Alyssa R. Corkrean MSN APRN FNP-C | Sean P. Corkrean Pharm D
PHONE: (352) 742-8080 | FAX: (352) 742-9292

PATIENT WELL WOMAN INTAKE FORM

Date: _____

Please Have Your Picture ID and Insurance Cards Ready To Provide

Personal Data

Name		Date of Birth
Social Security Number (optional for insurance verification)	Race	Gender Assigned at Birth Male / Female
Address	City State	Zip
Home phone	Cell phone	Work phone
Insurance Company / Self Pay	Policy Holder Name & D.O.B	Plan Number
Secondary Insurance	Policy Holder Name & D.O.B	Plan Number
Occupation	Employer	
Emergency Contact Name	Relationship to Patient	Phone Number
Email (Will be used for patient portal access):		
Preferred Lab	Preferred Imaging Center	Preferred Pharmacy

Was this a result of a motor vehicle accident? YES / NO DATE OF ACCIDENT: _____

Was this a result of a job-related injury? YES / NO DATE OF INJURY: _____

For any patient under the age of 18, please fill out this section:

Responsible Party (of the patient) Name: _____

Relationship to the Patient: _____

If you are not the patient's parent, please have supporting documentation ready to consent for today's visit.

Current Street Address: _____ Apt#/Floor/Suite#:_____

Date of Birth: ____/_____/_____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Primary Care Physician

Name	Phone

LIST ANY OTHER PHYSICIANS YOU SEE

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN	MEDICAL CONDITION

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Reason For Scheduling A Visit:

_____

_____

Symptoms Related To Reason For Visit:

_____

_____

_____

_____

Medications

Please list **ALL** prescription medications.
Include **ALL** over the counter **medications**, **supplements, and vitamins.**

Name of Medication	Dosage	Dosing schedule

Allergies

Are you allergic to any MEDICATIONS or Other Allergens (Prescription or OTC)

Medication | Allergen (egg, bees)	Type of reaction (anaphylaxis, swelling, itchy, rash, vomiting)

Past Surgical History

Surgical Procedure	Date Of Procedure

Vaccination / Childhood Illness History

Childhood Illness:	☐ Measles ☐ Mumps ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

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Immunizations & Dates (If Available)	Tetanus:	Varicella (chicken pox):
	Shingles:	MMR (Measles, Mumps, Rubella):
	Influenza:	HPV:
	Pneumonia:	Meningitis:
	Hepatitis:	Other/ Travel Vaccines:
	COVID-19 Vaccine (Manufacturer & Dates):	

MEDICAL HISTORY

*Do you **have or have you ever had** any of the following conditions: (Y-yes / N-no / P-Past)*

CONDITION	Y/N/P	CONDITION	Y/N/P	CONDITION	Y/N/P
High Cholesterol		Allergies		Arthritis	
Heart Disease/Attack		Infertility		HIV/AIDS	
Irregular Heart Beat		Endometriosis		Bleeding Disorder	
High Blood Pressure		PCOS		Anemia	
Stroke		ADHD		Blood Transfusion	
Blood Clots		Anxiety		Birth Defects	
Asthma		Depression		Kidney/Bladder Problem	
COPD		Restless Legs		Prostate Cancer	
Diabetes		Insomnia		Prostate Disease	
Thyroid Problems		Fibromyalgia		Colon Cancer	
Liver Disease		Autoimmune Disease		Ovarian Cancer	
Hepatitis		Severe Infection		Osteopenia/ Osteoporosis	
Gallstones		COVID 19		Cancer	
Eating Disorder		Post COVID 19 syndrome		Rheumatic Fever	

Any hospitalizations, serious illness/ injury, surgeries, either now or in the past?

_____

_____

Any ongoing sources of inflammation (e.g. eczema or other skin irritation, chronic post nasal drip, congestion, headaches, achy muscles/joints, swelling, pain, stiffness)?

_____

_____

PLEASE LIST ANY OTHER MEDICAL HISTORY/ ACTIVE MEDICAL PROBLEMS:

_____

_____

_____

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Family History

Please list ALL illnesses

(Autoimmune disorders, heart disease, stroke, diabetes, hypertension, cancers including breast, cervical, skin, prostate, lung, blood), etc.

If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/ Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		
Other Pertinent Family Medical Conditions		

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Social History

This information is strictly confidential and will be used **only** to address your symptoms and/or complaints.

