DEMOGRAPHICS and PERMISSION

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAAHP

4 Health and Wellness

Patient Legal Name: (First)_____ (Middle)_____ (Last)_____

Patient Nick Name _____ **Date of Birth** ___/___/_____

Mailing Address Street: _____ **City** _____ **State** ___ **Zip** _____

We may contact you on occasion to discuss confidential protected health information. Below is a list of ways for us to communicate with you. Please check how you would like us to get this information to you. E-mail or texting are sometimes convenient but e-mail or text delivery is not always reliable and privacy cannot be assured. Please indicate any restrictions, **e.g. "only leave name and callback number," "do not speak to family member,", "ok to leave detailed message", "only reply to my messages", "ok to initiate a detailed message", "general announcements only", etc.**

Phone #1 Home Cell Work (____) ____ - _____ **Restrictions:** _____

Phone #2 Home Cell Work (____) ____ - _____ **Restrictions:** _____

Phone #3 Home Cell Work (____) ____ - _____ **Restrictions:** _____

E-mail _____ **Restrictions:** _____

Text (____) ____ - _____ **Restrictions:** _____

We are serious about protecting your privacy. Please give permission **only** to the following individuals listed below to receive you protected health information; **Please circle names of emergency contacts.**

Name/relationship _____ **Contact Info**: _____ **Restrictions:** _____

Name/relationship _____ **Contact Info**: _____ **Restrictions:** _____

Name/relationship _____ **Contact Info**: _____ **Restrictions:** _____

☐ I DO ☐ I DO NOT have a **Living Will/Health Care Power of Attorney** (circle) on file with Dr. Weyrich/ 4 Health and Wellness.

Preferred Pharmacy: _____ (Dr. Weyrich prefers Walgreen's) **Phone:** (____) ____ - _____

I understand that Dr. Weyrich does not participate in any insurance plan and requires payment by cash, check, credit card, or PayPal at the time of service. I understand that I may be responsible for payment for any labs ordered by Dr. Weyrich. In some cases, a patient can submit Superbills from Dr. Weyrich to private insurance for partial reimbursement, but Dr. Weyrich makes no guarantees. Other providers at 4 Health and Wellness may have better insurance coverage. Please check all that apply:

- ☐ I am self-pay (cash, check, credit card)
- ☐ I am eligible for Medicare so Dr. Weyrich must have me sign certain paperwork acknowledging that he cannot bill Medicare.
- ☐ I have a PPO Medical Insurance Plan so I may be able to submit invoices from Dr. Weyrich for partial reimbursement, but Dr. Weyrich / 4 Health and Wellness can make no guarantee.
- ☐ I have a Medical Savings Account so I may be able to submit invoices from Dr. Weyrich for partial reimbursement, but Dr. Weyrich / 4 Health and Wellness can make no guarantee.

☐ **I am a former patient of Dr. Gear/Payson Heath and Wellness;** please transfer any/all chart information from Dr. Gear/Payson Heath and Wellness or Comprehensive Health Services to Dr. Weyrich/4 Health and Wellness

I understand that Dr. Weyrich / 4 Health and Wellness follows HIPAA privacy guidelines and will only disclose protected healthcare information to third parties as authorized in writing by me or as required by law.

This authorization/agreement supersedes all previous information provided to Dr. Weyrich, and can be revoked or modified by written notification IN WRITING at any time.

Patient's Signature _____ **Date**_____

404 W Main St, Ste A, Payson AZ 85541

Phone (888)-391-0414 or (928) 474-7409 or (480) 766-6007

Fax (888) 391-0414; Text (480) 766-6007

Web: DrWeyrich.com *** e-mail Orville@Weyrich.com

Version 2023

NEW PATIENT INTERNAL MEDICINE INTAKE FORM

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAAHP

4 Health and Wellness

Patient Name: _____ **Date of birth** ___/___/_____ **Today's Date** ___/___/_____

PRESENT COMPLAINTS

Please list your chief symptoms and complaints in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present. Attach additional paper as necessary.

Problem	Onset	Frequency	Severity
e.g. Headaches	June 2007	4 times per week	Severe = 10/10
1.			
2.			
3.			
4.			

