesterol, thyroid dysfunction, asthma, headaches, IBS, depression, obesity

1. _____ **2.** _____
3 _____ **4.** _____
5. _____ **6.** _____
7. _____ **8.** _____
9. _____ **10.** _____

Past Surgical History:

Type of surgery:	Example: Jan. 2000 Date of surgery:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Major Injuries:

Example: Car accident-head injury 2000

Type of injury:	Date of injury:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

FAMILY HISTORY:

Relationship	**Living**	**Deceased** (age of death)	**Cause of death**	**Medical problems**
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Children				
Children				
Children				
Children				

Patient Name: _____ **DATE OF BIRTH:** _____

Personal Background:

1. Do you feel that your health has gotten worse over the past two years? No ___ Yes ___
2. Have you lost or gained more than 10 percent of your body weight over the past five years, even though you were not intentionally dieting? No ___ Yes ___
3. Do you have trouble going to sleep or staying asleep? No ___ Yes ___
4. Does pain in your joints or muscles limit your physical activity or mobility? No ___ Yes ___
5. Do you commonly feel fatigued for no apparent reason? No ___ Yes ___
6. Are you frequently depressed or anxious? No ___ Yes ___
7. Do you have problems with memory? No ___ Yes ___
8. Is there a consistent ringing in your ears? No ___ Yes ___
9. Do you feel that you are losing your strength? No ___ Yes ___
10. Do you take more than two prescription medications? No ___ Yes ___
11. How about over-the-counter medications? Do you commonly take any of these?
    a. Anti-inflammatories No ___ Yes ___
    b. Antacids No ___ Yes ___
    c. Analgesics No ___ Yes ___
    d. Sleeping remedies No ___ Yes ___
12. Do you suffer from allergies? No ___ Yes ___
13. Do you occasionally have episodes of poor concentration or confusion? No ___ Yes ___
14. Do you commonly suffer from shortness of breath or feel winded? No ___ Yes ___
15. Have you lost any of your sense of taste or smell over the past few years? No ___ Yes ___
16. Do you feel you have lost significant amount of muscle mass over the past few years? No ___ Yes ___
17. Have you heard from a doctor that you have any of the following?
    a. Elevated blood pressure No ___ Yes ___
    b. Elevated blood cholesterol No ___ Yes ___
    c. Elevated blood glucose No ___ Yes ___
18. Has your dentist told you that you have gum or periodontal disease? No ___ Yes ___
19. Do you frequently alternate constipation and diarrhea or feel pain or discomfort in your digestive area? No ___ Yes ___
20. Have you been told that you have chronic bad breath? No ___ Yes ___
21. Are you shorter than you used to be, or have you any evidence of calcium deposits? No ___ Yes ___
22. Do you catch every cold and flu that's going around? No ___ Yes ___

Patient Name: _____ **DATE OF BIRTH:** _____

Social History:

Occupation: _____

Single: _____ Married: _____ Widowed: _____ Divorced: _____

Current tobacco use: No _____ Yes _____, packs per day _____ number of years _____

History of tobacco use: No _____ Yes _____, packs per day _____ number of years _____

Current drug abuse (alcohol, marijuana, cocaine, heroin, etc): _____

History of drug abuse (alcohol, marijuana, cocaine, heroin, etc:

Diet History:

How many cups of coffee do you drink daily? _____

How many cups of caffeinated tea do you drink daily? _____

How many sodas do you drink daily? _____

How much alcohol do you drink daily? _____

How often do you eat processed food? _____

How much water do you drink a day? _____

REVIEW OF SYMPTOMS (Check all that apply to you currently or in recent past):

Constitutional:

☐ Fevers ☐ Chills ☐ Weight Loss

Ears, Nose, Mouth, Throat:

☐ Earache ☐ Ringing in ears ☐ Difficulty hearing ☐ Sinusitis ☐ Sore throats

Respiratory:

☐ Cough ☐ Sputum production ☐ Coughing up blood

Gastrointestinal:

☐ Nausea or vomiting ☐ Diarrhea ☐ Constipation ☐ Liver problems

Genitourinary:

