Evolution Wave

Enhancement…Performance…Vitality

Name: _____

Address: _____

Home Phone:_____WorkPhone:_____

Email: _____ Cell Phone: _____

Age: _____DOB: _____Occupation: _____

Employer:_____

SSN: _____ Driver's License: State_____#_____

Emergency Contact: _____ Phone: _____

HIPPA PRIVACY NOTICE

This form is intended for the use and\or disclosure of Protected Health Information (PH)

when providing or seeking treatment, payment, and healthcare operations

1. This privacy Notice contains a thorough and complete description of the uses and\or disclosures of my protected health information ("PH") which are necessary to provide me with treatment, and which are also necessary for the Practice to obtain payment for that treatment and to perform other healthcare operations. I have been informed that, upon my request, the privacy notice will be made available to me. Prior to signing this Agreement, the Practice advised me of my right to obtain a copy of the Privacy Notice and has encouraged me to read it in its entirely, in accordance with applicable law.
2. To protect your privacy and to remain in compliance with applicable law, the Practice reserves the right to change the practices depicted in its Privacy Notice.
3. I am aware that the Practice's "Notice of Privacy Practices" is displayed in the waiting area and that I am free to request a copy of the same at any time.
4. The Notice of Privacy Practices contains my rights, as well as the duties and obligations of this office as it relates to my protected health information.

I have read and understand this notice in its entirety, and agree that any questions I may have had have been answered to my full and complete satisfaction and understanding.

_____ _____

Name of Individual (Printed) Signature of Individual

For Medic Use Below: BP____/_____ P_____ Allergy_____

R_____ WT_____ Meds _____

_____

Land O'Lakes Office
5420 Land O Lakes Blvd, Suite 101,
Land O Lakes, FL 34639

Largo Office
1600 West Bay Drive, Suite B
Largo, FL. 33770

P: 813-333-5593, Fax: 813-235-4135
* Erin Bolton, Functional Medicine Specialist
*Christopher Van Benschoten, MD

Email: admin@evo4health.com • ***Website:*** www.Evolution4Health.com

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Sexual Health Inventory for Men

Name: _____ DOB: _____Today's Date: _____

Patient Instructions: Please be sure that you select one and only one response for each question.

Over the past 6 months:

1.	How do you rate your confidence that you can maintain an erection?	Very low 1	Low 2	Moderate 3	High 4	Very High 5
2.	When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never\never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most of the time (much more than half the time) 4	Almost always/always 5
3.	During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never\never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most of the time (much more than half the time) 4	Almost always/always 5
4.	During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5.	When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never\never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most of the time (much more than half the time) 4	Almost always/always 5

The IIEF-5 scoring:

The IIEF-5 score is the sum of the ordinal responses to the 5 items.

22-25: No erectile dysfunction

17-21: Mild erectile dysfunction

12-16: Mild to moderate erectile dysfunction

8-11: Moderate erectile dysfunction

5-7 Severe erectile dysfunction Total: _____

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Medical Questionnaire

Difficulty getting an erection	Yes	No
Difficulty maintaining an erection	Yes	No
Peyronie's Disease (curved penis)	Yes	No

Please describe your main sexual concern _____

Do you have a family physician? Yes No When was your last physical? _____

Current medications: _____

Have you used any medications for erectile dysfunction?

	Never used	Good results	Poor results	Comments
Viagra	_____	_____	_____	_____
Cialis	_____	_____	_____	_____
Livitra	_____	_____	_____	_____
Caverject	_____	_____	_____	_____
Muse	_____	_____	_____	_____
Testosterone	_____	_____	_____	_____

Social History

Cocaine use: Yes No Alcohol: Yes No

Marijuana: Yes No Tobacco use: Yes No

Other: _____

Allergies

Have you had an allergic reaction to any medications? Yes No

If Yes please provide details _____

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Medical History

Arthritis	Yes	No	Headaches	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No
High Blood Pressure	Yes	No	Blocked Artery	Yes	No
Heart Attack	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Parkinson's Disease	Yes	No
Multiple Sclerosis	Yes	No	Liver Disease	Yes	No
Epilepsy	Yes	No	Kidney Disease	Yes	No
Hepatitis	Yes	No	Prostate Problems	Yes	No
Bowel Problems	Yes	No	Acute Swelling/Pain	Yes	No
Cancer	Yes	No	HIV Infection\AIDS	Yes	No
Blood Transfusion	Yes	No	Major Depression	Yes	No
Tuberculosis	Yes	No	Bleeding Problems	Yes	No
Uro-Gential Problems	Yes	No	Skin Problems	Yes	No
Sickle Cell Anemia	Yes	No	Sexually Transmitted	Yes	No
Sickle Cell Trait Only	Yes	No	Herpes	Yes	No
Peyronies Disease	Yes	No	Malaria	Yes	No
Fabry's Disease	Yes	No	Leukemia	Yes	No

Other:_____

Surgery

Heart	Yes	No	Blocked Artery	Yes	No
Prostate	Yes	No	URO-Genital	Yes	No
Bowel	Yes	No	Bladder	Yes	No
Hernia	Yes	No	Head	Yes	No
Orthopedic	Yes	No	Spine	Yes	No

Other: _____

Injuries

Head	Yes	No	Back	Yes	No
Pelvis	Yes	No	Extremities	Yes	No

Other: _____

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HIPPA Compliance Patient 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 law allows for the use of the information for treatment, payment, or healthcare operations.

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 buy you. However, such a revocation will not be retroactive.

By signing this form, I understand that:\

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Evolution reserves the right to change the privacy policy as allowed by law.
- Evolution 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 and all full disclosures will then cease.
- Evolution may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If yes, please name the members allowed: _____

_____

This consent was signed by: _____

(Print name please)

Signature: _____Date: _____

Witness: _____Date: _____

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Informed Patient Consent

Dear Patient,

You will be interviewed by our physician to obtain your medical history and to perform a brief physical exam. If there are no medical contra-indications, a plan for the Acoustical Wave Treatment will be discussed and implemented. There may be some mild discomfort from the treatments. Patient responses to the treatment are variable. While most have an improvement in their erectile dysfunction, some may not.

I, _____, fully understand the nature of the test and treatment described above. I have been given the opportunity to ask any questions I may have. I acknowledge that I have been previously cleared by my own treating Physician to have sexual activity and\or moderate exercise. I agree to pay a medical consultation fee of $_____ upon completion of my visit. I am aware that the purchase of any treatments I elect are final and nonrefundable. If I am cleared medically by the physician indicated below, I consent to treatment by the Evolution Wave clinical staff. I acknowledge that these services are considered to be elective treatments, and that they are not covered by Medicare or commercial insurance.

Signed this _____ day of _____, _____

Patient's Signature: _____

Doctor's Signature: _____

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