What diagnosis or explanation has been given to you? _____

_____

Do you have any OTHER chronic health problems or other diagnosis? *(Please list and give date when each was diagnosed)*

_____

_____

What are your treatment goals? What do you want to be able to enjoy doing that you cannot now?

_____

_____

_____

When was the last time you felt well? (E.g. High School, before last child was born, before I moved to AZ, etc)

_____

_____

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Version 1.82

Did something trigger your change in health? _____

_____

What makes you feel **worse**? _____

_____

What makes you feel **better**? _____

_____

What factors do you feel may be contributing to your current state of health? _____

_____

TREATMENTS TRIED

Please mark No or Yes to each of the treatments you have tried for your condition(s) and indicate the results (e.g. no change, gave me hives, helped slightly, helped a lot, etc.)

Treatment	No	Yes	Describe / Results
Pharmaceuticals (drugs)			
Surgery			
Chiropractic			
Acupuncture			
Homeopathy			
Herbs			
Colonics			
Biofeedback			
Massage			
Environmental medicine			
Nutritional Therapy			
Chelation Therapy			
Prayer / Meditation			
Other (describe)			
Other (describe)			

YOUR HEALTH CARE TEAM

Please list name and contact information for all Current (or your most recent) health care provider(s)

Name of Provider	Specialty (e.g. primary, endocrine, acupuncture, Naturopathic MD, etc)	Phone	Fax	Approximate date last office visit

PAST MEDICAL HISTORY

QUESTION	No	Yes	Describe / Comments
Do you have any implants (e.g. pacemaker, breast, screws, rods) or organ transplants?			
Have you ever had a bad reaction, complications, or unusual side effects to a vaccine, drug, food, or supplement? Have your medications or supplements ever caused you problems? If yes, please describe.			
Are you a biological male (XY)			
Are you a biological female (XX)			
Do you have a non-XX/non-XY karyotype? (Rare)			
Have you had "gender affirming" procedures to modify your gender phenotype? If yes, please describe.			
Do you have a history of being abused or assaulted? (Describe what/when if you wish)			

SURGICAL AND TRAUMA HISTORY

Please state what happened (e.g. tonsillectomy, auto accident, fell off horse, workplace accident, et cetera; and give the approximate date.

WHAT HAPPENED	Approximate Date	Describe / Comments

REVIEW OF SYSTEMS

Please mark No or Yes to all issues you are currently experiencing or have experienced in the past, and describe in the comments section. Add additional issues on blank lines as needed.

Head	No	Yes	Describe / Comments
Injury or Blow to head			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Headache (circle)			Migraine Frontal Occipital Temporal Squeezing Pulsing Worst ever Frequent Severe Other (specify)
Swelling/nodules			Where?
Head hair problems			Please enter details below under Hair, Nails
Other head problems (specify)			

Eyes	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Blurry vision			
Double vision			
Poor night vision			
See halos around lights			
Pain			
Eyebrow loss			
Discharge			
Dark circles under eyes			
Other eye problems (specify)			

Ears	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Loss or impairment of hearing			
Discharge			
Ringing (tinnitus)			
Other ear problems (specify)			

Nose	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Loss of smell			
Discharge			
Cold nose			
Other nose problems (specify)			

Mouth	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Mercury amalgam fillings			
Composite/plastic fillings			
Cavities			
Loss of taste/Unable to taste			
Bitter taste in mouth			
Bland taste in mouth			
Sweet or sticky taste in mouth			
Sour taste in mouth			
Salty taste in mouth			
Metallic taste in mouth			
Prone to chapped lips			
Tend to have dry mouth			
Other mouth problems (specify)			
Tonsils removed			
Adenoids removed			
Other mouth problems (specify)			

Throat	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Hoarse			
Other throat problems (specify)			

Neck	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Swelling/nodules			
Other neck problems (specify)			

Lungs, Chest	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Asthma, Shortness of breath, or Difficulty breathing (circle)			Upon exertion At night
Pleurisy or pleuritis			
Cough (circle)			Frequent Chronic Bloody Mucus
Sleep apnea			
Other lung or chest problems (specify)			

