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1106 Centre Ct. | LAS CRUCES, NM 88011 | (575) 532-5455 | FAX (575) 532-5641

**We serve the populations of people of age 50 and older  
Our Mission is to make healthy aging a reality through excellence in clinical care.**

Office Hours  
Monday–Thursday 8:00 am – 5:00 pm  
Friday 8:00 am – 12:00 pm

**To schedule an appointment or speak with a clinician, please call our office at 575-532-5455**

**For after hours, please call the above office number and the phone call will be transferred to the on-call physician.**

**In case of an Emergency, call 9-1-1 immediately.**

Southwest Center on Aging (SWCOA) offers a unique, comprehensive assessment of older persons in an outpatient setting. SWCOA uses multiple resources to look at the individual from medical, functional, and emotional perspectives. Our goal is to work with the patient's family to address strengths and weaknesses found during the assessment process. This assessment is valuable on a consultation basis or as a first step to ongoing primary care with us.

SWCOA coordinated medical, social, and hospice services for patients and families facing terminal illnesses. Assistance is provided in establishing Advance Directives, selecting resuscitation status and designing a Durable Power of Attorney. Care plans are individualized to the need of the patient and family, and focus on maximizing quality of life and comfort.



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### Patient Portal Consent Form

Patient Portal is a secure online source of confidential medical information for patients. This gives patients a convenient 24-hour access to personal health information, from anywhere with an Internet connection. Using a secure username and password, patients can:

- Access personal health information
- Request refills for prescriptions
- Review results for Labs/Tests
- Correspond with our staff and providers regarding your care

#### I agree to the following:

1. I will abide by all terms and conditions of Southwest Center on Aging Patient Portal.
2. Southwest Center on Aging is not responsible for any breach of information caused by patient misuse.
3. I understand that my activities within the Patient Portal will become part of my medical record.

#### I understand the following:

1. For medical emergencies, dial 911. The Patient Portal is NOT to be used for urgent needs.
2. All communication is sent to the nursing staff. You will receive a response within 24-48 business hours.
3. The Patient Portal is NOT a substitute for office visits with your provider and prescription requests for medications not currently being prescribed will NOT be honored.

I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal.

☐ I DECLINE access to the Patient Portal      ☐ I would like access to the Patient Portal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last 4 SS# \_\_\_\_\_

Secure Email Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship if representative: \_\_\_\_\_

|                                                             |
|-------------------------------------------------------------|
| For office use only<br>Portal Invite Sent by _____ on _____ |
|-------------------------------------------------------------|



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## INFORMED CONSENT FOR TELEMEDICINE SERVICES

I, the undersigned patient, hereby consent to participate in telehealth services offered by Southwest Center On Aging. I understand and agree to the following:

\_\_\_\_\_ Nature of Telehealth Services: I understand that telehealth services involve the use of electronic communications to enable healthcare providers at Southwest Center On Aging to diagnose, treat, and provide medical advice to me remotely.

\_\_\_\_\_ Benefits and Limitations: I understand that telehealth services have benefits and limitations compared to in-person medical visits. While telehealth can provide convenient access to healthcare, it may not replace all in-person visits and assessments.

\_\_\_\_\_ Privacy and Security: I acknowledge that Southwest Center On Aging will take reasonable steps to ensure the privacy and security of my medical information during telehealth services, but I also understand that there are inherent risks associated with electronic communication.

\_\_\_\_\_ Emergency Situations: I understand that in case of a medical emergency, I should call 911 or go to the nearest emergency room. Telehealth services are not a substitute for emergency care.

\_\_\_\_\_ Costs and Insurance: I acknowledge that telehealth services may be billed to my health insurance, and I am responsible for any applicable co-pays, deductibles, or other fees. I understand that it is my responsibility to check with my insurance provider regarding telehealth coverage.

I have read and understood the above information regarding telehealth services at Southwest Center On Aging. I consent to participate in telehealth services and acknowledge that no guarantees or assurances have been made regarding the outcome of these services.

