New Patient Paperwork

Practice Policies for Patients

Naturopathic Center For Wellness

23792 Rockfield Blvd, Suite 285
Lake Forest, CA 92630
www.naturocw.com

Office of Julianne Miller
PCs.D, RND, CTN, RN, BSN, CCWFN
Traditional Naturopath

Welcome!

We are so happy you have contacted us to help you along your health journey.

Please note:

This is an entire lifestyle change.The treatment is alternative or complementary to healing arts services licensed by the state. It will require effort, and while results are not always immediate, they are worth the changes made. Consistency is key.

Introduction

The Naturopathic Center For Wellness was created in 2003 by Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN, to be a peaceful environment where the health concerns of each patient would be treated holistically. Patients are comprehensively evaluated while their symptoms and concerns are used as clues to find and treat the root cause of their disorder, chronic illness, etc. As preventative healthcare practitioners, we provide encouragement and options to patients who are feeling lost or confused by their current medical care or condition. Our goal is to educate them concerning the health benefits of herbal, nutraceutical, homeopathic, and whole food supplementation, homeopathy and Cranial Sacral therapy application.

We are committed to helping each patient obtain optimal health and we believe that journey requires guidance through the physical, emotional, mental, and spiritual aspects of life. We strongly believe that our holistic healthcare philosophy will provide the knowledge and the tools needed to make informed personal choices regarding the complete self.

Please read the enclosed information carefully; print and fill out this packet in its entirety and bring the completed forms to your first appointment. Along with these forms, please bring any relevant medical test results you have had in the past year.

Business Hours

Tuesday: 10:30 - 5:30
Wednesday: 10:30 - 5:30
Thursday: 10:30 - 5:30

Appointment Information

New Patient Appointment:

The first appointment is a 90 minute assessment with a cost of $300, excluding supplements. A variety of tests will be performed during the first visit. You will receive a nutrition guide which includes three weeks of meal plans, approved snacks, weekly check-ins, and the ability to reach out to the office during set hours with any questions you may have. The follow up visits are recommended every 3 weeks for the first 3 months.

Children 13 and under:

The initial visit fee for children ages 13 and under is $225. This fee includes all services listed above. Follow-up appointments are 30 minutes in duration and are billed at $90, excluding the cost of any supplements.

Follow Up Appointments:

Each 30 minute visit after will be a base charge of $135, excluding supplements.
Julianne Miller may request that you come in for a 60 minute appointment, which has a base charge of $185, excluding supplements.

Cranial Sacral Therapy:

Cranial Sacral Therapy (CST) is the practice of light touch. When, and if, Julilanne Miller feels you are ready for CST, the appointments are 45 minutes long and the cost is $150.

Payment

Payment for services rendered and products purchased is due at the end of each appointment. Payment options include check, credit/ debit card, and Apple Pay; Visa, Mastercard, American Express, and Discover are accepted. We will accept cash; however, we do not use a cash drawer in the office, so any change will be applied as a credit for your next visit. There is a $25 service charge for returned checks.

Cancellations

Cancellations must be made **at least 24 hours before your appointment time/date.** In the event of a late cancellation or missed appointment, you will be charged a $50 fee.
As a courtesy to our patients, appointments will be confirmed by the front desk prior to the appointment time. It is the **patient's responsibility to respond to the confirmation text or call, and to reschedule as necessary.** If a response is not received, the appointment will be given to a patient from the waitlist; **especially in the case of new patients.**
Please make sure the front desk has your cell phone number, as home and work numbers are not as easily accessible.

Insurance Information

We do not bill for insurance, Medicare, or Medicaid.

Medical Records

In preparation for your first visit, you are welcome to bring previous medical records, or have them emailed to **naturocw@gmail.com**. To obtain medical records, they can be requested from the lab or physician that provided your care.

Emergencies

For all medical emergencies, call 911 or go directly to the nearest Emergency Room.

Lab Tests

Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN may request testing of saliva, urine,blood pressure,pulse,heart rate,weight, BMI, Basic Iridology, skin, nutritional exam, and/or Bio Meridian during your first visit. All the first visit tests will be performed in the office.

Supplementation

Herbal, nutraceutical, homeopathic, and whole food supplementation is available for purchase at the Naturopathic Center For Wellness; however, patients are under no obligation to purchase supplements through our office.

In the event that supplements are requested to be mailed to the patient, there is a $20 shipping and convenience fee.

Patient Awareness and Responsibility

Please know that any therapy, no matter how well appointed, may fail to resolve symptoms and improve health. Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN makes no claim of cure for any condition. Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN will inform you of the treatment plan most relevant to your condition, both conventional and alternative. You have the choice to accept, refuse or terminate these therapies at any time.

By agreeing to do your best to comply with, and implement, the agreed upon program for you, you will receive full benefit from your visits with Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN.

Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN will NOT ask you to stop taking any medicines prescribed by another physician. If you desire to stop taking any prescriptions, please consult the physician who prescribed the medication. Julianne Miller is not a licensed physician.

HIPAA Compliance & Consent

Consenting Patient: _____ Date: _____

Consent and Purpose of Obtaining Medical Information:
The privacy of your medical information is important to us.
By signing this form, you consent to the use and disclosure of your protected health information.
We will create a record of the care and services you receive at the Naturopathic Center For Wellness. This record will enable us to provide quality care, as well as comply with certain legal requirements.

Notice of Privacy Practice:
You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. This notice includes a description of our treatment, payment, and healthcare practices. It also includes the uses and disclosures we may make of your protected health information, as well as other important matters concerning your protected health information. A copy of this notice is available upon request.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. Upon revision of such notice, our office will issue a revised copy. Any changes may apply to the protected health information that we maintain.

Right to Revoke:
You have the right to revoke this consent at any time by giving written notice of your revocation, submitted to:
Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN
23792 Rockfield Blvd. Suite 285
Lake Forest, CA 92630

Please understand that revocation of this consent will not affect the action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you, if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand by signing this consent form that I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare plans.

_____ _____
Signature Authorized Provider Representative

_____ _____
Date Date

Patient Consent Form

Julianne Miller PCs.D, RND, CTN, RN, BSN, CCWFN

Naturopathic Center For Wellness

23792 Rockfield Blvd, Suite 285

Lake Forest, CA 92630

Name _____ Male __ Female __ DOB __/__/____

Address _____

City _____ State _____ Zip _____

Welcome to the Naturopathic Center For Wellness. We offer an alternative, holistic, and educational approach to total client care. Julianne Miller PSc.D, RND, CTN, RN, BSN, CCWFN, is a graduate of Mount Saint Mary's College of Nursing, where she obtained her Bachelor of Science in Nursing. She also attended Clayton College, where she received a Doctorate of Naturopathy and she has a Doctorate of Pastoral Science and Medicine. She has been licensed as a registered nurse since 1980, and as a Traditional Naturopath since 2006. She is also an advanced practitioner of Cranial Sacral Therapy.

The Naturopathic Center for Wellness wants to help you and your family members feel empowered. We will educate you so that you can make the best decisions for your own health care. We will discuss your health and review your personal history, making recommendations where applicable.

Our approach to "Total Health Care" may include the following Client Education: the physical, emotional, spiritual self; Nutrition, Basic Iridology, Herbal, Nutraceutical, Homeopathic, and Whole Food Supplementation; Cranial Sacral Therapy, Somato-Emotional Release, Acupressure, and blended Eastern/Western Medical Exams.

By signing below, you acknowledge that you have read this consent form and give full consent for us to enable you to empower yourself.

Date _____

Patient Name _____

Patient Signature _____

Relationship to Patient _____

Patient Contact Information

Patient Name _____ Date of First Visit_____

Date of Birth _____

Parent(s)/Guardian_____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

Email _____

Gender: Male _____ Female _____

Occupation _____

Employer _____

Marital Status _____

With Whom You Reside _____

Emergency Contact _____ Relationship _____

Contact # _____

Please provide Name and Contact Information for Healthcare Providers you are currently seeing, or have seen within the past 12 months; especially any Healthcare Providers from whom you have obtained prescription medications.

_____ Contact # _____

_____ Contact # _____

_____ Contact # _____

Health History Questionnaire

Present Complaint(s) _____

Healthcare Providers you are seeing, and their specialties _____

_____

First noticed? _____

# of Children _____

Religion (optional) _____

Have you been exposed to toxic chemicals? _____

What diagnosis were you given? _____

Health as a Child: Excellent Good Fair Poor

Were there any complications with your delivery? _____

Explain: _____

Were you breastfed? _____ How Long? _____

Did you have any serious emotional or mental trauma as a child?

_____

Please circle diseases for which you have been immunized:

Measles Mumps Rubella Smallpox Tetanus Diphtheria

What is your blood type? A B AB O Unknown

Allergies/Sensitivities (Please specify)

Chemicals _____

Drugs/Medications _____

Dust/Molds _____

Foods _____

Grasses/Weeds (Pollens) _____

Other _____

Test History

Please list the date of your most recent procedure and indicate any tests that were abnormal:

_____

_____

Family History

	Age	Health Problems
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
1	_____	_____
2	_____	_____
3	_____	_____
Children		
1	_____	_____
2	_____	_____
3	_____	_____
Grandmother(M)	_____	_____
Grandfather (M)	_____	_____
Grandmother(F)	_____	_____
Grandfather(F)	_____	_____

Health Habits

Please list all nutraceuticals, herbs, and homeopathic supplements you are currently taking:

_____

Please CIRCLE any of the medications you are currently taking, or have taken, in the past 3 months:

