HANSEN CLINIC

NATURAL MEDICINE | AESTHETICS | MESOTHERAPY

CONFIDENTIAL PATIENT INFORMATION

Dear Patient; please respond to the following questions as completely and accurately as possible. Your cooperation is greatly appreciated. This important information will enable us to serve you better. **PLEASE PRINT**

Patient Name: ____ Date:_________/_________/___________

Home Street Address: _____________________________________ Home Phone: ________________________

City: _________________________ State: ____________________ Zip Code _____________________________

Date of Birth: ______/______/_______ Age:______ Sex:_______ Social Security #: _______- _____-_______

Cell Phone: ________________________ Email address: ____

Employer: ____ Work Phone #: ________________________

Spouse's Name: ____ Contact Phone #: _____________________

Name Of Parents If Patient Is A Dependant Child: ____

Nearest Relative Not Living With You: _______________________ Phone #: _______________________________

Emergency Contact Person: _______________________________ Phone #: _______________________________

How Did You Hear About Us? Friend or Associate (please give their name)____________________________________

Yellow Pages (under which listing?) ____________________________ News Article _____________________

Newspaper Advertisement (which paper?) ________________________ Other ____________________________

PATIENT HEALTH HISTORY

What is your major complaint: ____

____

Other complaints: ____

____

How long have you had this condition? ____

____

Have you ever had this or a similar condition in the past? ___________________________________

How long has it been since you REALLY felt good? ____

List previous diagnosis and treatments you have received prior to your present complaint: ___________________

____

____

List any serious illnesses or surgical operations with dates or approximate dates: ____________________________

____

List all medications that you are currently taking, both over the counter and prescription. Please include pill strength and number taken per day (use back of this page if needed): ____

FAMILY HEALTH HISTORY

Many health conditions are the result of hereditary predisposition; this information about your family members will give us a better perspective of your total health picture.

Relationship to Yourself	Please List Any Significant Health Problems

P) 480.991.5092 F) 480.991.2027 8070 East Morgan Trail, Suite #120 Scottsdale, AZ 85258

TERMS OF PAYMENT

Payment for the services and dispensary items is due in full at the time such services or dispensary items are received. We accept cash, checks, MasterCard or Visa. Returned checks are subject to a $20.00 collection fee. Missed appointments and appointments cancelled without 24 hours advance notice are subject to a $25.00 charge to your account for the prevention of service that could have been provided to another patient during that time. We realize that temporary financial problems can occur; special arrangements must be made with the office manager prior to any services or distribution of dispensary items.

I, the undersigned, certify that the “Confidential Patient Information”, above is true and correct to the best of my knowledge and agree to notify you in the event of any change thereto. I have read and agree to the “Terms of Payment”, stated herein.

Signature: ____ Date: ______________________

Comprehensive Health Assessment

Name: **Date:**

Directions: In order to provide you with a comprehensive health assessment and plan, we need you to carefully complete the following questionnaire. Please select the answer that most closely matches your response:
0=None or Never, **1**=Mild or Occasional, **2**=Moderate or Frequent, **3**=Severe or Constant

Section 1: Psychological

	0	1	2	3		0	1	2	3		0	1	2	3
1. Anxiety					7. Poor Memory					13. Irritability				
2. Nervousness					8. Impatient					14. Cry Easily				
3. Depression					9. Moody					15. Jittery/Shaky				
4. Poor Concentration					10. Indecisive					16. Anger				
5. Mental Dullness					11. Fears					17. Grief				
6. Apathy					12. Perfectionist					18. Worry				

Section 2: Metabolism

	0	1	2	3		0	1	2	3		0	1	2	3
1. Restless/Hyper					5. Hot Tendency					9. Overweight				
2. Fatigue/Lethargy					6. Fevers					10. Underweight				
3. Cold Tendency					7. Perspiration					11. Tired after Eating				
4. Cold Hands & Feet					8. Night Sweats					12. Need AM Coffee				

Section 3: Skin & Hair

	0	1	2	3		0	1	2	3		0	1	2	3
1. Dry					7. Psoriasis					13. Hair Loss				
2. Oily					8. Brown Spots					14. Dark Under Eyes				
3. Acne					9. Warts					15. Swelling Under Eyes				
4. Rashes					10. Bruising					16. Brittle Nails				
5. Hives					11. Moles					17. Cellulite				
6. Itching					12. Red Spots					18. Wrinkles				

