ASPIRE HEALTH BHRT Intake Form

Name (required)

_____ _____

First Name Last Name

Gender (required)

☐ Female ☐ Male

REASON FOR YOUR VISIT (required)

What brings you in today?

_____

_____

_____

What symptoms are you experiencing that you believe may be related to hormonal imbalance?

_____

_____

_____

Have you previously used hormone replacement therapy?

☐ Yes ☐ No

If Yes, please list type / duration:

_____

_____

What are your goals with HRT? (e.g., mood, sleep, libido, energy, menopause symptoms)

_____

_____

_____

SYMPTOM CHECKLIST

Please indicate all that apply:

ENERGY & MOOD

☐ Fatigue

☐ Anxiety

☐ Depression

☐ Mood swings

☐ Irritability

☐ Brain Fog

SLEEP

☐ Insomnia

☐ Night sweats

☐ Difficulty staying asleep

☐ Early waking

SEXUAL HEALTH

☐ Low libido

☐ Painful intercourse

☐ Vaginal dryness (F)

☐ Erectile dysfunction (M)

☐ Loss of morning erections (M)

MENSTRUAL & REPRODUCTIVE HEALTH (F only)

☐ Irregular periods

☐ Heavy bleeding

☐ PMS/PMDD

☐ Menopausal symptoms

☐ Infertility

OTHER SYMPTOMS

☐ Weight gain

☐ Hair loss

☐ Hot flashes

☐ Dry skin

☐ Memory issues

☐ Other (please specify)

_____
_____
_____

HORMONAL HISTORY (required)

FEMALES

_____	_____	_____
Age of first period	Cycle length (days)	Date of last period

Are your cycles regular?

☐ Yes ☐ No

Are you menopausal?

☐ Yes ☐ No

If yes, age of onset:

_____

History of PCOS, endometriosis, fibroids?

☐ Yes ☐ No

Explain:

_____

Date of last hormone panel (if known):

_____

MALES

History of low testosterone?

☐ Yes ☐ No

Have you ever used anabolic steroids or testosterone therapy?

☐ Yes ☐ No

Date of last hormone panel (if known):

_____

CURRENT MEDICATIONS AND SUPPLEMENTS (required)

Please list any hormones you are currently taking (e.g., estrogen, progesterone, testosterone, DHEA, thyroid):

_____

_____

Other prescription medications:

_____

_____

Supplements (vitamins, herbs, etc.):

_____

_____

MEDICAL HISTORY (required)

Please indicate all that apply:

☐ Thyroid disease

☐ Adrenal fatigue

☐ Autoimmune disease

☐ Diabetes or insulin resistance

☐ Breast cancer (self / family)

☐ Ovarian or testicular cancer

☐ Heart disease or stroke

☐ Liver dysfunction

☐ Clotting disorders (e.g., DVT, PE)

☐ Other (please specify)

_____

_____

_____

Surgeries (especially reproductive or hormonal-related):

_____

_____

LIFESTYLE AND DIET

Sleep hours per night:

_____

Exercise routine:

_____

_____

Alcohol use:

☐ Never ☐ Occasionally ☐ Regularly *Amount:* _____

Tobacco / nicotine use:

☐ Yes ☐ No

Caffeine use:

☐ Yes ☐ No *Type and amount:* _____

Stress level (1-10):

_____

How do you manage stress?

_____

_____

DIETARY STYLE

Please indicate all that apply:

☐ Standard American

☐ Paleo

☐ Keto

☐ Vegetarian / vegan

☐ Mediterranean

☐ Other (please specify)

_____
_____
_____

LAB TESTING HISTORY

Have you had any of the following lab work done in the last 12 months?

☐ Hormone panel (blood, saliva, or urine)

☐ Thyroid panel

☐ Cortisol / adrenal testing

☐ Lipid panel

☐ Blood sugar / insulin

☐ Nutrient deficiencies

If yes, please provide reports and/or summarize below:

_____

_____

_____

_____

_____

_____

FUNCTIONAL MEDICINE GOALS (required)

What are your top three health goals related to hormone balance?

1. _____
2. _____
3. _____

What does success with HRT look like to you?

_____

_____

_____

_____

_____

_____

Signature (required)

_____

Date (required)

_____/_____/_____