Heart, Circulation, Blood	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Angina			
Palpitations			
Arrhythmias			
Heart flutters			
Bruise easily			
Poor circulation			
Varicose or spider veins			
Periodic numbness of hands and feet, especially at night			
Tendency to puffiness or edema			
Rheumatic fever			
Heart attack (MI)			When?
Anemia			What kind?
High blood pressure			
Low blood pressure			
Had a transfusion (circle)			When? Blood Serum
Electrocardiogram (EKG)			When? Result?
Stress test			When? Result?
Other heart tests? (specify)			
Other heart, circulation, or blood problems (specify)			

Liver, Gall-Bladder, Pancreas	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Wake up with bitter taste in mouth			
Gall stones			Kind?
Other liver, gall-bladder, or pancreas problems (specify)			

Digestion	No	Yes	Describe / Comments
Gluten sensitivity			
Lactose sensitivity			
Poor digestion of meat			
Poor digestion of fat			
Other digestion problems (specify)			

Abdomen, Stomach, Intestines, Anus	**No**	**Yes**	**Describe / Comments**
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Gas (flatulence)			
Belching			
Bloating			
Constipation (circle)			Hard stool Infrequent stool
Less than 1 BM/day			How often?
Diarrhea (circle)			Watery stool Soft stool Early morning urgent loose stools
Early morning urgent loose stools			
Bad smelling BM			
Light colored stools			
Black tarry stools			
Hemorrhoids or bloody stools			
Polyps in colon			
Heartburn			
Wake up with taste in mouth (circle)			Sour Bitter
Colonoscopy (circle)			Normal Abnormal When?
Poisoning (circle)			Food Chemical Drug
Irritable bowel syndrome (circle)			Usually constipation Usually diarrhea Varies
Inflammatory bowel disease, Celiac, or Crohn's.			
Parasites or worms			
Appendicitis (circle)			Appendix removed Appendix not removed
Colitis			
Ulcer			Where?
Had hernia repair			Where?
Had prolapse repair			Where?
Other digestion, abdomen, or anus problems (specify)			

Kidneys, Bladder, Urination	**No**	**Yes**	**Describe / Comments**
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Tendency to urinary tract infections			
Bladder problems			
Difficult urination (circle)			Difficult starting Slow/weak stream Painful
Wake at night to urinate			How many times?
Uncontrolled urination			
Discharge			
Abnormal urine (circle)			Colorless Dark color Contains protein Contains sugar Contains pus Contains blood Contains sediment Bad smell Unusual color (specify)
Kidney stones			Kind?
Other kidney, bladder, or urine problems (specify)			

Joints, Ligaments, Tendons	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Arthritis or rheumatism			
Joint disease			
Bursitis			
Dislocations (repeated)			
Strain			
Sprain			
Joints ache worse with movement			
Joint pain better with movement			
Other joint, ligament, tendon problems (specify)			

Back	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			Where?
Weakness			
Scoliosis			
Other back problem			Specify

Bones	No	Yes	Describe / Comments
Broken or cracked			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Bone disease			Osteoporosis Osteopenia Other (specify)
Other bone problems (specify)			

Shoulders, Arms, Hands	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Cold hands			
Weakness			
Swelling			Where?
Other shoulder, arm, hand problems (specify)			

Hips, Thighs, Knees, Legs, Feet	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Pain			
Cold feet			
Weakness			
Sciatica			
Lumbago			
Swelling			Where?
Other hip, thigh, knee, leg, foot problems (specify)			

Skin	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Rash			
Itching			
Hives			
Swelling/nodules			
Jaundice or yellowish complexion (abnormal for your race)			
Dark sooty complexion (abnormal for your race)			
Other abnormal color			Describe:
Dry, flaky skin			
Oily skin			
Red hemangiomas (cherry red spots) on skin			
Red acne			
Cystic or pustular acne			
Boils (frequent)			
Eczema			
Keloids			
Warts, moles, skin tags (circle)			Where?
Other skin problems (specify)			

Hair, Nails	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Unwanted/excess hair			Where?
Body hair loss (circle)			Patches Pattern All over
Head hair loss (circle)			Patches Male pattern Eyebrows All over
Premature graying			
Brittle/dry hair			
Brittle finger or toe nails			
Other hair problems (specify)			

