



## Vitalized Performance Group

### Demographic Information

Today's Date: \_\_\_\_\_

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.

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.

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:

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This consent was signed by (PRINT NAME): \_\_\_\_\_

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:

- o GAINSWave \_\_\_\_\_ treatments
- o AFFIRM dosage: \_\_\_\_\_
- o 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**

	<b>Father</b>	<b>Mother</b>	<b>Siblings</b>	<b>Grandparents</b>	<b>Children</b>
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:

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List all allergies to medications, food and environment:

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List Yes (Y), No (N) or Past (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:

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**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? \_\_\_\_\_

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**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
Arrhythmia:	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:

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**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

<input type="checkbox"/>	Abdominal hernia	<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	Abdominal surgery	<input type="checkbox"/>	Diverticulosis or diverticulitis
<input type="checkbox"/>	Abdominal distension	<input type="checkbox"/>	Fissures or fistulas
<input type="checkbox"/>	Acute liver failure	<input type="checkbox"/>	Hemorrhaging
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Hemorrhoidectomy
<input type="checkbox"/>	Aneurysm (all types)	<input type="checkbox"/>	Intestinal perforation
<input type="checkbox"/>	Cancer - specify type:	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Cardiac condition	<input type="checkbox"/>	Pregnant – due date:
<input type="checkbox"/>	Crohn’s disease	<input type="checkbox"/>	Rectal/colon surgery
<input type="checkbox"/>	Colitis	<input type="checkbox"/>	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:

<input type="checkbox"/>	Recent colonoscopy (date: _____ )	<input type="checkbox"/>	Hemorrhoids (internal / external)	<input type="checkbox"/>	BM difficult or painful
<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	Burning or itching anus
<input type="checkbox"/>	Constipation or diarrhea	<input type="checkbox"/>	Laxative use	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Bloating	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Infectious disease
<input type="checkbox"/>	Last menstrual cycle date:	<input type="checkbox"/>	UTI/bladder infection	<input type="checkbox"/>	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 effectiveness 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