Patient Information

General Information

AdvantAge Integrative Medicine

Name:
Date of Birth:
Social Security Number: *Used as your unique medical record identifier*
Home Telephone:
Work Telephone:
Mobile Telephone: May we leave detailed medical related messages? ☐ Yes ☐ No
Email Address: May we use your email to send medical related messages? ☐ Yes ☐ No *Your email will never be sold to a third party. You will only receive newsletters or other emails specific to IMC or its related clinics.*
Mailing Address:
Street Address (if different):
City / State:
Zip Code:

Emergency Contact:
Relationship:
Telephone:

Your Occupation:
Your Employer:

Current Physicians / Health Providers:

How did you hear about us?

Policies

Notice of Insurance, Billing & Missed Appointment Policies

Please read and initial each section – thank you!

Advantage Integrative Medicine does not participate in insurance plans, nor submit claims, nor complete paperwork for insurance claims. Payment is due in full at the time of service with cash, check or major credit card. Our returned check charge is $25.

Initials _____

Due to government regulations we are NOT able to provide services to **Medicaid beneficiaries** for any service that would normally be covered by Medicaid. We are allowed to provide services that are clearly not covered by Medicaid, such as low dose allergy injections or specialized IV therapies. Please contact us if you have questions about whether a specific therapy is allowed.

We gladly accept cancellations up to 24 hours in advance without penalty. Missed appointments without advance notice will be charged 50% of the scheduled visit fee and future appointments will require a credit card number in advance.

Initials _____

We will provide you with an invoice with diagnosis codes (ICD10) listed that you may submit to your insurance company for reimbursement. Some insurance companies will honor invoices for services provided and some will not. We do not have control over these practices.

If your insurance company incorrectly submits claims to other offices that Dr. Rollins works in, then those claims and any payments will be returned.

Initials _____

Medicare beneficiaries only:

Dr. Rollins *does not see Medicare beneficiaries*. I understand that Medicare beneficiaries need to see one of our Providers that have "opted out" of Medicare.

Initials _____

I, or my legal representative, agree not to submit a claim, nor ask the practitioner to submit a claim, to Medicare or items or services, even if such items or services are otherwise covered by Medicare.

Initials _____

By signing below, I confirm that I am not a Medicare or Medicaid beneficiary.

Signature _____ Date _____

I have read the above policy information and by signing below agree to the terms outlined.

Signature _____ Date _____

Health Questionnaire

Please fill out to the best of your knowledge

Check if *you* have ever had:

- o Allergies
- o Arthritis
- o Asthma
- o Autoimmune disease
- o Blood clots
- o Bowel disease
- o Cancer
- o Diabetes
- o Fibromyalgia
- o Frequent infections
- o Heart disease
- o High blood pressure
- o Kidney disease
- o Liver disease
- o Lung disease
- o Mental illness
- o Neurologic disease
- o Skin disorder
- o Stroke
- o Thinning of bones
- o Ulcers
- o Urinary infections

Check if *you* have ever had (WOMEN only):

- o Abnormal mammogram
- o Abnormal pap smear
- o Abnormal vaginal bleeding
- o Breast cancer
- o Cervical cancer
- o Fibrocystic breasts
- o Ovarian cysts
- o Uterine cancer
- o Uterine growths
- o Uterine infections

Check if *you* have ever had (MEN only):

- o Enlarged prostate
- o Mumps
- o Prostate cancer
- o Prostate infections
- o Testicle infection
- o Vasectomy

Other / Explain above: _____

_____

_____

Surgeries (dates): _____

_____

Allergies: _____

_____

Current Medications (dose/frequency) and Supplements including marijuana/CBD products:

_____

_____

_____

Health Questionnaire

Continued...

Hormones taken in PAST (dates): _____

_____

_____

Menstrual History (WOMEN only):

Age of first menses: _____ Date of last menses: _____

History of abnormal menses? _____ Explain: _____

_____

Date of last pap smear: _____ Date of last mammogram: _____

Family History

(list any conditions from category list on prior page – for deceased family members give cause of death and approximate age)

Father: _____

Mother: _____

Paternal GF: _____

Paternal GM:_____

Maternal GF: _____

Maternal GM: _____

Siblings: _____

Social History

Do you smoke or chew tobacco?_____ How much per day? _____

Do you drink alcohol? _____ How much per day? _____

Do you use any other drugs? _____ How much per day? _____

Do you exercise regularly? _____ How much per week? _____

How would you describe your stress level? Low / Moderate / High

Are you married? _____ Do you have children? _____ How Many? _____

Any toxic exposures, e.g. metals, pestisides, etc? _____

What foreign countries have you visited and when? _____

What are your GOALS for your consultation?