Neurological	No	Yes	Describe / Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Numbness			
Tingling			
Dizzy/lightheaded when standing up quickly			
Dizzy at other times			
Vertigo (room spinning)			
Fainting, loss of consciousness			
Poor balance			
Seizures, convulsions, epilepsy			
Tremors (circle)			Resting When active Other (describe):
Psychological disorder			Describe:
Paralysis/weakness			Where?
Brain fog			
Declining memory			
Poor concentration or attention span			
Neuritis			
Neuralgia			
Nervous breakdown			
Concussion			
Other neurological problems (specify)			

Hormones, Endocrine	No	Yes	Describe / Comments
Diabetes (circle)			Type 1 Type 2 Requires insulin Treated with pills
Thyroid (circle)			Underactive Overactive Swelling (goiter) Nodules
Adrenal (circle)			Underactive Overactive Fatigue
Parathyroid (circle)			Underactive Overactive
Pituitary problems?			Describe:
Do you take estrogen? (circle)			Cream Pellet Pill Inject Bio-identical Non-bio-identical
Do you take progesterone? (circle)			Cream Pellet Pill Inject Bio-identical Non-bio-identical
Do you take testosterone? (circle)			Cream Pellet Pill Inject Bio-identical Non-bio-identical
Do you take hCG?			
Do you take hGH			
Do you take peptides such as sermorelin?			Specify:
Do you take tryptophan or 5-HT? (circle)			
Do you take tyrosine?			
Tend to feel warmer than most people			
Tend to feel more chilly than most people			
Other endocrine or hormone problems (specify)			
Energy lower after meals			
Hypoglycemia or poor blood sugar regulation			

Infectious Diseases	No	Yes	Describe / Comments
Colds (frequent)			
Diphtheria			
Hepatitis (circle)			A B C D E Other (specify)
Infections (frequent)			
Meningitis			
Pneumonia			
Polio			
Scarlet fever			
Small pox			
Sore throat (frequent)			
Strep throat			
Sexually Transmitted Disease (circle)			Gonorrhea Chlamydia HPV HIV/AIDS Syphilis Herpes Other (specify)
Tuberculosis			
Other infectious diseases (specify)			

Immune System, Immunizations	No	Yes	Describe / Comments
History of cancer (specify)			When? What kind?
Currently active cancer			What kind?
COVID			When? Hospitalized? How long?
Hay fever			
Adhesive tape allergy/sensitivity			
Latex sensitivity allergy/sensitivity			
Food sensitivity (specify)			
Penicillin allergy/sensitivity			
Sulfa allergy/sensitivity			
Aspirin allergy/sensitivity			
Codeine allergy/sensitivity			
Morphine allergy/sensitivity			
Mycins allergy/sensitivity			
Vaccine allergy/sensitivity or bad reaction (specify)			
Antitoxin allergy/sensitivity			
Serum allergy/sensitivity			
Iodine or radiological dye allergy/sensitivity			
Nail polish allergy/sensitivity			
Other cosmetics allergy/sensitivity			
Other drug allergy/sensitivity (specify)			
Tetanus vaccination			When?
Pertussis vaccination			When?
Pneumovax (PPSV23) vaccination (for pneumonia)			When?
Prevnar (PCV13) vaccination (for pneumonia)			When?
Shingrix vaccination (for shingles)			When? How many doses?
Flu vaccination			When? Which brand?
MMR vaccination			When?
Chicken pox vaccination			When?
HPV vaccination			When?
COVID vaccination			When? How many doses? Which brand?
Small pox vaccination			When?
Polio vaccination			When? Which brand?
Other Vaccinations? (specify)			
5 or more courses of antibiotic treatment as a child / teen			
5 or more courses of antibiotic treatment as a adult			
5 or more courses of oral steroid treatment as a child / teen			
5 or more courses of steroid treatment as a adult			
Other (specify)			
Other (specify)			

Sleep	No	Yes	Describe / Comments
Difficulty falling asleep			
Difficulty staying asleep			
Short total sleep duration (less than 8 hours)			
Long total sleep duration (longer than 8 hours)			
Wake unrefreshed			
Need for naps			
Nightmares			
Excessive limb motion			

Weight	No	Yes	Describe / Comments
Bariatric surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Unexpected weigh loss			
Unwanted weight gain			
Difficulty losing weight			
Difficulty gaining weight			
Over-weight			
Under-weight			
Weight now		pounds	
Weight 1 year ago		pounds	
Maximum weight		pounds	When?