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? _____
- How many total years have you smoked? _____

How many caffeine-containing drinks do you have a day? _____ *(coffee, tea, sodas, energy drinks)*
Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? _____

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? ☐ Yes ☐ No

- If yes, what substance(s) and how often? _____

LIFESTYLE QUESTIONS

Do you take anything to help you fall asleep? _____

Do you feel like you sleep well? _____ Average hours of sleep per day _____

What time do you go to bed at night? _____ How long until you fall asleep? _____

Do you go to sleep with the TV on? _____ How many times do you wake up a night? _____

Why do you wake up during the night? _____

What do you do when you wake up at night? _____

What time do you wake up in the morning on a typical workday? _____

Do you feel refreshed when you wake up? _____ Do you eat after 8PM? _____ YES _____ NO

On a scale of 1 – 10, how would you rate your energy level. (1 = lowest) _____

To what do you attribute this energy level? _____

Do you exercise for at least 30 minutes at a time, at least 3 days per week? _____ YES _____ NO

How much exercise do you do on average per week? _____

What do you do for exercise? _____

What time of day do you usually exercise? _____ After exercising are you sore the next day? _____

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How many meals a day do you eat? _____ Do you snack between meals? ____ YES ____ NO

Do you drink at least 64 ounces of water per day? ____YES _____ NO

How much water do you drink on average per day? _____

What is your current weight? _____ Weight 6 months ago _____

Would you like your weight to be different? _____ If so what? _____

What was your most successful diet? _____ How much did you lose? _____

How much weight would you realistically like to lose in the next year? _____ pounds.

What was your age when you were last at your ideal weight? _____

Do you have any food allergies or sensitivities? _____

Are you currently following any diet restrictions? (ex. Gluten Free, Dairy Free, Paleo, Vegan):

_____

What percentage of your food is home cooked? _____

Where do you get you not home cooked food? _____

Do you crave sugar, carbs, alcohol, coffee, cigarettes, other food (please specify), or have any addictions?

_____

What is the general status of your dental health? _____

Any troubling dental work or history of dental/ oral infections? Dentures? Root canals?

_____

How many silver/ mercury fillings do you have? _____Have you had any replaced?_____

Other major dental work/ issues beyond basic cleanings?

_____

Occupation: _____

Would you consider your job stressful? _____

Average work hours per week: _____

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What was the last time you felt really vibrant and well?

_____

If you could wave a magic wand and change two things, what would they be?

_____

What do you do to relax & How often? _____

What was your general health and well being as a child? _____

Have you ever taken antibiotics more than a short course or two as a child? If so, when/how often? For What? And for how long? _____

Any remarkable exposure to toxins? (e.g. current or childhood home (lead, mold,etc.), nearby industrial community, job, hobbies, travel, pesticides, heavy medals, etc.): _____

Any healers, helpers, counselors, beliefs, mentors, pets, of therapies with which you are involved? Please list.

_____

_____

What are your primary hobbies? _____

STRESS QUESTIONS

- *Please **circle** all current stressors in your life.*

MOVED YOUR HOME	JOB CHANGE	JOB STRESS/LOSS
ILL FAMILY MEMBERS	MARITAL PROBLEMS	DIVORCE/SEPARATION
DEATH OF SPOUSE/CHILD	FORECLOSURE/BANKRUPTCY	LEGAL PROBLEMS
NEW MARRIAGE	RETIREMENT	TROUBLE W/ IN-LAWS
PROBLEMS WITH CHILDREN	NEW PERSON LIVING WITH YOU	

OTHERS _____

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Previous OB/GYN Care

Name	Phone	
Address	City State	Zip

Gynecological History If Applicable

Date of last PAP smear? _____ Physician who performed: _____

Physician's Phone Number _____

Date of last mammogram? _____ Facility where performed: _____

Facility Phone Number: _____

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had any vaginal infections? If yes, what was the abnormality _____		
Have you ever had any reproductive or fertility concerns? If yes, what was the concern _____		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes?		
Have you noticed any lumps in your breasts?		

Are you using a birth control method? If yes, what kind?

_____

Are you still having menstrual periods? If yes, when was the first day of your last period?

_____

Are your periods regular? _____ How Frequent? _____
How many days is your flow? _____
Do you have severe cramping or other symptoms associate with your period? _____

Please describe any problems you have with your periods:

_____

Periods are (were): ☐ regular ☐ irregular ☐ painful ☐ crampy ☐ heavy ☐ light ☐ other

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Age periods began: _____ # days of bleeding _____ How frequent? (cycle length in days) _____

If you are no longer having periods, at what age did your periods stop? _____

If your periods stopped less than one year ago, how many months ago was your last period? _____

Did your periods stop because you had a hysterectomy? ☐ Yes ☐ No

- If yes, what was the reason for the surgery? _____
- Were the ovaries removed at the same time? ☐ Yes ☐ No ☐ Not Sure

Do you have or have a history of any of the following cancers:

☐ Vulva ☐ Ovary ☐ Other: _____
☐ Uterus ☐ Fallopian Tube
☐ Vagina ☐ Breast _____
☐ Cervix ☐ Colon

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

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Patient Expectations

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

What is your desired health outcome? (weight loss, blood pressure control, pain control)

_____
_____
_____

What is your expectation of time needed to achieve your desired health outcome?

_____
_____
_____

What is your expectation of the providers of THE CORKREAN CLINIC FOR HEALTH AND WELLNESS in treating you?

