Texas Star Pharmacy Patient Intake Form

Personal Information

Date:	Date of Birth:
Name:	Blood Type:
Address:	Sex:
City/State/Zip Code:	Circle: Right Handed • Left Handed
Home Phone:	Height:
Cell Phone:	Weight: Ideal Weight:
Email:	Occupation:
Do you have a FlexCard or HSA? Y/N	Marital Status: # of Children: Ages:
What are the 5 primary concerns/goals/reasons you are seeking advice? (Please be specific)	
1.	2.
3.	4.
5.	Other:
List all the current prescription medications (indicate strength and frequency) you are taking:	
1.	2.
3.	4.
5.	6.
7.	8.
List all over-the-counter supplements, herbs and/or homeopathies you currently take: (Note: Please bring ALL supplements to your appointment or you will be rescheduled. NO EXCEPTIONS)	
1.	2.
3.	4.
5.	6.
7.	8.

Medical Information

Physician(s)	
1.	2.
Allergies:	
Family Health History (Especially Cancer)	
Mother	Father
Sibling	Sibling
Sibling	Sibling
Date of Last Lab Work: If less than 1 year, please bring to appointment	
Medical Conditions Current:	
Medical Conditions Past:	
Surgeries (List) Type/Year	
1.	2.
3.	4.
5.	6.
Hysterectomy: Yes/No	Date of last menstrual period:
Do you exercise regularly: Yes/No	If so, what type and how often:
Do you have any special dietary preferences (i.e. No Pork, Gluten-Free) we should take into consideration?	
Whom may we thank for your referral:	
How did you find out about our services?	

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Lifestyle Choices	
How often do you cook at home?	Typical foods cooked?
How much water do you drink daily?	Water type:
How often do you eat out/fast food?	Restaurants:
Do you consume artificial sweeteners?	Type/Frequency:
Do you drink alcoholic beverages?	Type/Frequency:
Do you use tobacco or tobacco products more than casually? Yes/No Type/Frequency:	
Do you have pets? (Indicate # of each) ___Dog ___Cat ___Fish ___Bird ___Other _____	
Do you use organic products? Yes/No	How often:

By signing below, I verify that I understand that the providers, Christina Reiter and Donna Barsky are not physicians and that the counsel given is restricted to the correction of underlying deficiencies, optimizing hormonal imbalances, dietary guidance, symptom management and nutritional counseling. This counseling is not a substitute for medical care by my primary care physician, nor is it intended to diagnose or treat any disease. I also understand that I am responsible for full payment at the time of services for consultations, testing kits and medications and supplements, and that no third-party billing or any form of non-cash payment will be accepted in lieu of actual payment. (Please sign below)

Signature:	**Date:**

Rates For Consultations and Other Services Are As Follows:

Bio-Identical Hormone Consultation (Appt. Only)	$299.00 (Annual Program)
Doctor of Pharmacy Consultation (Appt. Only)	$150.00/30 Minutes
Nutritional Counseling	$50.00/30 Minutes
Body Composition Testing	$25.00
Blood Typing	$25.00
5-Hormone Panel Saliva Testing	$260.00
Telephone Consultation (outside of program guidelines; BHRT prior approval only) Please call.	

Kindly, please give a 24-hour notice for cancellation of appointments

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