Section 4: Head/Eyes/Ears/Nose/Throat

	0	1	2	3		0	1	2	3		0	1	2	3
1. Headaches					9. Itching Ears					17. Swollen Glands				
2. Eye Strain					10. Sinus Problems					18. Bleeding Gums				
3. Visual Disturbances					11. Nasal Congestion					19. Receding Gums				
4. Poor Night Vision					12. Runny Nose					21. TMJ (click/pain)				
5. Hay Fever					13. Post Nasal Drip					22. Canker Sores				
6. Poor Hearing					14. Sneezing					23. Cold Sores				
7. Ringing in Ears					15. Poor Taste Sense					24.Nose Bleeds				
8. Earaches					16. Sore Throats					25. Fullness in Throat				

Directions: 0=None or Never, **1**=Mild or Occasional, **2**=Moderate or Frequent, **3**=Severe or Constant

Section 5: Lung/Respiratory System

	0	1	2	3		0	1	2	3		0	1	2	3
1. Cough or Phlegm					4. Bronchitis					7. Exposure to Smog				
2. Difficulty Breathing					5. Asthma					8. Smoking Tobacco				
3. Ever had Pneumonia	No		Yes		6. Ever had Pleurisy	No		Yes		# of Cigarettes per day				

Section 6: Cardiovascular

	0	1	2	3		0	1	2	3		0	1	2	3
1. Chest Pain					6. Lack of Exercise					11. Swelling in Ankles				
2. Irregular Heartbeat					7. Rapid pulse (>82)					12. Cold Extremities				
3. High Blood Pressure					8. Heart palpitations					13. Varicose Veins				
4. High Chol. (>200)					9. Heaviness in Legs					14. Heart Attack History				
5. High Trig (>135)					10. Pain in Legs					15. Stroke History				

Section 7: Immune Function

	0	1	2	3		0	1	2	3		0	1	2	3
1. Colds					5. Slow to Heal					9. Cold Sores/Herpes				
2. Flu's					6. Fevers					10. Childhood Vaccines				
3. Slow Recover					7. Frequent Antibiotic					11. Chronic Fatigue				
4. Swollen Lymph Glands					8. Sore Throats					12 History of Shingles	No		Yes	

Section 8: Gastrointestinal Tract

	0	1	2	3		0	1	2	3		0	1	2	3
1. Appetite					8. Mucous in Stool					15. Heartburn				
2. Thirst					9. Dark Stool					16. Abdominal Pain				
3. Burping					10. Light Stool					17. Hemorrhoids				
4. Bloating					11. Hard Stool					18. Itching in Rectum				
5. Gas					12. Thin Stool					19. Fatigue after Eating				
6. Constipation					13. Nausea					20. History of Gallstones	No		Yes	
7. Loose Stool					14. Vomiting					21. History of Ulcer	No		Yes	

Section 9: Urinary Tract

	0	1	2	3		0	1	2	3		0	1	2	3
1. Frequent Urination					6. Dripping after Urine					11. Bed Wetting				
2. Urgency to Urinate					7. Urine Involuntary					12. Full Sensation				
3. Awaken to Urinate					8. Cloudy Urine					13. Straining				
4. Pain while Urinating					9. Strong Urine Odor					14. Flank/Kidney Pain				
5. Hard to start Urine					10. Urinary Infections					15. History of Stones	No		Yes	

Section 10: Sleep

	0	1	2	3		0	1	2	3		0	1	2	3
1. Difficulty falling Asleep					3. Awaking at Night					5. Need > 9 hrs Sleep				
2. Restless Sleep					4. # Times Awakened					6. Awaken by Sunlight				

Directions: 0=None or Never, **1**=Mild or Occasional, **2**=Moderate or Frequent, **3**=Severe or Constant

Section 11: Musculoskeletal

	0	1	2	3		0	1	2	3		0	1	2	3
1. Joint Pain					5. Muscle Cramps					9.Auto Accident	No		Yes	
2. Neck Pain					6. Stiffness					10. Disc Herniation				
3. Back Pain					7. Arthritis					11. Spinal Curvature				
4. Muscle Spasms					8. Tendonitis/Bursitis					12. Loss of Height				

Section 12: Neurological

	0	1	2	3		0	1	2	3		0	1	2	3
1. Loss of Balance					3. Numbness					5. Trembling				
2. Lightheadness/Dizzy					4. Tingling					6. Poor Concentration				