Allergy Medication	Chemotherapy	Oral Contraceptives	Ulcer Medication
Antacids	Cortisone	Pain Medication	Other_____
Anti-Inflammatory	Heart Medication	Radiation	
Antibiotics/Antifungal	High Blood Pressure	"Recreational Drugs"	
Antidepressants	Hormones	Relaxants	
Anti-diabetic / Insulin	Laxatives	Sleeping Pills	
Aspirin/Tylenol/Advil	Lithium	Thyroid	

Please indicate use of the following:

__ Tobacco Packs per Day/Week _____ How Many Years? _____

__ Coffee per Day/Week _____ How Many Years? _____

__ Black Tea per Day/Week _____ How Many Years? _____

__ Alcohol per Day/Week _____ How Many Years? _____

__ Soda per Day/Week _____ How Many Years? _____

__ Artificial Sweetener per Day/Week _____ How Many Years? _____

How many times a week do you eat in a restaurant? Breakfast _____ Lunch _____ Dinner _____

What types of restaurants do you go to? _____

What are your favorite foods? _____

Do you crave sweets? _____ At what time(s)? _____

Do you add salt to your food? _____

Other foods you crave: Bread Pasta Dairy Meat Other: _____

What foods do you really dislike? _____

Are you on any specific diet? Which Diet? _____

Would you like to increase or decrease your weight? If so, by how much: _____

When was your last significant change in weight (more than 10lbs)? _____

What exercise do you do and how often? _____

____ Sedentary

____ Mild Exercise (I.E. Climbs stairs, walk 3 blocks, golf)

____ Occasional Vigorous exercise (I.E. work or recreation, less than 4x/week for 30 min.)

____ Regular Vigorous exercise (I.E. Work or recreation, 4x/week for 30 minutes

How many hours do you sleep each night? _____

Do you wake rested? _____

Are you currently sexually active? _____

Any difficulties? _____

Method of birth control: _____

Please rate your current stress level from 1-10 (10 being highest): _____

How much does this affect you? _____

What are the major stress factors? _____

_____

Rate your current Emotional Health: Excellent Good Fair Poor Unstable Crisis

Are you currently in Psychotherapy? _____

Do you have a good support team? _____

Does your home environment have a supportive effect on your health? _____

How many hours of relaxation do you give yourself during the work week? _____

During Weekends? _____

Favorite recreational activities? _____

When was your last Eye Exam? _____ Do you wear contacts? _____ Hard or Soft

Do you drink purified bottled water? _____ If so, what brand? _____

Do you have an air purifier in the room you sleep in? _____ What brand? _____

Do you have Amalgam (silver fillings)? _____

Any other dental problems? _____

Do you make an effort to eat organically grown foods? _____ What %? _____

Are you considering any elective surgery or medical procedures in the near future?_____

Women Only:

Age of onset of Menstruation _____

No. Miscarriage/C-section/Abortions _____

Age of onset of Menopause_____

Please check the appropriate area if you have had any of the following health problems.

	NOW	PAST	Treatment / Dates
Anemia	_____	_____	_____
Anorexia/Bulimia	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Blood pressure (high/low)	_____	_____	_____
Bone/Joint	_____	_____	_____
Cancer	_____	_____	_____
Cirrhosis/Liver Disease	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____
Eye Disease/Blindness	_____	_____	_____
Fibromyalgia/Muscle Pain	_____	_____	_____
Glaucoma	_____	_____	_____
Headaches	_____	_____	_____

	NOW	PAST	Treatment / Dates
Head Injury/Brain Tumor			
Heart Disease			
Hepatitis/Jaundice			
Kidney Disease			
Lung Disease			
Menstrual Pain			
Oral Health/Dental			
Stomach/Bowel Problems			
Stroke			
Thyroid			
Tuberculosis			
AIDS/HIV			
STDS			
Learning Problems			
Speech Problems			
Anxiety			
Bipolar Disorder			
Depression			
Eating Disorder			
Hyperactivity/ADD			
Schizophrenia			
Sexual Problems			
Sleep Disorder			
Suicide Attempts/Thoughts			

Circle the corresponding number.	
1	**MILD** symptom (occurs rarely)
2	**MODERATE** symptom (occurs several times a month)
3	**SEVERE** symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

___ ___ ___ TOTAL
1 2 3

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

___ ___ ___ TOTAL
1 2 3

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

___ ___ ___ TOTAL
1 2 3

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

___ ___ ___ TOTAL
1 2 3

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

___ ___ ___ TOTAL
1 2 3

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

___ ___ ___ TOTAL
1 2 3

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

___ ___ ___ TOTAL
1 2 3

GROUP 7B

119.	1 2 3	Increase in weight
120.	1 2 3	Decrease in appetite
121.	1 2 3	Fatigue easily
122.	1 2 3	Ringing in ears
123.	1 2 3	Sleepy during day
124.	1 2 3	Sensitive to cold
125.	1 2 3	Dry or scaly skin
126.	1 2 3	Temporary constipation
127.	1 2 3	Mental sluggishness
128.	1 2 3	Hair coarse, falls out
129.	1 2 3	Tension in head upon arising wears off during day
130.	1 2 3	Slow pulse below 65
131.	1 2 3	Changing urinary function
132.	1 2 3	Sounds appear diminished
133.	1 2 3	Reduced initiative