This consent was signed by \_\_\_\_\_ (print name) DOB: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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## **HIPAA Compliance Patient Consent Form**

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

### **Your rights:**

- Get a copy of your health and claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

### **Our Responsibilities:**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.



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### **Patient Financial Responsibility**

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

**It is the responsibility of each patient to know the details of his or her insurance plan** in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill, please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

**\_\_\_\_\_ If an account is not paid in full within 90 days, a 25% collection processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.**

**\_\_\_\_\_ Checks returned for any reason will be assessed a \$50.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.**



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**\_\_\_\_\_ We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. SWCOA also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current no-show fee is \$50.00 and is subject to change without notice. (YOUR INSURANCE WILL NOT COVER THIS FEE)**

**\_\_\_\_\_ The following fee will apply for copying medical records: If you request a copy of your medical records, there will be a \$50.00 charge. The fee includes preparing electronic records exported on a CD, USB or printed, cost of labor, and supplies. If a new physician requests your medical records, you will not be charged. Please allow seven to 14 business days for completion of a medical records request. Please be aware that it can take up to 30 days as allowed by law.**

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time all full disclosures will then cease
- The practice may condition receipt of this treatment upon execution of this consent

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY, READ, AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **HIPPA Policy and Responsibilities**
- **Patient Financial Responsibility including collections, returned checks and no-show policy**
- **Medical Records and Form Charge**

This consent was signed by \_\_\_\_\_ (print name) DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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## Patient Authorization for Release of Medical Records

Name (Please Print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

I hereby authorize:

Release to:

Name: \_\_\_\_\_

Dr. Jesus R. Duran

Phone #: \_\_\_\_\_

Tyson Kay, PA-C

Address: \_\_\_\_\_

Mary Younger, NP

Fax #: \_\_\_\_\_

Rebecca Ellis, NP

**Records requested are as follows:**

- ☐ Lab Reports, X-Rays, EKG Reports
- ☐ History and Physical, Echocardiograms
- ☐ Nuclear/ Regular Stress Test
- ☐ Holter Monitor
- ☐ Cath/PTCA/Stent Reports
- ☐ All Records
- ☐ Other: \_\_\_\_\_

**I specifically authorize the release of information relating to:**

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ STD related information (HIV and AIDS related testing)
- ☐ Mental health (including psychotherapy notes)

\_\_\_\_\_  
Signature of patient or Legal Guardian

I understand that I have the right to revoke this authorization at any time. I also understand that I must do so in writing and present my written revocation to the Southwest Center on Aging at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.

Signature of the patient or legally authorized representative \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Witness-Printed Name & Signature \_\_\_\_\_ Date \_\_\_\_\_



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### Release of Medical Information

I, \_\_\_\_\_ hereby give authority to \_\_\_\_\_  
(Patient's Name) (Other than Physician)

\_\_\_\_\_, to have access to the medical information below, effective  
(Relationship to Patient)

\_\_\_\_\_.  
(Date)

\_\_\_\_\_ Procedures

\_\_\_\_\_ Medications

\_\_\_\_\_ Appointment times and cancellations

\_\_\_\_\_ Patient history

\_\_\_\_\_ All medical information may be released to the above mentioned person(s)

**I understand that I may request to cancel this release of information in writing for whatever reason, at any time and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Southwest Center on Aging cannot be held liable for any misuse of information obtained by the mentioned above.**

\_\_\_\_\_  
**Patients Signature**                      **Date**                      **DOB**

\_\_\_\_\_  
**Witness**                      **Date**



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## REQUEST FOR PHYSICIAN LETTERS AND FORMS

**Fees are subject to change without notice**

\_\_\_\_\_ Any letter for disability, competency, diagnosis, etc. **-\$35.00**

\_\_\_\_\_ Jury Duty Excuse **-\$25.00**

\_\_\_\_\_ Handicap parking placard form/ MVD Medical Report **-\$20.00**

\_\_\_\_\_ Family Medical Leave Act form **-\$100.00**

\_\_\_\_\_ Life Insurance Form **-\$100.00**

\_\_\_\_\_ Mailing out any documents listed above as well as any documents in our file **-\$5.00**

**\*Payment must be done before we start the process of any form. We will only accept cash or check addressed to: Dr. Jesus Duran**

**\*Please allow seven to 14 business days for completion of a letter or form request.**

\_\_\_\_\_  
**Patients Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**



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### General Information

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse/Partner: \_\_\_\_\_ Phone #: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

### Preferred Provider (please circle)

Jesus R. Duran, III MD, CMD   Tyson Kay, MSPAS, PA-C   Mary Younger, AGACNP-BC   Rebecca Ellis, CNP-BC

**\* In the event that preferred provider is not available; to avoid a delay in care, you agree to see an alternate provider. Schedules are subject to change.**

### In Case of Emergency Contact (other than spouse)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_



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### Medical Questionnaire

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Circle the highest year of education- Elementary: 1 2 3 4 5 6 7 8 H.S.: 1 2 3 4 College 1 2 3 4 Post- Grad 1 2 3 4

