Vitalized Performance Group

Demographic Information

Today's Date: _____

Please bring in your valid Government issue ID and hand it to your provider

Name: _____ Date of Birth: _____

Address: _____ Email: _____

City, State: _____ Cell Phone: _____

Zip Code: _____ Home Phone: _____

Emergency Contact: _____ Contact's Phone: _____

Reason for today's visit: _____

How long have you had this issue? _____

Have you seen anyone else to address this issue? Who? _____

What other treatments have you received? _____ _____

Are you under the routine care of a physician or other PCP? _____

Physician's /PCP's name and contact info: _____

How did you hear about us?

- Physician (who and where?) _____
- Friend/Family Member _____
- VPG Client _____
- Radio/TV Ad (what channel?) _____
- Coupon (where?) _____
- Sign (where?) _____
- Internet search (what were your search terms?) _____

  _____
- Other (where) _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. Vitalized Performance Group is a collaborative practice and by signing this form you give each one of us permission to look at your file and discuss amongst each other your medical condition and treatment plan.

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

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.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potential anonymous use in publication. You have the right to revoke this consent in writing, signed by you.

By signing this form, I understand that:

- Protected health information may be disclosed or used of treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed only by law.
- The practice has the right to restrict the information, but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time and the full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
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Our Email: **vpgwaves@gmail.com** is a HIPAA COMPLIANT 3RD PARTY ENCRYPTED EMAIL: PLEASE USE THIS EMAIL FOR ALL IMPORTANT AND CONFIDENTIAL EMAILS. ALL PROVIDERS HAVE ACCESS TO THIS EMAIL. We understand that many households use shared e-mail addresses. You give us permission to send emails where others can potentially access the information. With today's advances in technology and the busy lifestyles that people lead, email is often preferred over other forms of communication when it comes to confirming appointments or sending lab test results. However, patients/clients should be aware that even despite extensive efforts on the part of the healthcare provider to protect sensitive information, no email is 100% safe.

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

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

May we discuss your medical condition with any member of your family or other medical establishment: Yes No

If YES, please provide the names of members allowed:

_____

_____

This consent was signed by (PRINT NAME): _____ Legal Guardian _____

Signature: _____ Date: _____

Witness: _____ Date: _____

(Please note: this form is for male patients.)

Patient Name:_____Patient DOB: _____

Procedure: **GAINSWave®**

Primary Goal**: Erectile Performance ED Peyronie's**

Medical History**: DM HTN CVD**

Current Med Use**: Beta-Blockers SSRIs PDE5i [Cialis, Viagra]**

Prior use of PDE5i: **(circle one) YES NO** PDE5i Response**: None / Poor / Good**

Erectile Hardness Score

1. Penis is larger but not hard.
2. Penis is hard, but not hard enough for penetration.
3. Penis is hard enough for penetration but not completely hard.
4. Penis is completely hard and fully rigid.

SHIM

1. How would you rate your confidence that you can get and keep an erection?
0 - no confidence 1 - very low 2 - low 3 – moderate 4 – high 5 - very high

2. When you have erections with sexual stimulation how often are your erections hard enough for penetration?
0 – no sexual activity 1 – never 2 - a few times 3 – sometimes 4 - most times 5 - always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?
0 – no sexual activity 1 – never 2 - a few times 3 – sometimes 4 - most times 5 - always

4. During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse?
0 – no intercourse 1 - extremely difficult 2 - very difficult 3 – difficult 4 - slightly difficult 5 - not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?
0 – no intercourse 1 – never 2 - a few times 3 - sometimes 4 - most times 5 - always

Erectile Hardness Score_____ **SHIM Total Score** _____

0-7 Severe ED 8-11 Moderate ED 12-16 Mild moderate ED 17-21 Mild ED 22-25 No ED

Treatment Recommendations:

- GAINSWave _____ treatments
- AFFIRM dosage: _____
- Penis pump (10 minutes in 1-minute increments)

Date: _____

Detailed Patient Intake Form for: (please print) _____

Date of Birth: _____ Age: _____ Gender: _____ Pronoun preference: _____

Are you under the routine care of a licensed medical provider? ____ Name/location: _____

Weight: _____ Height: _____ Diabetic type: 1 / 2 / not diabetic

Weight one year ago: _____ Maximum weight: _____ (when: _____) Ideal weight: _____

Do you have good or adequate or low energy? _____

Do you experience fatigue? _____

Does fatigue affect you most in the morning ____, afternoon ____, or evening ____?