Exercise	No	Yes	Describe / Comments
Aerobic (walk, dance, etc)			Average minutes per week? Describe:
Weights/resistance			Average minutes per week? Describe:
Stretching (Yoga, other)			Average minutes per week? Describe:
Other (describe)			

Chills, Fever	No	Yes	Describe / Comments
Chills with fever			
Chills without fever			
Fever without chills			
Alternate chills and fever			
Hot flashes			

Perspiration	No	Yes	Describe / Comments
Lack of sweating			
Excessive sweating			
Spontaneous sweating without reason			
Night sweats			

Thirst, Appetite	No	Yes	Describe / Comments
Lack of thirst			
Thirst despite drinking water			
Poor appetite			
Excessive appetite			
Crave sweets			
Crave salty			
Other cravings			

Types of Pain	No	Yes	Describe / Comments
Distending (swelling/bloating)			Where?
Pricking			Where?
Wandering			Where?
Static or fixed location			Where?
Cold			Where?
Burning			Where?
Dull			Where?
Hollow			Where?
Heavy			Where?
Aching			Where?
Pulling			Where?
Other pains			Describe:

Emotions	No	Yes	Describe / Comments
Prone to joyfulness			
Prone to anger			
Prone to worry			
Prone to longing			
Prone to sadness			
Prone to fear			
Prone to shock			
Prone to anxiety			
Prone to depression			
Prone to weepiness			
Prone to irritability			
Prone to jumpiness			
Prone to jitteriness			
Tend to fidget			

General	No	Yes	Describe / Comments
Injury (other)			
Surgery (other)			Please describe in SURGICAL AND TRAUMA HISTORY on page 3.
Tired, weak, lack energy, lethargic			
Chronic fatigue syndrome			
Enlarged glands			Where?
Other (specify)			

SOCIAL HISTORY

These questions help Dr. Weyrich better understand how you interact with your environment. You may write "declined" as the answer to any question you feel is too personal. But please put something in each line.

Question	Answer / Comments
Birth place	
Other places lived	
Ethnicity	
Religious/spiritual preference	
Self-identified gender	(If same as biological gender please write "same")
Current living situation (circle)	Own home Rent apartment Roommate Mobile home Homeless Live with relative Other (specify)
Interpersonal relationship (circle)	Single Celibate Married Partner Casual Dating Divorced Widowed Separated Hetero Homo Bi Other (specify) Who?
How many living children do you have?	
Current occupation	
Previous occupations	
Do you like your work?	☐ No ☐Yes. Why?
Hours spent with TV or computer a day?	
Hours spent on spent with a cell phone a day?	
Hours spent on spent reading/writing a day?	
Hours spent outdoors a day?	
Hours spent on spent with social interactions a day?	
Hours spent on spent hobbies or other recreational activities/day?	Describe:
How do you spend most of your time?	
About how many days a year do you take vacation?	
About how many days a week do you take relaxing and recharging?	
Do you have pets?	Describe:
How do you "exercise" your brain?	Describe:
Tobacco use	☐ Never ☐ Now ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew ☐ Snuff ☐ Other (specify)? ☐ Quit (when?) How much/day?
Alcohol use	☐ Never ☐ Now ☐ Treated for abuse ☐ In recovery ☐ Beer ☐ Wine ☐ Spirits ☐ Other (specify)? ☐ Quit (when?) How much/day?
Marijuana use	☐ Never ☐ Now ☐ Treated for abuse ☐ In recovery ☐ Medicinal ☐Recreational ☐ Quit (when?) How much/day?
Street drug use	☐ Never ☐ Now ☐ Treated for abuse ☐ In recovery ☐ Medicinal ☐Recreational ☐ Opioids ☐ Cocaine ☐ Amphetamines ☐ Other (specify)? ☐ Quit (when?) How much/day?