_____

_____

_____

Symptoms

General Review

Please check any circles for which *you have* or *recently have had* problems with:

General:
- o Fever
- o Night sweat
- o Weight loss
- o Weight gain
- o Fatigue
- o Change in appetite
- o Change in hair
- o Change in nails
- o Trouble tolerating hot or cold

Mental:
- o Anxiety
- o Feeling blue or sad
- o Moodiness
- o Memory loss
- o Sleep disturbance
- o Thoughts of suicide
- o Difficulty with sex
- o Family/marital difficulties
- o Trouble with alcohol/drugs

Ears/Nose:
- o Nasal congestion
- o Nasal discharge
- o Bloody nose
- o Sinus trouble or pain
- o Decreased hearing
- o Ringing in ears
- o Ear pain or drainage

Eyes:
- o Change in vision
- o Sudden loss or decrease in vision
- o Double or blurry vision
- o Redness
- o Infection

Nerves:
- o Numbness
- o Tingling
- o Weakness in extremities
- o Loss of balance
- o Loss of coordination
- o Tremor
- o Shaking
- o Paralysis
- o Smell or taste change

Mouth:
- o Teeth or gum problems
- o Frequent sore throat
- o Difficulty swallowing or speaking
- o Bleeding gums
- o Mouth pain
- o Lesions
- o Hoarseness
- o Bad taste or breath
- o Change in voice

Heart/Lungs:
- o Shortness of breath
- o Cough
- o Blood sputum
- o Wheezing
- o Pain with deep breath
- o Chest heaviness
- o Awaken at night short of breath
- o Heart skip beats or races
- o Fainting
- o Sleep sitting up
- o Chest pain or pressure
- o Pain or tightness in neck or arms
- o Leg or ankle swelling

Abdomen:
- o Abdominal pain
- o Pain relieved or worsened by food
- o Frequent gas or bloating
- o Heartburn or indigestion
- o Nausea
- o Vomiting
- o Blood in vomit
- o Constipation
- o Diarrhea
- o Blood in feces
- o Black or tarry colored feces
- o Hemorrhoids
- o Rectal pain

Skin:
- o Rash
- o Lesion or unusual mole
- o Recent change in mole size, color or shape

Bladder:
- o Burning with urination
- o Urinating frequently
- o Get up at night to urinate
- o Recurrent bladder infections
- o Slow start of urine flow or dribbling
- o Lose urine with cough or strain
- o Brown or pink urine

Bone:
- o Bone or joint swelling or stiffness
- o Back pain
- o Neck pain

Muscular:
- o Aching or stiff muscles
- o Pain in muscles

Blood:
- o Easy bruising
- o Easy bleeding
- o Blood clots
- o Varicose veins
- o Pain in calves when walking

Female:
- o Abnormal periods
- o Bleeding between periods
- o Trouble with periods
- o Vaginal discharge, itch or odor
- o Breast pain, swelling or lumps
- o Nipple discharge
- o Sexual difficulties

Male:
- o Discharge from penis
- o Testicular pain, swelling or lump

Master Symptoms

Questionnaire - AdvantAge Integrative Medicine

Symptom score

0 = none
1 = mild / rarely
2 = moderate / occasionally
3 = severe / frequently
4 = extreme / always

To What Degree Do You Experience the Following?

Estrogen Deficiency Symptoms (women)	0	1	2	3	4
Hot Flashes or Night Sweats					
Temperature Swings					
Difficulty Concentrating / Forgetfulness					
Mood Changes					
Loss of Skin Radiance					
Weight Gain					
Back or Joint Pains					
Episodes of Rapid Heartbeat					
Vaginal Dryness					
Frequent Urinary Tract Infections					
Painful Intercourse					
Inability to Reach Orgasm					

Progesterone Deficiency Symptoms (women)	0	1	2	3	4
PMS					
Painful, Cystic or Swollen Breasts					
Water Retention / Swollen Fingers					
Abdominal Bloating					
Depressed Mood					
Anxiety, Irritability or Nervousness					
Headaches					
Insomnia					
Missed Periods					
Heavy and Frequent Periods					
Spotting a few days before Period					

Testosterone Deficiency Symptoms	0	1	2	3	4
Lack of Energy and Stamina					
Lack of Sexual Desire					
Flabbiness or Muscle Weakness					
Poor Body Image					
Loss of Coordination or Balance					
Decreased scalp, armpit, pubic, body hair					
Lack of Motivation					
Indecisiveness or Insecurity					
Lack of interest in activities					
Erectile difficulties (men)					

Master Symptoms

Continued...