___ ___ ___ TOTAL
1 2 3

GROUP 7C

134.	1 2 3	Failing memory with age
135.	1 2 3	Increased sex drive
136.	1 2 3	Episodes of tension in head
137.	1 2 3	Decreased sugar tolerance

___ ___ ___ TOTAL
1 2 3

GROUP 7D

138.	1 2 3	Abnormal thirst
139.	1 2 3	Bloating of abdomen
140.	1 2 3	Weight gain around hips or waist
141.	1 2 3	Sex drive reduced or lacking
142.	1 2 3	Tendency for stomach issues
143.	1 2 3	Immune system challenges
144.	1 2 3	Menstrual disorders

___ ___ ___ TOTAL
1 2 3

GROUP 7E

145.	1 2 3	Dizziness
146.	1 2 3	Headaches
147.	1 2 3	Hot flashes
148.	1 2 3	Hair growth on face or body (female)
149.	1 2 3	Sugar in urine (not diabetes)
150.	1 2 3	Masculine tendencies (female)

___ ___ ___ TOTAL
1 2 3

GROUP 7F

151.	1 2 3	Weakness, dizziness
152.	1 2 3	Tired throughout day
153.	1 2 3	Nails weak, ridged
154.	1 2 3	Sensitive skin
155.	1 2 3	Stiff joints
156.	1 2 3	Perspiration increase
157.	1 2 3	Bowel discomfort
158.	1 2 3	Poor circulation
159.	1 2 3	Swollen ankles
160.	1 2 3	Crave salt
161.	1 2 3	Areas of skin darkening
162.	1 2 3	Upper respiratory sensitivity
163.	1 2 3	Tiredness
164.	1 2 3	Breathing challenges

___ ___ ___ TOTAL
1 2 3

GROUP 8

165.	1 2 3	Muscle weakness
166.	1 2 3	Lack of stamina
167.	1 2 3	Drowsiness after eating
168.	1 2 3	Muscular soreness
169.	1 2 3	Heart races
170.	1 2 3	Hyperirritable
171.	1 2 3	Feeling of a band around head
172.	1 2 3	Melancholia (feeling of sadness)
173.	1 2 3	Swelling of ankles
174.	1 2 3	Change in urinary function
175.	1 2 3	Tendency to consume sweets/carbohydrates
176.	1 2 3	Muscle spasms
177.	1 2 3	Blurred vision
178.	1 2 3	Involuntary muscle action
179.	1 2 3	Numbness
180.	1 2 3	Night sweats
181.	1 2 3	Rapid digestion
182.	1 2 3	Sensitivity to noise
183.	1 2 3	Redness of palms of hands and bottom of feet
184.	1 2 3	Visible veins on chest and abdomen
185.	1 2 3	Hemorrhoids
186.	1 2 3	Apprehension (feeling that something bad is going to happen)
187.	1 2 3	Nervousness causing loss of appetite
188.	1 2 3	Nervousness with indigestion
189.	1 2 3	Gastritis
190.	1 2 3	Forgetfulness
191.	1 2 3	Thinning hair

___ ___ ___ TOTAL
1 2 3

FEMALE ONLY

192.	1 2 3	Very easily fatigued
193.	1 2 3	Premenstrual tension
194.	1 2 3	Menses more painful than usual
195.	1 2 3	Depressed feelings before menstruation
196.	1 2 3	Painful breasts during menses
197.	1 2 3	Menstruate too frequently
198.	1 2 3	Hysterectomy/ovaries removed
199.	1 2 3	Menopausal hot flashes
200.	1 2 3	Menses scanty or missed
201.	1 2 3	Acne, worse at menses

___ ___ ___ TOTAL
1 2 3

MALE ONLY

202.	1 2 3	Less involved in exercise/social activities
203.	1 2 3	Difficult to postpone urination
204.	1 2 3	Weak urinary stream
205.	1 2 3	Feeling of "blues" or melancholy
206.	1 2 3	Feeling of incomplete bowel evacuation
207.	1 2 3	Lack of energy
208.	1 2 3	Muscles in arms and legs seem softer/smaller
209.	1 2 3	Tire too easily
210.	1 2 3	Avoid activity
211.	1 2 3	Leg nervousness at night
212.	1 2 3	Diminished sex drive

___ ___ ___ TOTAL
1 2 3