What is your marital status? Single Married Divorced Widowed

Reason for today visit: \_\_\_\_\_

Are you under a health care provider's care for any condition? YES \_\_\_ NO \_\_\_

If yes, what is the health care provider's name: \_\_\_\_\_ Last date seen by provider: \_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR GENERAL HEALTH

How would you rate your general health: Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_

#### PAST MAJOR ILLNESSES:

Lung Disease Date: \_\_\_\_\_ Neurological Problems Date: \_\_\_\_\_

Heart Disease Date: \_\_\_\_\_ Gallbladder Disease Date: \_\_\_\_\_

Kidney Disease Date: \_\_\_\_\_ Epilepsy / Seizures Date: \_\_\_\_\_

Tuberculosis Date: \_\_\_\_\_ Migraine / Headaches Date: \_\_\_\_\_

Blood Disorder Date: \_\_\_\_\_ Blood Transfusion Date: \_\_\_\_\_

Diabetes Date: \_\_\_\_\_ Anxiety / Depression Date: \_\_\_\_\_

Stroke / TIA Date: \_\_\_\_\_ High Blood Pressure Date: \_\_\_\_\_

Swelling Date: \_\_\_\_\_ Parkinson's Disease Date: \_\_\_\_\_

Glaucoma Date: \_\_\_\_\_ Colitis / Bowel Disease Date: \_\_\_\_\_

Cataracts Date: \_\_\_\_\_ Seasonal Allergies Date: \_\_\_\_\_

Gallbladder Disease Date: \_\_\_\_\_ Loss of Consciousness Date: \_\_\_\_\_

Epilepsy / Seizures Date: \_\_\_\_\_ Osteoarthritis Date: \_\_\_\_\_

Thyroid Problems Date: \_\_\_\_\_ Rheumatoid arthritis Date: \_\_\_\_\_

Migraine / Headaches Date: \_\_\_\_\_ Cancer Date: \_\_\_\_\_



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**NAME:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**SURGERIES:**

Appendectomy YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Cholecystectomy YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Hysterectomy YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Cataract Surgery YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Heart Surgery YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Heart Catheterization YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Hip surgery YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Tonsillectomy YES \_\_\_ NO \_\_\_ DATE \_\_\_\_\_

Other Surgeries not mentioned above:

\_\_\_\_\_

Broken Bones:

\_\_\_\_\_

Hospitalizations:

\_\_\_\_\_

**FAMILY HISTORY:**

Parents: Mother living \_\_\_ deceased \_\_\_ age and cause of death \_\_\_\_\_

Father living \_\_\_ deceased \_\_\_ age and cause of death \_\_\_\_\_

Siblings: Number living \_\_\_ Number Deceased \_\_\_\_\_

Children: Number living \_\_\_ Number Deceased \_\_\_\_\_

Do you have family in the local area? YES \_\_\_ NO \_\_\_

**Any family history of the following:**

Cancer If so, who \_\_\_\_\_

Depression If so, who \_\_\_\_\_

Diabetes If so, who \_\_\_\_\_

Heart Disease If so, who \_\_\_\_\_

Stroke If so, who \_\_\_\_\_

Dementia/Senility If so, who \_\_\_\_\_

Have any of your friends or relatives pass away recently?

If so, who and when \_\_\_\_\_



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**NAME:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY:**

Who would assist you in an emergency? \_\_\_\_\_

Are you Retired? YES \_\_\_ NO \_\_\_ YEAR \_\_\_\_\_

Do you have a living will or a Medical Power of Attorney ? YES \_\_\_ NO \_\_\_

What type of work have you done? \_\_\_\_\_

What kind of activities are you involved in now? \_\_\_\_\_

Do you live by yourself? YES \_\_\_ NO \_\_\_

If not, who do you live with? \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR RECENT HEALTH STATUS:**

When was your last Mammogram? YEAR \_\_\_\_\_ Not applicable \_\_\_

When was your last pelvic exam or Pap Smear? YEAR \_\_\_\_\_ Not applicable \_\_\_

When was your last Prostate exam? YEAR \_\_\_\_\_ Not applicable \_\_\_

When was your last hearing exam? YEAR \_\_\_\_\_ Not applicable \_\_\_

When was your last bone density exam? YEAR \_\_\_\_\_ Not applicable \_\_\_

When was your last eye exam? YEAR \_\_\_\_\_

When was your last dental exam and cleaning? YEAR \_\_\_\_\_

When was your last Colonoscopy? YEAR \_\_\_\_\_

When was your last Pneumococcal Immunization? YES \_\_\_ NO \_\_\_ Date \_\_\_\_\_