Does fatigue prevent you from necessary activity? _____

List your health concerns in order of importance:

1)	4)
2)	5)
3)	6)

Family History

	Father	Mother	Siblings	Grandparents	Children
Age living/deceased	_____	_____	_____	_____	_____
Reason for death:	_____	_____	_____	_____	_____
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N
Cancer:	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N

List all your Surgeries & Hospitalizations, including date they occurred:

_____

_____

_____

_____

List all allergies to medications, food and environment:

_____

_____

_____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Alcohol: _____ per day/week:	Y N P	Alcohol Addiction:	Y N P	Alcohol Treatment: When?	Y N P
Recreational Drug Use: Type:	Y N P	Drug Addiction: Type:	Y N P	Drug Treatment: When?	Y N P
Pain Meds: Type:	Y N P	Steroids:	Y N P	Soda/Energy Drinks: Type:	Y N P
Coffee:	Y N P	Laxatives:	Y N P	Antacids:	Y N P
Cigarettes:	Y N P	Cigarettes per day:		For _____years	

List all prescription medicines & nutrients/supplement/herbs that you are taking and including brand name and dosage:

_____

_____

_____

_____

_____

_____

_____

Daily Living

Do you enjoy your work? _____ Hours worked per week: _____ Highest Level of Education: _____

Rate the quality of significant relationships (spouse, family, coworkers): _____

Do you have a history of sexual, mental/emotional, physical abuse? _____

If yes/past please explain: _____

_____

_____

Exercise

How often do you exercise? _____ What type of exercise? _____

For how long? _____ Hobbies: _____

Amount of screen time per day including TV, Tablets, Computers, Phones: _____

Sleep

How long per night? _____ If you wake up frequently, what is the reason? _____

Wake Refreshed:	Y N P	Must nap during the day:	Y N P
Snore:	Y N P	Grind teeth:	Y N P
Sleepwalk:	Y N P	Nightmares:	Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

_____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

What areas of natural medicine have you had experience with? (Circle all that apply)

Acupuncture/Chinese Medicine	Herbal Medicine	Homeopathy	Ayurveda	Osteopathic Medicine
Massage Therapy	Chiropractic	Midwifery	Environmental Medicine	Chelation Therapy

Comments/Any adverse effects? _____

_____

_____

_____

HEAD

Headache:	Y N P	Migraines:	Y N P
Dandruff:	Y N P	Head injury:	Y N P
Oily/dry hair:	Y N P	Hair loss:	Y N P

NECK

Stiffness:	Y N P	Swollen glands:	Y N P
Restricted movement:	Y N P	Tightness:	Y N P

RESPIRATORY

Cough:	Y N P	Tuberculosis:	Y N P
Shortness of breath on	Y N P	Bronchitis:	Y N P
Shortness of breath while	Y N P	Pneumonia:	Y N P
Shortness of breath while	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P

CARDIOVASCULAR

High blood pressure:	Y N P	Rheumatic fever:	Y N P
Low blood pressure:	Y N P	Murmur:	Y N P
Arrythmia:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest pain:	Y N P

URINARY TRACT

Incontinence:	Y N P	Painful urination:	Y N P
Frequent infections:	Y N P	Kidney Stones:	Y N P
Urgency:	Y N P	Discharge/blood:	Y N P

GASTROINTESTINAL

Heartburn:	Y N P	Bowel movement frequency:	_____x/day
Indigestion:	Y N P	Recent BM change:	Y N P
Bloating:	Y N P	Diarrhea/constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall bladder disease:	Y N P
Change in appetite:	Y N P	Liver disease:	Y N P
Pancreatitis:	Y N P	Ulcer:	Y N P

MUSCULOSKELETAL

Weakness:	Y N P	Arthritis:	Y N P
Stiffness:	Y N P	Leg cramps:	Y N P
Tremors:	Y N P	Pain:	Y N P

