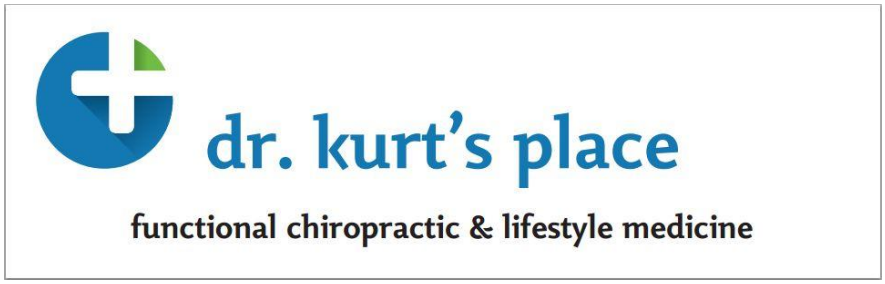

4239 N. Nevada Ave, Suite 104, Colorado Springs, CO 80907. 719.602.4545. Hello@DrKurtPerkins.com

Please fill out the following information THOROUGHLY so we can best serve you and help you achieve the results you desire. If you have no answer, please put N/A in the space provided.

Dr. Kurt

Client Information

Name: _____ Gender: M F DOB: / / Age:_____
Address: _____ City, State, Zip: _____
Phone: ( ) _____. Is this Home, Work, Cell (please circle)? Marital Status: S M D W
Occupation: _____ Place of Employment: _____
Email Address:_____
SSN #: - -
Children (names and ages)_____

What is the Purpose of Your Visit Today? _____
_____
_____.

Who Else Have You Seen For this and What Was Done? _____
_____
_____
_____.

On a scale of 1-10 (10 being highest), how serious are you about taking care of your health? _____

Unless it's a 1, why isn't your number lower? _____
_____
_____.

Have You Experienced Any of the Following in the Past 6 Months? Please Circle.

Hot Flashes	Decrease Muscle Size	Sensitivity to Chemicals
Night Sweats	Rapid Aging	Emotional Stress
Incontinence	High Cholesterol	Cold Body Temperatures
Foggy Thinking	Swelling or Puffy Eyes/Face	Sugar Cravings
Memory Lapse	Slow Pulse Rate	Elevated Triglycerides
Tearful	Decreased Sweating	Weight Gain – Waist
Depressed	Dry or Brittle Hair	Decrease Libido
Heart Palpitations	Brittle or Breaking Nails	Loss Scalp Hair
Bone Loss	Thinning Skin	Increase Facial or Body Hair
Sleep Disturbed	Infertility Problems	Acne
Headaches	Constipation	Mood Swings
Neck Pain	Rapid Heartbeat	Tender Breasts
Fibromyalgia	Hearing Loss	Low Back Pain
Morning Fatigue	Goiter	Nervous
Evening Fatigue	Hoarseness	Irritable
Allergies (Specify)	Increased Urinary Urge	Anxious
Low Blood Pressure	Low Blood Sugar	Water Retention
Numbness – Feet or Hands	High Blood Pressure	Uterine Fibroids
Bleeding Changes	Decreased Stamina	Weight Gain – Hips
Sinus Problems	Recurrent Colds/Flu	Recurrent Nausea
Chest Pains	Indigestion/Heartburn	Menstrual Irregularities
Chronic Muscle Tension	Migraines	Dizziness

List Any Health Conditions/Symptoms Not Listed or Clarify Allergies: _____

_____

Medications (Prescription and Over-the-Counter)

Name of Medication	What Condition Is It For?	Dosage?	How Long Have You Been Taking It?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Supplements/Vitamins

Name of Supplement	Why Do You Take It?	Dosage?	How Long Have You Been Taking It?

Lifestyle Questionnaire – Answer Honestly

- I consume fat-free & sugar-free (artificially sweetened) foods on a daily basis. Yes No
  - If NO, how often do you consume these foods? _____
- I have raw fruits or vegetables with EVERY meal. Yes No
  - If NO, how often do you consume these foods? _____
- I consume pasta, cereal, or bread on a daily basis. Yes No
  - If NO, how often do you consume these foods? _____
- I consume milk or other dairy products on a daily basis. Yes No
  - If NO, how often do you consume these foods? _____
- In the last 3 days, I have gone for a walk/jog/run of at least 1 mile. Yes No
  - If NO, when was the last time you went at least 1 mile? _____
- In the last 3 days, I have performed a resistance exercise workout. Yes No
  - If NO, when was the last time you did a resistance workout? _____
- On an average daily basis (work or home), I sit for more than 3 hours per day. Yes No
  - If YES, How many hours do you spend each day sitting? _____
- I consume alcohol (beer, wine, liquor) on a regular basis Yes No
  - If YES, How often and how much do you consume? _____
- I smoke cigarettes, marijuana, and/or other recreational drugs on a regular basis? Yes No
  - If YES, what do you use and how often? _____

Lifestyle Questionnaire Continued...

- I achieve 7-9 hours of sleep each and every night. Yes No
  - If NO, how much sleep do you get each night? _____
- I look forward to my job. It may be hard and demanding but I enjoy it. Yes No
  - If NO, why? _____
- I have a social group that I interact with in person on a weekly basis. Yes No
  - If NO, why? _____
- On a daily basis, I send more than 10 text messages or emails on my mobile device. Yes No
  - If YES, how many texts or mobile emails do you send each day? _____
- I am responsible for what happens in my life and can control my emotions. Yes No
  - If NO, why not? _____
- I consume coffee and/or other caffeinated beverages daily. Yes No
  - If YES, how many each day? _____

History of Surgeries

What Kind of Surgery	For What Condition	Year Performed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

History of Accidents

Date of Accident	What Happened
_____	_____
_____	_____
_____	_____
_____	_____

What Are Your TOP 3 Health Goals?

1. _____
2. _____
3. _____

Statement of Financial Responsibility:

I understand that I am financially responsible for this visit and future care. Whether the office accepts my insurance carrier or not, I am still responsible for services rendered until benefits are verified by a staff member. The office accepts Cash, Check, Credit Card (V, D, MC, A, HSA, FSA). The office can provide an itemized receipt upon request.

I will be charged $125 for today's visit no matter what insurance coverage may be. Once we establish we want to work with each other, you may use insurance to help with investments of future recommendations.

_____ _____ _____

(Print Name of Financially Responsible Party) (Signature) (Date)

Acknowledgement of Receipt of Notice and Privacy Practices

I understand that I have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and discloses. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes,
- The right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

Appointment Reminders and Health Care Information Authorization.

Members of the staff of this clinic may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you do not answer, a message will be left on your voicemail or answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Signature:_____ Date:_____

For Office Use Only:

Signed Form Received by: _____ Date: _____