Symptom score

0 = none
1 = mild / rarely
2 = moderate / occasionally
3 = severe / frequently
4 = extreme / always

To What Degree Do You Experience the Following?

Thyroid Deficiency Symptoms	0	1	2	3	4
Fatigue, especially in morning					
Headaches, especially in morning					
Swelling or "puffiness"					
Muscle aches or joint stiffness					
Weight Gain					
Low Body Temperature					
Cold Intolerance					
Thinning Hair (diffusely all over scalp)					
Thinning Eyebrows (especially outer third)					
Brittle or slow growing nails					
Dry Skin					
Constipation					
Slow Pulse Rate					
Inability to focus or slow thinking					
Poor memory and concentration					
Depressed Mood					
Lack of interest in activities					

Cortisol Deficiency Symptoms	0	1	2	3	4
Fatigue, especially in morning					
Energy boost late morning					
Afternoon fatigue, "crash"					
Energy boost after supper / evening					
Dizziness or lightheadedness					
Low blood sugar if not eating frequently					
Shakiness or shaky hands					
Feeling of panic / inability to handle stress					
Inability to focus or slow thinking					
Rage or sudden angry outbursts					
Emotional hypersensitivity					
No patience or easily irritated					
Flu-like symptoms, achey all over					
Headaches					
Difficulty falling asleep					
Night-time awakening					

Master Symptoms

Continued...

Symptom score

0 = none
1 = mild / rarely
2 = moderate / occasionally
3 = severe / frequently
4 = extreme / always

To What Degree Do You Experience the Following?

Stomach Support Symptoms	0	1	2	3	4
Excessive belching or burping					
Gas immediately following a meal					
Bad breath					
Sense of fullness during and after meals					
Difficulty digesting fruits and vegetables					
Undigested foods in stool					
Pass large amount of foul smelling gas					
More than 3 bowel movements daily					
Frequent use of laxatives					
Difficulty with bowel movement					

Biliary Suppory Symptoms	0	1	2	3	4
Greasy or fatty foods are bothersome					
Gas / bloating several hours after eating					
Bitter taste in mouth, esp. in morning					
Itchy skin					
Occasional clay colored stools					
Pass large amount of foul smelling gas					
More than 3 bowel movements daily					
Frequent use of laxatives					
History of gallbladder problems or removal					

Intestinal Support Symptoms	0	1	2	3	4
Fiber and roughage lead to constipatoin					
Indigestion 2-4 hours after eating					
Fullness 2-4 hours after eating					
Excessive belching or burping					
Pass large amount of foul smelling gas					
Nausea after eating					
Mucous or greasy appearing stools					
Loose stools					
Difficulty losing weight					
Increased thirst and appetite					

Master Symptoms

Continued...

Symptom score

0 = none
1 = mild / rarely
2 = moderate / occasionally
3 = severe / frequently
4 = extreme / always

To What Degree Do You Experience the Following?

Insomnia Questionnaire (IF APPLICABLE)
How long have you had a sleep problem?
Did it begin after a stressful time?
Does insomia run in your family?
What time do you lie down to sleep?
What time do you fall asleep?
How often do you awaken?
What times do you awaken?
How long until you fall back asleep?

Type 1 Serotonin/Melatonin Deficiency	0	1	2	3	4
Night Owl - Hard to get to sleep					
Disturbed sleep, premature awakening					
Negativity, depression					
Worry, anxiety / Panic attacks / phobias					
Low self esteem					
Obsessive thoughts / behaviors					
Hyperactivity / tics					
Perfectionism, controlling behavior					
Winter blues					
Irritability, rage					
Dislike of hot weather					
Afternoon / evening cravings carbs, alcohol					

Type 2 GABA Deficiency	0	1	2	3	4
Overstressed and burned out					
Unable to relax / loosen up					
Stiff or tense muscles					
May experience panic attacks					
Respond well to meds, e.g. xanax					

Type 3 High Cortisol	0	1	2	3	4
"Wired but tired" before bedtime					
Awaken alert "ready to get to work"					
Awaken agitated or hypervigilant					
Awaken startled or shocked feeling					

Candida Questionnaire

Score Sheet

This questionnaire is designed for adults and the scoring system isn't appropriate for children. It lists factors in your medical history which promote the growth of the common yeast, Candida Albicans (Section A), and symptoms commonly found in individuals with yeast-connected illness (Sections B and C).

For each "Yes" answer in Section A, circle the Point Score in that section. Total your score and record it in the box at the end of the section. Then move on to Sections B and C and score as directed.