☐ Burning with urination ☐ Frequent urinary infections ☐ Prostate problems

☐ Blood in urine ☐ Urinary incontinence (inability to hold urine)

Musculskeletal:

☐ Arthritis ☐ Muscle cramps

Neurological:

☐ Seizures ☐ Fainting spells ☐ Loss of consciousness

Skin:

☐ Rashes ☐ Skin ulcers

Emothional/Psychiatric:

☐ Depression ☐ Anxiety ☐ Psychiatric Problems

Endocrine:

☐ Enlarges thyroid ☐ Sweating ☐ Diabetes ☐ Feeling unusually hot or cold

Hematological/Lymphatic Oncologic:

☐ Anemia ☐ Iron deficiency ☐ Cancer

Allergic/Immunologic:

☐ Hay fever ☐ Seasonal Allergies

Patient Name: _____ **DATE OF BIRTH:** _____

Toxin Exposure:

History of root canal(s)? No ____ Yes ____ How many? _____
History of amalgam (silver) fillings? No ____ Yes ____
History of smoking, welding, working with batteries, synthetic rubber or plastics? No ____ Yes ____
How many times a week do you eat restaurant food? _____
History of exposure to pesticides or fungicides? No ____ Yes ____
History of jewelry making with wire or metal? No ____ Yes ____ Metal type? _____
Have you ever lived on a farm or farmed? No ____ Yes ____
Do you buy organic produce? No ____ Yes ____ If no, do you wash your produce? No ____ Yes ____
Do you live near an industrial area (power plant, paper mill, coal plant) or have worked in a factory? No ____ Yes ____
Are there any chemicals that you have been exposed to in your life? _____

Symptoms of Adrenal Fatigue:

Do you feel tired when you first wake up in the morning? No ____ Yes ____
Do you feel tired in the afternoon between 2:00 to 4:30 PM? No ____ Yes ____
Do you take naps? No ____ Yes ____

Symptoms of Low Thyroid:

Do you feel cold or do you have a low body temperature? No ____ Yes ____
Do you have cold hands or feet? No ____ Yes ____
Do you have constipation or do you take something to help you have regular bowel movements? No ____ Yes ____
Do you have dry hair, brittle hair, hair that breaks easily? No ____ Yes ____
Do you have hair loss on head, body or lateral eyebrows? No ____ Yes ____
Do you have dry skin, eczema, or puffiness around eyes? No ____ Yes ____
Do you have a history of thyroid problems? No ____ Yes ____
Are you on thyroid medication now? No ____ Yes ____ Name of medication _____ Dose ____
Do you have a family history of thyroid problems? No ____ Yes ____

Patient Name: _____ **DATE OF BIRTH:** _____

Symptoms of Hormonal Imbalance (Women Only):

When was your last menstrual period? _____ Are your periods regular? _____
When was your last mammogram performed? _____ Where? _____
When was your last pap performed? _____ Where? _____

*** To expedite your treatment, please bring a copy of your last mammogram and pap/pelvic results to your appointment.**

Symptoms of Low Estrogen (Women Only):

Do you have any hot flashes or night sweats? No ____ Yes _____
Do you have foggy brain or inability to think clearly? No ____ Yes ____
Do you have sleep disturbance (either inability to fall asleep or stay asleep)? No ____ Yes ____
Do you feel tearful easily? No ____ Yes ____
Do you have vaginal dryness? No ____ Yes ____
Do you have urinary incontinence (inability to hold your urine)? No ____ Yes ____
Do you have frequent bladder infections? No ____ Yes ____

Symptoms of Low Progesterone (Women Only):

Do you have heavy bleeding or uterine fibroids? No ____ Yes ____
Do you have breast tenderness? No ____ Yes ____
Do you have weight gain around the middle? No ____ Yes ____
Do you have water retention (swollen, ankles, legs, fingers, or face)? No ____ Yes ____
Have you had any miscarriages? No ____ Yes ____
Have you had problems with infertility? No ____ Yes ____
Do you have fibrocystic breasts (many small lumps that can be felt)? No ____ Yes ____
Do you have anxiousness, irritability or foggy brain? No ____ Yes ____
Do you have insomnia? No ____ Yes ____