NERVOUS

Paralysis:	Y N P	Sciatica:	Y N P
Tingling/numbness:	Y N P	Carpal tunnel syndrome:	Y N P
Seizures:	Y N P	Fainting:	Y N P

MENTAL/EMOTIONAL

Depression:	Y N P	Anger/irritability:	Y N P
Suicidal:	Y N P	High-strung/tense:	Y N P
Anxiety:	Y N P	Fear/panic:	Y N P
Eating disorder:	Y N P	Psychiatric treatment:	Y N P

SKIN

Rashes:	Y N P	Color change:	Y N P
Hives:	Y N P	Lump(s):	Y N P
Psoriasis/eczema:	Y N P	Itchiness:	Y N P
Dryness:	Y N P	Warts/moles:	Y N P
Cancer/type: _____	Y N P	Perspiration:	Y N P

FEMALE REPRODUCTIVE

Age period began:		Days in menstrual cycle:	
How long period lasts:		Heavy bleeding:	Y N P
Menstrual cramping:	Y N P	Menstrual pain:	Y N P
PMS:	Y N P	Food cravings	Y N P
Number of pregnancies:		Number of births:	
Miscarriages:		Terminations:	
Last pap smear:		Sexual orientation:	
Abnormal pap smear(s)	Y N P	When was result	
Menopausal since:		Hormone use:	Y N P
Type of hormones used:		Healthy libido:	Y N P
Vaginal dryness:	Y N P	Sexually active:	Y N P
Painful intercourse:	Y N P	Vaginitis:	Y N P
STD/STI:	Y N P	Mammography:	Y N P
Bone density test:	Y N P	Bone density results:	

List any birth control used and ages when used:

_____

_____

_____

MALE REPRODUCTIVE

Testicular pain/swelling:	Y N P	Sexually active:	Y N P
Hernia:	Y N P	STD/STI:	Y N P
Discharge:	Y N P	Prostate	Y N P
Impotence:	Y N P	Sexual orientation:	

Health History Questionnaire for Colon Hydrotherapy

What is a Contraindication? *(con·tra·in·di·ca·tion)* A contraindication is a specific health condition for which a Drug, Disease, Procedure, Treatment or Surgery is inadvisable as it may be harmful to the health of the client/patient.

Mark (x) any contraindications and note the dates of diagnosis or experience

	Abdominal hernia		Dialysis
	Abdominal surgery		Diverticulosis or diverticulitis
	Abdominal distension		Fissures or fistulas
	Acute liver failure		Hemorrhaging
	Anemia		Hemorrhoidectomy
	Aneurysm (all types)		Intestinal perforation
	Cancer - specify type:		Lupus
	Cardiac condition		Pregnant – due date:
	Crohn's disease		Rectal/colon surgery
	Colitis		Renal insufficiencies (kidney disease)

If you have ***NOT*** been diagnosed with any of the above listed contraindications to colon hydrotherapy,

please initial here: _____ date: _____

Please mark (x) all that apply to you:

	Recent colonoscopy (date:)		Hemorrhoids (internal / external)		BM difficult or painful
	Blood in stool		Rectal bleeding		Burning or itching anus
	Constipation or diarrhea		Laxative use		Vomiting
	Bloating		High blood pressure		Infectious disease
	Last menstrual cycle date:		UTI/bladder infection		Latex allergy

I am aware that this clinic uses FDA Colon Hydrotherapy Devices and the trained therapist is *not* required to be state licensed. This clinic does have a Licensed Medical Director who may NOT be on site at the time of your appointment. No studies have been conducted for this alternative and complementary modality. I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon hydrotherapy devices and/or enema kits. Should I experience resistance during my nozzle insertion, I will immediately stop my session. If during the session, I experience discomfort or pain, I am responsible for immediately stopping my session. If you are taking Medications that may increase the risk for potential side effects, then you should consult with your physician before proceeding with your colonic. (please initial to confirm: _____)

I have reviewed and discussed with the LIBBE Device Trained Therapist that I *do not* have any diseases, contraindications or other health concerns that prevent me from safely receiving colonics and I wish to proceed with my colon hydrotherapy sessions:

Signature: _____ Date: _____

As a Trained Therapist, I will always follow the LIBBE Manufacture operation, use & maintenance guidelines. I have reviewed and discussed this form with above client.