DIET

Please fill in below with the foods and beverages that represent a typical day for you

Question	Answer/Comments
Typical breakfast foods	
Typical lunch foods	
Typical dinner foods	
Typical snack foods	
Which, if any particular food(s) do you strongly crave?	
Amount of fluids you drink daily (oz):	Water___ Soda: ___ Milk: ___ Coffee ___ Tea: ___ Energy ___ Other __
How often do you eat out weekly?	
What restaurants do you frequent?	
Do you use artificial sweetener? (circle)	NO YES Describe:
Would you say you read food labels (circle)?	Always Sometimes Never I don't know how

FAMILY HISTORY

Mark the number of cases if a relative has ever been diagnosed with the any of these diseases – leave blank otherwise. For example, if you have two children with asthma, mark that box with "2"

Disorder	Mother	Father	Siblings	Children	Comments
Alcoholism, substance abuse disorder, or drug dependence					
Alzheimer's					
Anemia or other blood disorder					
Arthritis					
Asthma, hives, eczema, hay fever, or allergies					
Autoimmune disease					
Birth defects					
Bleeding disorder					
Cancer - colon, lung, or brain					
Cancer - breast, prostate or uterine					
Cancer - ovarian or testes					
Cancer - cervical					
Cancer - skin					
Cancer - other (specify)					
COPD or Emphysema					
Diabetes					
Epilepsy					
Genetic disease					
Glaucoma					
Heart trouble					
Irritable bowel					
Keloids					
Kidney disease					
Liver or gall-bladder disease					
Mental illness or depression					
Migraines					
Nervous breakdown					
Stroke					
Suicide					
Thyroid problems					
Other (specify)					
Other (specify)					
Other (specify)					
Other (specify)					

MEDICATION and SUPPLEMENT LOG

Please indicate the type of prescription medications, over-the-counter medications, and dietary supplements you have taken in the past month. Indicate who prescribed/recommended each (may be "self").

Include laxatives, vitamins, sedatives, tranquilizers, sleeping aids, pain relievers, hormones, appetite suppressants, herbs, heart, thyroid, diabetic medications, etc.

Medication/Supplement	Who prescribed	Dosage each	# Per Day	Reason for Use (Purpose)

NEW PATIENT INTERNAL MEDICINE INTAKE –MALE ADDENDUM

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAAHP

4 Health and Wellness

Patient Name: _____ **Date of birth** ___/___/_____ **Today's Date** ___/___/_____

REVIEW OF MALE SYSTEMS

Please mark No or Yes to all issues you are currently experiencing or have experienced in the past, and describe in the comments section. Add additional issues on blank lines as needed.

MALE	No	Yes	Comments
Injury			
Surgery			Please describe in SURGICAL AND TRAUMA HISTORY on page 3 of NEW PATIENT INTERNAL MEDICINE INTAKE FORM.
Vasectomy			
Fertility problems			
Erection problems			
Swelling/nodules			
Penile discharge			
Low libido (desire)			
Breast enlargement (gynecomastia or "man-boobs")			
Digital rectal exam (circle)			When? Normal Abnormal (explain)

OTHER COMMENTS

404 W Main St, Ste A, Payson AZ 85541

Phone (888)-391-0414 or (928) 474-7409 or (480) 766-6007

Fax (888) 391-0414; Text (480) 766-6007

Web: DrWeyrich.com *** e-mail Orville@Weyrich.com

Consent to Treat

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAAHP

4 Health and Wellness

Patient Name: _____ **Date of birth** ___/___/_____ **Today's Date** ___/___/_____