Symptoms of Low Testosterone (Men Only):

Do you have morning erections? No ____ Yes ____
Do you have a noticeable decrease in muscle mass? No ____ Yes ____
Do you have decreased sex drive? No ____ Yes ____
Do you have decreased quality of erection or decreased sexual performance? No ____ Yes ____
Do you have decrease mental ability, decrease memory, or foggy brain? No ____ Yes ____
Do you have decreased stamina for exercise or sexual activity? No ____ Yes ____
Do you have low motivation or depression? No ____ Yes ____
Do you wake up at night to urinate? No ____ Yes ____
Have you ever had an elevated PSA or prostate cancer? No ____ Yes ____

_____ _____

Patient/Guardian Signature **Date**

Crossroads Healing Arts

Patient Supplement List

Patient Name: ______________________________ Date of Birth: ________________

Date	Supplement	Directions	Reason for Use

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Dear Patients and Friends,

The Providers of Crossroads Healing Arts are always striving to bring you the best in preventive care. Therefore, we would like to remind you that certain health examinations and screenings are recommended on a regular basis. Review the recommendations below and then speak to your provider about which ones are right for you.

RECOMMENDED PERIODIC HEALTH EXAMINATIONS FOR ADULTS:

AGE	RECOMMENDED SCREENING	FREQUENCY
Men and Women		
18 years & above	Blood pressure, height, weight	Periodically or as needed.
35 years & above (or earlier if risk factors)	Lipid Profile, Blood Chemistry Profile, Complete Blood Count, & Thyroid Profile	Yearly or more if abnormal or at high risk.
50 years & above	Stool for microscopic blood Sigmoidoscopy or Colonoscopy	Yearly Every 5-10 years
Women		
25 years & above (younger if sexually active)	Pap, Pelvic, Breast exam	Yearly, especially if taking hormones
	Self Breast Exam	Monthly
40 years & above (or at age 35 if strong family history of breast cancer)	Mammogram and/or Thermography	Every 1-2 years Yearly if taking any hormones
45-50 years & above Or earlier if menopausal Or family history	Bone Density measurement	Every 1-2 years
Men		
50 years & above	PSA Blood Test Prostate Exam Bone Density measurement	Yearly Yearly Every 1-2 years

I have read and understand the Preventive Healthcare Recommendations. I will take the appropriate action to make arrangements for the necessary exams. (Note: these are just recommendations, not required. By signing says we have informed you of your options.) Thank You!

Signature: _____ Witness Signature: _____

Printed Name: _____ Printed Name: _____

Date: _____ Date: _____

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Hormone Therapy Consent Form

Natural or Bio-identical Hormone Replacement Therapy is the therapeutic use of hormones that are identical to the hormones made naturally by the body. There are many different types but the ones used predominantly in our clinic include: testosterone, progesterone, estradiol (E2), estriol (E3), DHEA, cortisol, and thyroid. These hormones are typically used to treat symptoms of perimenopause, menopause, andropause (male menopause), thyroid dysfunction and adrenal fatigue, although other symptoms may be treated as well.

The Women's Health Initiative Study (WHI) studied 16,608 postmenopausal women aged 50-79 years old with an intact uterus. The women received either ***Premarin*** (0.625mg), ***Prempro*** (0.625/2.5mg), or placebo daily. These hormones were non-human, no-bioidentical hormones.
Users of *Premarin* and *Prempro* had:

- 41% more strokes (29 HRT VS 30 placebo in 10,000 person years)
- 29% more heart attacks (37 HRT VS 30 placebo in 10,000 person years)
- Twice as many blood clots (34 VS 16 placebo in 10,000 person years)
- 26% more breast cancer (38 VS 30 placebo in 10,000 person years)
- 66% increase in Alzheimer's Dementia (45 HRT VS 22 in 10,000 person years)
- 37% less colorectal cancer (0.63 relative risk reduction)
- 33% fewer hip fractures (0.66 relative risk reduction)

The average age of the study participants was 63 years of age, and on average started hormone therapy 12 years after menopause. Synthetic hormones (Ex. Progestins), and bio-identical hormones such as progesterone have different effects on the body.

