New Patient Intake Form

Please complete all sections to the best of your ability.
Tap any field to type. When finished, save and send via the Spruce Health app prior to your appointment.

David Walters, DO, PhD, MBA
iCONMED
Hot Springs, SD | Colorado Springs, CO
719-544-0199

PATIENT INFORMATION

Full Legal Name: Date of Birth: Age:

Sex: ☐ Male ☐ Female Height: Weight:

Cell Phone: Email:

Preferred Contact: ☐ Phone ☐ Email ☐ Spruce

Street Address:

City: State: ZIP:

Occupation / Employer: Referred by:

EMERGENCY CONTACT

Name: Relationship: Phone:

CURRENT MEDICATIONS & SUPPLEMENTS

List all prescriptions, supplements, and vitamins (name, dose, how often):

ALLERGIES

☐ No known drug allergies

List any medication or substance allergies and your reaction:

REASON FOR YOUR VISIT

Check all symptoms that apply to you:

☐ Fatigue / low energy
☐ Erectile dysfunction
☐ Increased body fat
☐ Mood swings / irritability
☐ Poor sleep
☐ Infertility concerns
☐ Hot flashes / night sweats
☐ Weight gain
☐ Joint pain
☐ Low sex drive
☐ Hard to build muscle
☐ Brain fog
☐ Depression or anxiety
☐ Low T (diagnosed)
☐ Bone density loss
☐ Menopausal symptoms
☐ Thyroid concerns
☐ Other

Describe your main concern in your own words:

How long have you had these symptoms? Severity (1 = mild, 10 = severe):

Have you seen another doctor for these symptoms? What did they conclude?

PRIOR HORMONE THERAPY

Have you ever received hormone therapy? ☐ Yes ☐ No

If yes, check all that apply:

- ☐ Testosterone (injection)
- ☐ Testosterone (gel/cream)
- ☐ Testosterone (pellet)
- ☐ Clomid / Enclomiphene
- ☐ Estrogen
- ☐ Progesterone
- ☐ Thyroid medication
- ☐ Other

When and for how long?

Why did you stop?

MEDICAL HISTORY

Check any conditions you have now or have had in the past:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Heart disease
- ☐ Stroke
- ☐ Blood clots
- ☐ Sleep apnea / CPAP
- ☐ Thyroid disease
- ☐ Prostate problems
- ☐ Elevated PSA
- ☐ Cancer
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Depression / anxiety
- ☐ Seizures
- ☐ Asthma / lung disease

Other conditions:

SURGICAL HISTORY

List any surgeries and approximate year:

FAMILY HISTORY

Any family history of heart disease, cancer, diabetes, hormone issues?

LIFESTYLE

Tobacco: ☐ Never ☐ Former ☐ Current

Alcohol (drinks/week): Recreational drugs: ☐ Yes ☐ No

Exercise type & frequency:

Sleep (hours/night): ☐ Trouble sleeping

CHEMICAL & ENVIRONMENTAL EXPOSURES

Everyday chemicals can affect your hormones. Check any that apply to you:

- ☐ Drink unfiltered tap water
- ☐ Regularly drink from plastic water bottles
- ☐ Microwave food in plastic containers
- ☐ Use non-stick cookware (Teflon)
- ☐ Use scented products (candles, air fresheners, cologne)
- ☐ Handle store receipts frequently (work in retail)
- ☐ Use lawn / garden pesticides or herbicides
- ☐ Work around industrial or agricultural chemicals
- ☐ Eat mostly processed / packaged foods
- ☐ Use plastic food storage containers daily

Occupational chemical exposure (describe):

YOUR GOALS

What do you hope to achieve? Check all that apply:

- ☐ More energy
- ☐ Better sex drive
- ☐ Build muscle
- ☐ Lose fat
- ☐ Better mood
- ☐ Sharper thinking
- ☐ Better sleep
- ☐ Fertility / family planning

Other goals:

ANYTHING ELSE?

Anything else you'd like Dr. Walters to know before your visit?

Date:

Patient Signature (sign after printing, or add in your PDF app)