_____
_____
_____

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Disclosure / Liability Waiver

The Corkrean Clinic for Health & Wellness

Bio-identical Hormone Replacement, Compounded Medication, and Supplement Program

While numerous safety measures are taken by our providers and staff, incidental events may occur that are beyond the control of our providers or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of compounded medications and/ or bio-identical hormones does provide true medical benefit and is being used at our clinic to lessen/treat non-life-threatening symptoms you have identified as bothersome, undesirable, and unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all compounded and /or bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from **The Corkrean Clinic for Health & Wellness**, its staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement, Compounded Medication, and Supplement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

_____ _____
Signature of Patient Date

_____ _____
Print Name Date

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. For females of certain age and risk you must have routine physical examinations including recommended mammography / pap smear screenings. You must have routine physical examinations including a prostate examination and PSA testing. Your signature below indicates that you will comply by obtaining the age and risk factor appropriate cancer/ pap smear/ prostate screening from your primary care physician, Women's Health Physician, or other speciality provider within three months of beginning the Bio-Identical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care gynecological, and or other specialty providers.

I accept all terms and conditions of this program.

_____ _____
Signature of Patient Date

_____ _____
Print Name Date

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AUTHORIZATION AND RELEASE

Please Initial and Sign Below

____ **Authorization for Treatment:** I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

____ **Authorization for use of e-mail/cell phone:** I voluntarily consent to the use of my personal e-mail and/or cellular phone via voice or text to receive newsletters or notifications. This is NOT to be used for my private medical records or health information.

____ **Assignment of Insurance Benefits:** I authorize payment directly to THE CORKREAN CLINIC FOR HEALTH AND WELLNESS for all benefits otherwise payable to me.

____ **Guarantee of Payment:** I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

____ **Release of Records:** I authorize THE CORKREAN CLINIC FOR HEALTH AND WELLNESS to release (verbal or in writing) individually identifiable health information ("protected health information") to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes in order to carry out treatment , payment, and/or healthcare operations.

____ **Receipt of Privacy Practices:** I acknowledge that I have received and read the Notice of Privacy Practices of THE CORKREAN CLINIC FOR HEALTH AND WELLNESS I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ _____ DATE: _____

CONSENT FOR NOTIFICATION OF TEST RESULTS/MEDICAL INFORMATION

I give permission to THE CORKREAN CLINIC FOR HEALTH AND WELLNESS to:

1. Follow- up phone calls or call backs regarding care at THE CORKREAN CLINIC FOR HEALTH AND WELLNESS using this phone #: (____) _____- _____

2. Leave message on my answering machine: (circle one) Yes / No

3. Discuss my health information with the following people: _____

PATIENT SIGNATURE: _____ DATE: _____

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Financial Responsibility Form

Thank you for trusting in The Corkrean Clinic For Health And Wellness as your comprehensive healthcare team to optimize your overall wellness. The medical services you see imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding the financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. By signing below and/or receiving medical services from The Corkrean Clinic For Health And Wellness you agree to the following prices listed below. These prices are subject to change and patients will be notified of any updates. Please note that the following cost only cover time with the providers. Additional costs may be accrued during your visit. These costs may include labs, medication, and supplements. Many of these are specialty labs, medications, and supplements that may not be covered by insurance. The Corkrean Clinic For Health And Wellness does not bill your insurance for you and all payment must be rendered at the time of service.

New Patient Compressive Wellness- Initial Visit	**$200.00 (Average Visit Time 1.5- 2 Hours)**
Comprehensive Wellness Follow- Up Visit #1	**$175.00**
Comprehensive Wellness Follow- Up Visit #2	**$125.00**
Comprehensive Wellness Follow- Up Visit #3	**$125.00**
Comprehensive Wellness Follow- Up Visit #4	**$125.00**
Comprehensive Wellness Follow- Up Visits #5+	**$100.00/ ½ Hour (Average Visit Time)**
Well Woman Visit	**$115.00 + Lab Fee (vary based on insurance)**
Supplement Membership Benefits	**20% off all Supplements**
Specialty Labs	**Prices Vary**
Onsite Lab Draws	**$20.00 Draw Fee**
Additional cost may occur with onsite testing/procedures Super Bill available upon request.	**Price Vary (EKG, COVID Testing, POC Testing, etc.)**

I accept all terms and conditions of this program.

_____ _____
Signature of Patient Date

_____ _____
Print Name Date

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CONSENT FOR PELVIC EXAMINATION

I understand by law my health care practitioner requires written informed consent to perform a Pelvic Examination on me. I have been informed that I may be receiving a Pelvic Examination if deemed medically necessary.

Description of the Examination A "Pelvic Examination" means an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combinations of modalities which may include, but may not be limited to, the health care provider's gloved hand or instrumentation. I have been informed as to the nature and process of the Pelvic Examination. Any and all questions have been answered to my satisfaction.

I _____ (Patient Name & Date of Birth), hereby GIVE MY INFORMED AND VOLUNTARY CONSENT to receive a pelvic examination by providers employed at THE CORKREAN CLINIC FOR HEALTH AND WELLNESS.

By my signature below I acknowledge that I have read and understand the contents of this form.

_____ _____
Signature of Patient/ Legal Representative Date

_____
Print Name of Patient/ Legal Representative

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