Filling out and scoring this questionnaire should help you and your provider evaluate the possible role of yeasts in contributing to your health problems, but it will not provide an automatic "Yes" or "No" answer.

SECTION A: HISTORY

Have you taken antibiotics for acne for 1 month (or longer)?	35
Have you taken other antibiotics for 2 months or longer, or in shorter course multiple times in a single year?	35
Have ever you taken a broad spectrum antibiotic?	6
Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?	25
Have you been pregnant 2 or more times? 1 time?	5 3
Have you taken birth control pills for more than 2 years? For 6 months to 2 years?	15 8
Have you taken steroids, such as prednisone or cortisone more than 2 weeks? For 2 weeks or less?	15 6
Does exposure to perfumes, insecticides, fabric shop odors or other chemicals provoke moderate to severe symptoms? Mild symptoms?	20 5
Are your symptoms worse on damp, muggy days or in moldy places?	20
Have you had athlete's foot, ringworm, "jock itch" or other chronic fungal infections of the skin or nails, with severe or persistent symptoms? With mild to moderate symptoms?	20 10
Do you crave sugar?	10
Do you crave breads?	10
Do you crave alcoholic beverages?	10
Does tobacco smoke *really* bother you?	10
TOTAL SCORE, SECTION A	

Candida Questionnaire

Score Sheet Continued...

SECTION B: MAJOR SYMPTOMS
For each symptom which is present, enter the appropriate figure in the Point Score column:

If a symptom is occasional or mild.....SCORE 3 points
If a symptom is frequent and/or moderately severe.....SCORE 6 points
If a symptom is severe and/or disabling.....SCORE 9 points

Add total score for this section and record it in the box at the end of this section.

Fatigue or lethargy	
Feeling of being "drained"	
Poor memory	
Feeling "spacey" or "unreal"	
Inability to make decisions	
Numbness, burning or tingling	
Insomnia	
Muscle aches	
Muscle weakness or paralysis	
Pain and/or swelling in joints	
Abdominal pain	
Constipation	
Diarrhea	
Bloating, belching or intestinal gas	
Troublesome vaginal burning, itching or discharge	
Prostatitis	
Impotence	
Loss of sexual desire or feeling	
Endometriosis or infertility	
Cramps and/or other menstrual irregularities	
Premenstrual tension	
Attacks of anxiety or crying	
Cold hands or feet and/or chilliness	
Shaking or irritable when hungry	
TOTAL SCORE, SECTION B	

Candida Questionnaire

Score Sheet Continued...

SECTION C: OTHER SYMPTOMS
For each symptom which is present, enter the appropriate figure in the Point Score column:

If a symptom is occasional or mild.....SCORE 1 point
If a symptom is frequent and/or moderately severe.....SCORE 2 points
If a symptom is severe and/or disabling.....SCORE 3 points

Add total score for this section and record it in the box at the end of this section.

Drowsiness	
Irritability or jitteriness	
Loss of coordination	
Inability to concentrate	
Frequent mood swings	
Headaches	
Dizziness or loss of balance	
Pressure above ears or feeling of head swelling	
Easy bruising	
Chronic rashes or itching	
Psoriasis or recurrent hives	
Indigestion or heartburn	
Food sensitivity or intolerance	
Mucous in stools	
Rectal itching	
Dry mouth or throat	
Rashes or blisters in mouth	
Bad breath	
Foot, hair or body odor not relieved by washing	
Nasal congestion or post nasal drip	
Nasal itching	
Sore throat	
Laryngitis or loss of voice	
Cough or recurrent bronchitis	
Pain or tightness in chest	
Urinary frequency, urgency or incontinence	
Burning on urination	

Candida Questionnaire

Score Sheet Continued...

Spots in front of eyes or erratic vision	
Burning or tearing of eyes	
Recurrent infections or fluid in ears	
Ear pain or deafness	
TOTAL SCORE, SECTION C	
TOTAL SCORE, SECTION B	
TOTAL SCORE SECTION A	
GRAND TOTAL SCORE (add up total score from sections A, B and C)	

The Grand Total Score will help us decide if your health problems are yeast-connected. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

WOMEN

If you GRAND SCORE is:
< 60 then yeast connected health problems are *not likely* present
>60 then yeast connected health problems are *possibly* present
>120 then yeast connected health problems are *probably* present
>180 then yeast connected health problems are *very likely* present

MEN

If you GRAND SCORE is:
< 40 then yeast connected health problems are *not likely* present
>40 then yeast connected health problems are *possibly* present
>90 then yeast connected health problems are *probably* present
>140 then yeast connected health problems are *very likely* present

This questionnaire is adapted from
"The Yeast Connection Handbook" by William Crook, MD.