Section 13: Male Issues

1. Impotence					4. Swollen Genitals					7. History of STD*	No	Yes
2. Pain in Genital Area					5. Rash in Groin					8. History of Prostatitis	No	Yes
3. Inguinal Hernia					6. Penile Discharge					9. Enlarged Prostate	No	Yes

*STD = Sexually Transmitted Disease

Section 14: Lifestyle Questions
Directions: Please answer all questions by checking Yes or No or filling in the blank where appropriate

	NO	YES
1. Have you ever had heart disease?		
2. Has anyone in your immediate or extended family had heart disease? Who?		
3. Do you smoke? If yes, how many packs per day? For how long?		
4. Do you drink alcohol? If yes, how much? How often?		
5. Do you exercise regularly? If yes, #days per week? For how long?		
6. How many times per week do you eat meat (beef, pork, poultry, or fish)?		
7. How many times per week do you have dairy products?		
8. How many soft drinks do you drink per week?		
9. How much time do you spend in the outdoors per week?		
10. How many caffeine drinks do you drink per week? Coffee: Other:		
11. How often do you take Aspirin, Ibuprofen, or Antacids?		
12. How many hours do you sleep per day?		
13. How many hours/day are you exposed to 2nd hand smoke?		
14. How would you rate your exposure to Air Pollution? Low Med High (circle one)		
15. How many x-rays have you had in your lifetime? Chest: Other:		
16. Have you ever worked, gone to school, or lived in a building with asbestos?		
17. Have you ever been diagnosed with Colitis Polyps Diverticulosis (circle if appropriate)		
18. What type of water do you drink?		
19. Have you ever chewed tobacco? If yes how long?		
20. How would you rate your level of exposure to the sun? Low Med High (Circle one)		
21. Does your skin sunburn easily? How many times have you been burned?		
22. Do you live near electrical towers or lines? If yes, how close?		
23. Do you bruise easily, or get small red bumps on your skin?		
24. How often do you eat smoked foods?		
25. Has anyone in your immediate or extended family had cancer?		
25. a) If yes, what was their relationship to you? How old were they?		
25. b) What type of cancer did they have?		

Section 15: Subjective Stress Assessment

Name: **Date:**

Directions: Circle the number that corresponds most closely to how you rate yourself on the scale below. For example, if you are almost always relaxed, circle 1; if you are almost always tense, circle 10; a rating of 5 would be half-and-half. Usually, the answer that comes to your mind first is the most accurate.

1. Relaxed	1 2 3 4 5 6 7 8 9 10	Tense
2. Calm	1 2 3 4 5 6 7 8 9 10	Anxious
3. Worry Free	1 2 3 4 5 6 7 8 9 10	Worry Excessively
4. Happy	1 2 3 4 5 6 7 8 9 10	Depressed
5. High Energy	1 2 3 4 5 6 7 8 9 10	Low Energy
6. Sleep Well	1 2 3 4 5 6 7 8 9 10	Sleep Poor
7. Bed Comfortable	1 2 3 4 5 6 7 8 9 10	Uncomfortable
8. Unhurried	1 2 3 4 5 6 7 8 9 10	Hurried/Pressured
9. Carefree	1 2 3 4 5 6 7 8 9 10	Overcommitted
10. Daily Relaxation	1 2 3 4 5 6 7 8 9 10	No Daily Relaxation
11. Time for hobbies & recreation	1 2 3 4 5 6 7 8 9 10	No time for hobbies/recreation
12. Time for Contemplation	1 2 3 4 5 6 7 8 9 10	No time for contemplation
13. Enjoy Occupation	1 2 3 4 5 6 7 8 9 10	Detest Job
14. Satisfying Life	1 2 3 4 5 6 7 8 9 10	Frustrated
15. Expectations Fulfilled	1 2 3 4 5 6 7 8 9 10	Not Fulfilled
16. Achieving Personal Goals	1 2 3 4 5 6 7 8 9 10	Not Achieving personal goal
17. Loved	1 2 3 4 5 6 7 8 9 10	Not Loved
18. Loving	1 2 3 4 5 6 7 8 9 10	Angry/Resentful
19. Quiet Environment	1 2 3 4 5 6 7 8 9 10	Noisy Environment
20. Ordered Surroundings	1 2 3 4 5 6 7 8 9 10	Chaotic Surroundings

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Comprehensive Hormone Test

Please circle the number that best describes your situation regarding each of the statements in the grids below and then add the numbers you circled to get your total score.