Bioidentical hormones can be used and metabolized as our body was designed to do, minimizing side effects. Bio-identical hormone dosages can be fine-tuned to your specific needs. Many European studies suggest that bio-identical hormones are safer than synthetic hormones. However, that doesn't mean that bio-identicals are perfect. We also do not have any large scale, double blinded, placebo controlled trials on bio-identicals.

Relative Contraindications: Personal family history of breast, ovarian or endometrial cancer and a strong family history of breast or ovarian cancer. Close collaboration with an oncologist may be needed in these situations. Unexplained vaginal bleeding may be another contraindication.

Precautions: BHRT does not increase heart disease risk, if given at the proper dosage and ratio. Patients with previous deep vein thrombosis require careful monitoring if they are taking oral estrogen. Women with known heart disease need routine evaluation and annual labs including cholesterol levels and EKG. They will need to be followed up by their primary care physician for this condition.

Baseline hormone levels are ordered at your initial visit. **Women are required to have pap smears (yearly or as indicated per ACOG standards), mammograms/thermograms, and DEXA Scans (as indicated). It is required that you either schedule with our providers to have these done or supply us with a copy of these results for our records. Hormones are not prescribed or renewed unless these records are up to date.**

You will then be given an individualized prescription of BHRT based on your symptoms and test results. Symptom resolution is not immediate. It can take anywhere from 1-6 months until patients feel like they have the perfect fit. There are many different preparations of BHRT (topical creams, sublingual troches, injections, pills, and sublingual drops). Some women respond to one form better than another. Blood tests are measured as needed until stable. When stable, hormone levels are then monitored every 6-12 months depending on the situation.

Patient's bodies and lifestyles change and so do their hormonal needs. Hormones are usually measured via blood and/or saliva samples.

Men on testosterone therapy are required to have their testosterone levels checked at least every three months for the first year and then at least once per year thereafter. Levels may be checked more often depending on response to therapy. If men are under the age of 60, they may require HCG injections on a weekly basis as well. HCG helps the body continue to make its own testosterone and prevent testicular atrophy (shrinkage). The HCG injections are given in our office for the patient to self-administer at home. **Men are also required to have digital rectal exam and PSA levels prior to starting hormone and at least yearly while on treatment.**

Most Bio-identical hormones are made at compounding pharmacies. We send most of our patients to Customized Medications. BHRT may be reimbursed by insurance companies. On request, the pharmacy will provide you with a form that you can fill out and submit to your insurance company for reimbursement. Many women generally use anywhere from one to three hormone preparations. The cost, on average, per hormone is $35-$40 for a 30 day supply. Many times we can combine 2 or 3 hormones into one preparation once we have the correct dose for each of the individual hormones. This will also help keep the cost down. Injectable hormones for women are administered monthly in our office for $45. Male testosterone injections can be called in to regular pharmacies and can be reimbursed by insurance.

An instructional sheet on your Bio-identical hormone therapy will be given to you on any side effects and when to contact the office. **We also require that you have a current primary care physician to manage all your other health needs.**

I understand and agree to the above statements and all my questions have been answered to my satisfaction. I understand all of the risks associated with hormone therapy. I am consenting for bio-identical hormone treatment at Crossroads Healing Arts and have also been given my instructional sheet on side effects and when to contact the office.

Signature: _____ Date: _____

Witness: _____ Date: _____

Crossroads Healing Arts, LLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have read and been offered a copy of
(Patient's Name)
Crossroads Healing Arts' Notice of Privacy Practices.

I, _____, give Crossroads Healing Arts, LLC, permission to discuss my medical status, laboratory results, appointment time(s), and all other medical care with the following person(s) effective immediately. This authorization will remain in effect until I notify Crossroads Healing Arts' office manager of any change in writing.

_____ _____ _____
Patient's Signature DOB Date

_____
Witness Signature

NAME	RELATIONSHIP