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*Congratulations on taking a positive step toward improving your health.
Enclosed please find a New Patient Packet which includes:*

1. **Medical History Intake Form.** Once completed, please return the form and you will then be contacted to schedule an appointment. A credit card number will be required at the time of scheduling to reserve your appointment time.
2. **Information regarding Costs, Payment Policy, and Insurance information.**
3. **Client Provider Agreement**

If applicable, please include the Following Medical Records— these can be mailed to the office ahead of time or bring them with you to your scheduled appointment:

1. Most recent Mammogram
2. Most recent Pap smear.
3. Most recent Bone Density Scan
4. All blood work completed within the last year
5. Any other information pertinent to your situation.

Thank you for your cooperation and I look forward to meeting with you soon.

Sincerely,

Lynn A. Chadd, MSN, ARNP



Medical History Intake Form - Women

Date: _____ Name: _____ Birth Date: _____

Health Maintenance:

Date of last Mammogram _____ Normal Abnormal
If abnormal please explain: _____

Date of last Pap smear _____ Normal Abnormal
If abnormal please explain: _____
Any history of abnormal pap smears? No Yes If yes please describe: _____

Date of last bone density test _____ Normal Abnormal
If abnormal please explain: _____

Date of last colon cancer screening _____ Sigmoidoscopy or Colonoscopy
If abnormal please explain: _____

Date of last Diabetic Blood screening _____ Normal Abnormal
If abnormal please explain: _____

Date of last Cholesterol Blood screening _____ Normal Abnormal
If abnormal please explain: _____

Lifestyle:

Do you smoke? No Yes
If yes, how many per day? _____
Please include previous smoking history
How much and for how long? _____

Do you drink alcohol? No Yes
If so, how much and how often: _____

How many caffeinated beverages do you drink a day? _____
How many sodas do you drink per day? _____

Do you exercise regularly? No Yes
If so, what type and how often: _____

Do you practice any stress management techniques? No Yes
If so, what and how often: _____

What type of work do you do? _____

Diet: Describe your typical daily food intake:

First Meal: Second Meal: Third Meal: Snacks

Any allergies to medications? No Yes if yes please list

Medication Type of Reaction

- 1.
- 2.
- 3.

Please list medications:

Medication Name Dose Times a day prescribed by:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Please list supplements:

Supplement Name Dosage Times of day

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Past Medical History:

Please circle all that apply.

- Heart Disease
- High Cholesterol
- High Blood Pressure
- Breast Cancer
- Uterine Cancer
- Other Cancers
- Ulcers
- Thyroid Problems
- Blood clotting problems
- Respiratory Conditions
- Diabetes
- Arthritis
- Depression
- Anxiety
- Epilepsy
- Headaches/Migraines
- Visual problems
- Osteoporosis or Osteopenia
- Other:

Please List Surgeries:

- 1.
- 2.
- 3.
- 4.
- 5.

Menstrual history: Date of last menstrual period? _____

Skip this section if no longer having periods

How often do you have periods? _____

Tampon/pad size used on heaviest days: Super plus Super Regular Pads Both

On your heaviest days how often to you change your protection? _____

Average length (in days) of periods _____

Do you have any spotting in between your periods? If so describe:

Do you experience any pre-menstrual symptoms? If so, please describe:

Do you have painful periods? Yes No

If so, what do you use for pain control, how often, and for how many days?

Do you miss work due to the pain? Yes No

Obstetrical history:

Number of pregnancies _____

Number of full term deliveries _____

Vaginal or c-sections deliveries _____

Current contraception: Tubal Ligation Vasectomy Birth Control Pills Condoms Other Please Describe: _____

Menopause History:

Last period: _____

Are you currently taking any hormone replacement therapy? No Yes

If yes, please describe: _____

Have you had any problems with hormone replacement you have taken in the past? No Yes

If yes, please describe: _____

Family History:

Please circle all that apply and indicate your relationship:

Breast Cancer Maternal Paternal

Ovarian Cancer Maternal Paternal

Uterine Cancer Maternal Paternal

Colon Cancer Maternal Paternal

Heart Disease Maternal Paternal

Diabetes Maternal Paternal

Osteoporosis Maternal Paternal

Thyroid disorders Maternal Paternal

Other

Please rate the severity of the current symptoms you are experiencing:

Severity	None	Mild	Mod	Severe
Hot flashes	0	1	2	3
Night sweats	0	1	2	3
Vaginal dryness	0	1	2	3
Pain with intercourse	0	1	2	3
Dry eyes	0	1	2	3
Heavy periods	0	1	2	3
Painful periods	0	1	2	3
Uterine fibroids	0	1	2	3
Endometriosis	0	1	2	3
Water Retention	0	1	2	3
Bloating	0	1	2	3
Breast tenderness	0	1	2	3
Depression	0	1	2	3
Difficulty with memory	0	1	2	3
Foggy thinking	0	1	2	3
Mood swings	0	1	2	3
Fatigue	0	1	2	3
Sleep disturbance	0	1	2	3
Anxiety	0	1	2	3
Irritability	0	1	2	3
Headaches	0	1	2	3
Heart palpitations	0	1	2	3
Acne	0	1	2	3
Hair loss	0	1	2	3
Weight gain	0	1	2	3
Decreased sexual desire	0	1	2	3
Decreased sexual arousal	0	1	2	3
Decreased sexual response	0	1	2	3
Thinning skin	0	1	2	3
Muscle Aches	0	1	2	3
Joint Pain	0	1	2	3

Other:

Please circle if experiencing any of these symptoms:

- Snoring
- Sleep apnea or stop breathing while sleeping
- Dozing while seated or inactive
- Nodding off while driving



General Cost Information

- New Patient Consult appointment cost is \$317.00. Your first follow-up appointment is included in this price. Face-to-face appointments can be scheduled at the Peshastin, Washington office or at the Poulsbo Compounding Pharmacy. Telephone appointments are also available for our distance patients; cost is the same as an in office appointment.
- Saliva Test cost is \$175.00 --- Saliva Testing is required while being treated with bio-identical hormones. On average, saliva testing is completed when treatment is initiated, when prescriptions are adjusted and yearly when treatment has stabilized. Frequency of saliva testing will vary from person to person, depending on response to treatment.

Payment Policy

- Payment is due at the Time of Service, as insurance billing services are not provided.
We accept Master Card, Visa, Checks, or Cash.
- Appointments will be reserved with a credit card or check. Please submit checks in advance of telephone appointments.
- For appointment cancellations, 48 hour notice is appreciated. Failing to show will result in a \$125.00 charge.
- Refunds for supplements and/or test kit purchases will be provided for up to 90 days after the purchase date. Restrictions may apply.

Insurance Information

- At the time that services are paid, an itemized statement will be provided. This will include all necessary insurance codes and information for self billing. Please consult with individual insurance plans for correct self billing instructions and appropriate forms. It is advised to make copies of all forms prior to submitting insurance claims.
- Please be informed that Lynn is an Out of Network Provider/Non-Preferred Provider and is not contracted with any insurance companies.
- Medicare does not permit patients to self bill.



Client Provider Agreement

- I understand that Lynn A. Chadd, ARNP does not accept insurance as payment and that I am responsible for payment at the time of service. I have read and agree with the cancellation policy.
- I understand that if Medicare is my insurance—I cannot self bill Medicare for reimbursement as per Medicare’s billing policy and that I am agreeing to pay “out of pocket” for all services—at the time of service.
- I understand that the main focus of Lynn Chadd’s practice is preventative healthcare, integrative care of chronic problems, and treating hormone imbalance in men and women. **I understand that Lynn Chadd does not provide after hour, urgent, emergency or on call care.** I have been advised to retain or maintain a Primary Care Provider for my other health care needs. I have been advised that in the event of an emergency I should dial 911 or go to my local emergency department.
- I have provided accurate medical history information on the Medical History Intake Form.
- I understand that all of my records and information will be confidential according to “The Healthcare Privacy Act”.

Name: _____ Birth date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please list any phone numbers where you would like to be contacted and/or messages left:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Please include an E-mail Address for receiving messages, results and reminders:

Client Signature: _____ Date: _____