ALDOSTERONE					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) I urinate too many times a day.	0	1	2	3	4
2.) I crave salty foods.	0	1	2	3	4
3.) My blood pressure is low.	0	1	2	3	4
4.) I feel dizzy when I stand up.	0	1	2	3	4
5.) I feel much better lying down than standing up.	0	1	2	3	4

Total Score:

Score:

5 or less: Satisfactory level.

Between 6 and 10: Possible aldosterone deficiency.

11 or more: Probable aldosterone deficiency.

CORTISOL					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) My face looks thinner.	0	1	2	3	4
2.) My friends call me skinny.	0	1	2	3	4
3.) I have eczema, psoriasis, urticaria ("nettle rash"), skin allergies, or other rashes.	0	1	2	3	4
4.) My heart beats quickly.	0	1	2	3	4
5.) My blood pressure is low.	0	1	2	3	4
6.) I crave salt or sugar (to the extreme of bingeing).	0	1	2	3	4
7.) I have digestive problems.	0	1	2	3	4
8.) I have allergies (hay fever, asthma, etc.).	0	1	2	3	4
9.) I'm stressed out.	0	1	2	3	4
10.) I'm easily confused.	0	1	2	3	4

Total Score:

Score:

10 or less: Satisfactory level.

Between 11 and 20: Possible cortisol deficiency.

21 or more: Probable cortisol deficiency.

DHEA					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) My hair is dry.	0	1	2	3	4
2.) My skin and eyes are dry.	0	1	2	3	4
3.) My muscles are flabby.	0	1	2	3	4
4.) My belly is getting fat.	0	1	2	3	4
5.) I don't have much hair under my arm. (0= plenty of hair / 4= hairless)	0	1	2	3	4
6.) I don't have much hair in the pubic area. (0= plenty of hair / 4= hairless)	0	1	2	3	4
7.) I don't have much fatty tissue in the pubic area. (flat "mount of Venus" in women). (0= padded / 4= flat)	0	1	2	3	4
8.) I can't tolerate noise.	0	1	2	3	4
9.) My libido is low.	0	1	2	3	4

Total Score:

Rating: *10 or less*: Satisfactory level; *Between 11 and 20*: Possible DHEA deficiency; *21 or more*: Probable DHEA deficiency.

ESTROGEN					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) I am losing hair on top of my head.	0	1	2	3	4
2.) I'm getting thin, vertical wrinkles above my lips.	0	1	2	3	4
3.) My breasts are droopy.	0	1	2	3	4
4.) My face is too hairy.	0	1	2	3	4
5.) My eyes are dry and easily irritated.	0	1	2	3	4
6.) I have hot flashes.	0	1	2	3	4
7.) I feel tired constantly.	0	1	2	3	4
8.) I am depressed.	0	1	2	3	4
9.) My menstrual flow is light. (0= moderate / 1-3= low / 4= none)	0	1	2	3	4
10.) *Women **with** periods*: My cycles are irregular, too short (< 27 days, or too long > 31 days).	0	1	2	3	4
11.) *Women **without** periods*: I do not feel like making love anymore.	0	1	2	3	4

Total Score:

Rating: *10 or less*: Satisfactory level; *Between 11 and 20*: Possible estrogen deficiency; *21 or more*: Probable estrogen deficiency.

GROWTH HORMONE					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) My hair is thinning.	0	1	2	3	4
2.) My cheeks sag.	0	1	2	3	4
3.) My gums are receding.	0	1	2	3	4
4.) My abdomen is flabby. (I've got a "spare tire")	0	1	2	3	4
5.) My muscles are slack.	0	1	2	3	4
6.) My skin is thin and/or dry.	0	1	2	3	4
7.) It's hard to recover after physical activity.	0	1	2	3	4
Growth Hormone continued 8.) I feel exhausted.	0	1	2	3	4
9.) I don't like the world. I tend to isolate myself.	0	1	2	3	4
10.) I feel continuously anxious and worried.	0	1	2	3	4

Total Score:

Rating: *10 or less*: Satisfactory level. *11 and 20*: Possible growth hormone deficiency. *21 or more*: Probable growth hormone deficiency.

INSULIN					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) Crave sugar and sweets, and eat a lot of them.	0	1	2	3	4
2.) I'm always thirsty.	0	1	2	3	4
3.) I urinate a lot during the day as well as at night.	0	1	2	3	4
4.) I have difficulty healing.	0	1	2	3	4
5.) My stomach and buttocks are skinny.	0	1	2	3	4

Total Score:

Score:

5 or less: Satisfactory level.