- ❑ I request treatment by Dr. Orville Weyrich, Jr., PhD NMD, a licensed Naturopathic Medical Doctor in the State of Arizona, by any appropriate method that is within his scope of practice, including (but not limited to) nutritional, botanical and pharmaceutical agents, manipulation, exercise, acupuncture, IV, IM, and SC injections, biofeedback, electrical modalities, cold laser, homeopathy, mind/body techniques, and minor surgery. I understand that the methods listed above may cause pain or superficial lesions such as bruising, and may require touching or other invasion of my personal space; that I have the right to request discontinuance of treatment at any time. I understand that while Dr. Weyrich's scope of practice overlaps with other health care professionals such as MD, DO, DC, PsyD, MSW, LAc, PT, and LMT, he does not possesses any of these designations.
- ❑ Dr. Weyrich's education includes BA in Chemistry, Math, and Physics (triple major magna cum laude; Union College of Kentucky), AM in Chemistry (Duke University), PhD in physical organic chemistry (University of Tennessee, Knoxville), ABD in Computer Science and Engineering (Auburn University), Naturopathic Medical Doctor (Southwest College of Naturopathic Medicine, 2007), and additional graduate level studies in Math and Statistics (Grand Canyon University). He is Board Certified in Neurofeedback (BCN) by the Biofeedback Certification International Alliance, and a Board Certified Health Practitioner Diplomate in the Clinical Science of Anti-Aging by the American Board of Anti-Aging Health Practitioners (ABAAHP).
- ❑ Dr. Weyrich has earned an Epigenetic Level 1 Coaching Certification from Apeiron Academy and offers epigenetic coaching to patients as well epigenetic coaching clients.
- ❑ Dr. Weyrich has received training in Pain Medicine from the American Academy of Pain Medicine, but there is currently no board certification process for NMD. His license does not allow him to prescribe opiate narcotics, benzodiazepines, gabapentin, trazodone, Valium, or Soma. Therefore, Dr. Weyrich does not offer conventional pain-management services, but does offer various complementary and alternative modes of treatment (physical medicine, electro-magnetic therapies, biofeedback, neurofeedback, acupuncture, herbs, nutrition, etc) in coordination with your conventional doctors.
- ❑ Dr. Weyrich has received the standard training in Mind-Body medicine as part of his NMD degree, and provides limited counseling services. He has been trained as a "Lay Counselor" by Scottsdale Bible Church (AZ) and a "Crisis-line Counselor" by Contact Teleministries (TN), and has obtained additional training from Christian Leaders Institute. He has no professional counseling certification beyond his basic NMD degree. Prayer is available at no cost upon request.
- ❑ Generally speaking, insurance will pay for drug prescriptions written by Dr. Weyrich, but may impose limits, require co-pay, restrict prescriptions to drugs listed on their list of approved drugs (formulary), or require submission of chart notes. Insurance companies rarely pay for compounded medications such as low dose naltrexone (LDN), bio-identical hormones, or drugs used "off-label."
- ❑ Most insurance (in particular all HMOs, AHCCCS, Medicare, Medicaid, Tri-Care, or other government-sponsored program) will NOT pay for office visits, treatments, lab tests or radiology exams ordered by Dr. Weyrich. You either have to pay out of pocket for these services when required, or request a doctor "in network" of your insurance company to order these. Dr. Weyrich will prepare a "coordination of care" letter to request such services from your in-network health care provider upon request as a paid service, but there is no guarantee that the HCP will sign-off on the requests.