Have you had a flu shot this season? YES \_\_\_ NO \_\_\_ Date \_\_\_\_\_

Have you had a Tetanus Immunization? YES \_\_\_ NO \_\_\_ Date \_\_\_\_\_

Do you exercise regularly? YES \_\_\_ NO \_\_\_

Do you smoke or have you ever smoked? YES \_\_\_ NO \_\_\_

If so, how many years? \_\_\_\_\_ How many packs a day? \_\_\_\_\_

Do you still smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol? YES \_\_\_ NO \_\_\_

• Social \_\_\_\_\_

• Occasional \_\_\_\_\_

• Daily \_\_\_\_\_

How many glasses a day? \_\_\_\_\_



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**NAME:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ACTIVITIES OF DAILY LIVING:**

Can you handle your own personal care (Toileting, Eating, Walking, Dressing, Bathing)?

YES \_\_\_ NO \_\_\_ SOME \_\_\_

Do you do your own cooking? YES \_\_\_ NO \_\_\_

Do you do your own cleaning? YES \_\_\_ NO \_\_\_

Do you do your own shopping? YES \_\_\_ NO \_\_\_

Do you handle your own finances? YES \_\_\_ NO \_\_\_

Do you handle your own medications? YES \_\_\_ NO \_\_\_

If you answered no to any of these questions, who does these things for you?

Do you use the phone to call family, friends or for emergencies? YES \_\_\_ NO \_\_\_

Do you drive? YES \_\_\_ NO \_\_\_

If so, have you had any accidents or near accidents in the last two years? YES \_\_\_ NO \_\_\_

Have you ever gotten lost? YES \_\_\_ NO \_\_\_

**PLEASE INDICATE IF YOU ARE HAVING PROBLEMS WITH ANY OF THE FOLLOWING:**

Dizziness YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Blurred Vision YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Headaches YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Swelling YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Chest Pain YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Insomnia YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Sexual Function YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Memory Loss YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Easily Fatigued YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Recent Fall YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Painful/Burning Urination YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Diarrhea/Constipation YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Indigestion/Heartburn YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Weight loss/ Weight gain YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Muscle or Joint Pain YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Anxiety/ Depression YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Recent appetite changes YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Shortness of Breath YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_

Cough YES \_\_\_ NO \_\_\_ Comments \_\_\_\_\_



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Please complete this intake form so we can better understand your needs and provide personalized care.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Symptom & Lifestyle Assessment**

1. Do you experience any symptoms of urinary incontinence? (circle all that apply):

Leakage / Frequent urination/ Sudden urgency / Difficulty holding urine

2. Do you get up during the night to urinate? Yes / No If yes, how many times per night? \_\_\_\_\_

3. Do you use pads or incontinence products? Yes / No

If yes, how many times do you change them per day? \_\_\_\_\_

4. Do you feel urgency with little time to reach the restroom? Yes / No

5. Do physical activities such as laughing, coughing, sneezing, running, or jumping ever cause urine leakage? Yes / No

If yes, how much? • A few drops • Moderate amount • Enough to require a pad

6. If you are male, do you experience erectile dysfunction (ED)? Yes / No

### **Balance, Stability & Core Wellness (Bonus Assessment)**

7. Do you feel unsteady or notice balance issues during daily activities? Yes / No

8. Do you have difficulty going from sitting to standing (hesitation, weakness, or needing momentum)? Yes / No

9. Do you experience lower back pain that may be related to core or pelvic floor weakness? Yes / No

Additional Comments or Goals:

Thank you for completing this form. Your responses help us deliver thoughtful, individualized care



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NAME: \_\_\_\_\_

Date of birth: \_\_\_\_\_

**Current Medication List**

| Medication Name | Dosage | Frequency |
|-----------------|--------|-----------|
| 1.              |        |           |
| 2.              |        |           |
| 3.              |        |           |
| 4.              |        |           |
| 5.              |        |           |
| 6.              |        |           |
| 7.              |        |           |
| 8.              |        |           |
| 9.              |        |           |
| 10.             |        |           |
| 11.             |        |           |
| 12.             |        |           |
| 13.             |        |           |
| 14.             |        |           |
| 15.             |        |           |
| 16.             |        |           |
| 17.             |        |           |
| 18.             |        |           |
| 19.             |        |           |
| 20.             |        |           |

Drug Allergies: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_

**PLEASE MAKE SURE TO BRING YOUR ALL MEDICATION BOTTLES TO ALL  
APPOINTMENTS WITH US.  
THANK YOU!**