Between 6 and 12: Possible insulin deficiency.

13 or more: Probable insulin deficiency.

MELATONIN					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) I look older than I am.	0	1	2	3	4
2.) I have trouble falling asleep at night.	0	1	2	3	4
3.) I wake up during the night.	0	1	2	3	4
4.) I can't get back to sleep after waking up.	0	1	2	3	4
5.) My mind is busy with anxious thoughts while I'm trying to fall asleep.	0	1	2	3	4
6.) My feet are too hot at night.	0	1	2	3	4
7.) When I get up I don't feel rested.	0	1	2	3	4
8.) I feel like I'm living out of sync with the world, going to bed late and waking up late.	0	1	2	3	4
9.) I can't tolerate jet lag.	0	1	2	3	4
10.) I smoke, drink, and/or use a beta-blocker or a sleep aid.	0	1	2	3	4

Total Score:

Score:

10 or less: Satisfactory level.

Between 11 and 20: Possible melatonin deficiency.

21 or more: Probable melatonin deficiency.

PREGNENOLONE					
Signs and Symptoms of Deficiency	*Never*	*Sometimes*	*Regularly*	*A Lot*	*Constantly*
1.) I have memory loss.	0	1	2	3	4
2.) My joints hurt (fingers, wrists, elbows, feet, ankles, knees).	0	1	2	3	4
3.) I'm feeling a bit drained and I have a hard time handling stress.	0	1	2	3	4
4.) I don't see colors as brightly as before.	0	1	2	3	4
5.) I have lost interest in art; I don't appreciate art as much anymore.	0	1	2	3	4
6.) I don't have much hair under my arms or in the pubic area. (0= plenty of hair / 4= hairless)	0	1	2	3	4
7.) My muscles are flabby.	0	1	2	3	4
8.) I have abundant, light-colored urine during the day.	0	1	2	3	4
9.) I have low blood pressure.	0	1	2	3	4
10.) I crave salty foods.	0	1	2	3	4

Total Score:

Score:

10 or less: Satisfactory level.

Between 11 and 20: Possible pregnenolone deficiency.

21 or more: Probable pregnenolone deficiency.

PROGESTERONE					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) My breasts are large.	0	1	2	3	4
2.) My close friends complain I'm nervous and agitated.	0	1	2	3	4
3.) I feel anxious.	0	1	2	3	4
4.) I sleep lightly and restlessly.	0	1	2	3	4

Total Score:

Rating: *4 or less*: Satisfactory level. *Between 5 and 8*: Possible Progesterone deficiency. *9 or more*: Probable progesterone deficiency.

TESTOSTERONE					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) My face has gotten slack and more wrinkled.	0	1	2	3	4
2.) I've lost muscle tone.	0	1	2	3	4
3.) My belly tends to get fat.	0	1	2	3	4
4.) I'm constantly tired.	0	1	2	3	4
5.) I feel like making love less often than I used to.	0	1	2	3	4
6.) My breasts are getting fatty.	0	1	2	3	4
7.) I feel less self- confident and more hesitant.	0	1	2	3	4
8.) My sexual performance is poorer than it used to be.	0	1	2	3	4
9.) I have hot flashes and sweats.	0	1	2	3	4
10.) I tire easily with physical activity.	0	1	2	3	4

Total Score:

Rating:

10 or less: Satisfactory level.

Between 11 and 20: Possible testosterone deficiency.

21 or more: Probable testosterone deficiency.

THYROID HORMONES					
Signs and Symptoms of Deficiency	Never	Sometimes	Regularly	A Lot	Constantly
1.) I'm sensitive to cold.	0	1	2	3	4
2.) My hands and feet are always cold.	0	1	2	3	4
3.) In the morning my face is puffy and my eyelids are swollen.	0	1	2	3	4
4.) I put on weight easily	0	1	2	3	4
5.) I have dry skin.	0	1	2	3	4
6.) I have trouble getting up in the morning.	0	1	2	3	4
7.) I feel more tired at rest than when I am active.	0	1	2	3	4
8.) I am constipated.	0	1	2	3	4
9.) My joints are stiff in the morning.	0	1	2	3	4
10.) I feel like I am living in slow motion.	0	1	2	3	4

Total Score:

Score:

10 or less: Satisfactory level.

Between 11 and 20: Possible thyroid hormone deficiency.

21 or more: Probable thyroid hormone deficiency.