- ❑ Dr. Weyrich does NOT participate in any insurance program. Some private insurance plans will reimburse the patient for "out of network services" provided by Dr. Weyrich, but it is the patient's responsibility for submitting statements for reimbursement. No representation is made that third parties will reimburse all or part of services/products billed or that coding complies with third-party regulations. All amounts billed remain the responsibility of the patient.
- ❑ Payment of all new charges are expected at time of service. Prescriptions will be withheld by the front office until scheduled payments are made. Dr. Weyrich does not accept deferred payment for personal injury cases.
- ❑ Due to current inflationary trends in the economy, prices are subject to change. Multi-session discounts may be available, which will lock in the price for the sessions purchased in advance.
- ❑ Phone consultations for coaching clients are billed via PayPal. There is no cost to schedule an appointment.
- ❑ I understand that Dr. Weyrich follows HIPAA privacy guidelines and will only disclose protected healthcare information to third parties as authorized by a records release form signed by the patient, or as required by law. Records pertaining to private-paid services will not be released to insurance companies without a records release form signed by the patient, but in order to obtain certain services from insurance companies (e.g. prior authorization), Dr. Weyrich may be required to allow disclosure.
- ❑ This constitutes disclosure of Dr. Weyrich's HIPAA policy and the patient acknowledges that he/she has been given a copy thereof.
- ❑ Due to legal constraints, Dr. Weyrich does guarantee response to text or voice messages to his cell phone. For reliable communications, please leave a message on his answering service, (888) 391-0414.
- ❑ Due to legal constraints, all patients being treated by Dr. Weyrich must have a designated primary care physician (PCP), and Dr. Weyrich must coordinate care with that PCP (exchange SOAP notes and discuss treatment). If the patient has no other PCP, then Dr. Weyrich legally must assume the role of PCP and provide full standard of care (which includes general health screening and treatment, or appropriate referral), at additional cost to the patient. Dr. Weyrich may decline service if in his opinion he cannot meet this legal requirement.
- ❑ In order to access many insurance services, your PCP acts as the "gate-keeper." Since Dr. Weyrich is not recognized by most insurance companies (especially HMOs, AHCCCS, Medicare, Medicaid, Tri-Care, or other government-sponsored programs), Dr. Weyrich may not be able to function effectively as your PCP.
- ❑ Dr. Weyrich aims to provide treatment that maximizes a patient's ability to engage in the activities of daily living (and participate in the workplace). This usually does not mean that pain is completely eliminated, since higher doses may interfere with proper mentation and reflexes for safely engaging in these activities. Dr. Weyrich expects that patients will actively engage in such exercises, nutritional programs, and other treatments as Dr. Weyrich deems to be appropriate, and that patients will not simply rely on drugs for their treatment.
- ❑ Dr. Weyrich expects that patients will follow directions given for use of medications, patients will not take any medications not approved by Dr. Weyrich, and patients will not in any way sell/give/loan/etc their medications to other persons. Patient agrees to keep Dr. Weyrich informed of any medications or supplements or changes thereof prescribed by other health care providers or self-prescribed. Dr. Weyrich will NOT replace lost drugs. Patients are responsible for securing their medications from theft and misuse by others, including children in the household.
- ❑ Failure to follow these principles can result in a patient being IMMEDIDIATELY dismissed from Dr. Weyrich's practice or Dr. Weyrich refusing to prescribe additional medications to the patient.

Understood and agreed by patient:

Print name: _____

Sign name: _____ Today's date: _____

Dr. Weyrich Fees

Effective 1/1/2023

(Subject to change)

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAAHP

4 Health and Wellness

Physical Therapies:

Naturopathic spinal manipulation [adjustment] (97140, 30 min) **$40**

McManus spinal traction [Manipulative surgery] (97140, 30 min) . . . **$65**

Ultrasound (97035, 15 min) **$35**

Massage/G5 (97124, 15 min) **$35**

Diathermy (97024, 15 min) **$30**

Mechanical intermittent traction (97012, 15 min) **$30**

Far IR Sauna (97026, 15 min) **$30**

Neurostim/SCENAR (97032, 15 min) **$35**

Therapeutic exercise (97110, 15 min) **$35**

Neuromuscular rehab (97112, 15 min) **$35**

Therapeutic activities (97530, 15 min) **$35**

Acupuncture (97810 +97811 15 min) **$35**

Acupuncture + estim (97812 +97813 15 min) **$35**

Biofeedback (90901 30 min) **$65**

Evaluation and Management (Office Visit):

New patient, physical medicine (99202, 20 min) **$35**

New patient, internal medicine (99202, 20 min) **$78**

New patient, internal medicine (99203, 30 min) **$110**

New patient, internal medicine (99204, 45 min) **$170**

New patient, internal medicine (99205, 60 min) **$210**

Prescription refill by phone (99211, 5 min) **$23**

Established patient (99211, 5 min) $23

Established patient (99212, 10 min) $45

Established patient (99213, 15 min) $75

Established patient (99214, 25 min) $110

Established patient (99215, 40 min) $150

Established patient, prolonged (first 30 min more than 99205 or 99215, +99354) . . **$50**

Established patient, prolonged (each additional 30 min more than 99354, +99355) . **$50**

404 W Main St, Ste A, Payson AZ 85541

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