Therapist Signature: X_____

I, _____, have decided to undergo a Colon Hydrotherapy session.

Colon Hydrotherapy is intended to irrigate the large intestine with the use of the FDA-approved colon hydrotherapy LIBBE system. I understand there may be benefits resulting from this session; however, I understand and agree that no warranties have been made as to the effectives or outcome of this session.

• We do not diagnose.

• We make no attempt to cure any condition.

• We make no claim or imply any claim that suggestions are given to cure any condition.

• We do not claim that any supplemental material that we discuss will cure any condition or that its purpose is to treat any condition.

I understand that I will insert a tube/speculum into my rectum and agree that I will witness that the tubing the certified therapist is using is sterile from a new, sealed container. _____ (Initial Here)

I understand that all the therapists here are not attempting to portray or conduct the activities of a medical doctor and I waive any liability on behalf of the certified therapist. _____ (Initial Here)

I confirm that I am not a woman who is pregnant as this would make me an unsuitable candidate for this session. _____ (Initial Here)

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment. I hereby give consent for this Colon Hydrotherapy treatment and release the certified therapist, the person performing the Colon Hydrotherapy session and the facility from liability associated with this and all subsequent treatments with the above understood.

Client Signature: _____ Date: _____ / _____ / _____

Patient Consent:

Consent for GAINSWave Procedure:

(**Please inform your medical practitioner if you have a clotting or bleeding disorder or are taking blood thinners as these may be contraindications to the GAINSWave Procedure**)

I authorize the practitioner to treat my condition. I understand the purpose of the therapy procedures to be: Extracorporeal Shock Wave Therapy (ESWT) with an FDA cleared medical device to those areas the Practitioner believes will be the most effective in optimizing sexual health. Although ESWT has been performed on thousands of patients and the risks are very low, I understand that common risks associated with the procedure are swelling, reddening of the skin, soreness, hematomas or bruising and petechiae (minor broken blood vessels). I also understand that there may be risks or complications from both unknown and known causes or treatment. I am aware that there is no guarantee of treatment outcome. I have informed the practitioner of any known allergies to drugs or other substances and any past reactions to any anesthetics. I have informed the practitioner of all current medications and supplements I am taking.

_____ Signature of Patient and Date

Consent for Acupuncture/ Chinese Herbs/ Cupping and Gua Sha

I understand that acupuncture is performed by the insertion of needles through the skin on or near the surface of the body in attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to regulate the body's physiological functions. I am aware of the possible side effects such as but not limited to: local bruising, minor bleeding, fainting, pain or discomfort. I understand that *gua sha* and cupping therapy can lead to bruising, sore muscles and aches. I am aware that Chinese Herbal Therapies or Homeopathic remedies which are used to normalize body function can lead to changes in bowel movements, abdominal pain or discomfort. All therapies can lead to possible aggravation of symptoms. Should I experience any side effects I will notify my practitioner. I have notified my practitioner of any allergies I may have as well as any drugs or supplements that I am taking. I have carefully read and understand all the information and am fully aware of what I am signing, and I consent to treatment.

_____Signature of Patient and Date

Consent for Colon Hydrotherapy:

I am aware of the possible adverse events that may occur during Colon Hydrotherapy including perforation, redness or tenderness at the insertion point. Should I experience resistance during my nozzle insertion, I will immediately stop my session. If during if during the session I experience any discomfort or pain I will stop my session immediately and notify the Practitioner. I have notified my Practitioner of any allergies that I may have including an allergy to latex and any prescription drugs or supplements that I am currently taking. I have reviewed and discussed my medical history with my LIBBE device trained therapist and I do not have any diseases, contraindications or any other health concerns that may affect my treatment. I also understand the possible side effects including but not limited to increased or decreased energy, nausea, vomiting, cramping, lightheadedness, gas and bloating, overheating, diarrhea, headache, body and joint aches, hemorrhoids (which may become irritated, inflamed or bleed.)

_____Signature of Patient and Date