New Patient Intake Form

Please complete all sections to the best of your ability.

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*Please complete and send via the **Spruce Health app** prior to your appointment.*

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

Patient Signature _____ Date _____