The Anabolic Clinic, S.C.

Prospective Client Questionnaire

This questionnaire must be completed in its entirety.

Just because you submit the completed questionnaire does not ensure that you will be accepted to The Anabolic Clinic, SC, as a client.

Certain conditions prevent us from accepting you as a client because the anabolic substances currently available are contraindicated.

If you have any of these conditions, do not submit a questionnaire or the other material:

> If you are a man with a history of untreated prostate cancer or breast cancer, currently available anabolic substances are contraindicated. We will not accept you as a client.
>
> If you are a woman with a history of breast cancer, are trying to get pregnant or have Polycystic Ovary Syndrome (PCOS) currently available anabolic substances are contraindicated. We will not accept you as a client.

By submitting this questionnaire and other material to us, you acknowledge that the information you provide is true and correct. Do not forget to sign and date it (at the end of the questionnaire).

Further, you agree to inform us within 5 calendar days of any change(s) in your condition, status or situation that would result in a different response to any of the information requested in this questionnaire.

After submitting your completed, signed and dated questionnaire, it will be reviewed. You will be contacted by us. At that time we will inform you of whether you have been accepted as a client of The Anabolic Clinic, SC.

If you have been accepted, we will schedule your consultation. Expect the consultation to last approximately one hour.

Even if you are accepted, please note that should subsequent testing or the face-to-face consultation reveal that it is inappropriate for you to receive treatment with anabolic substances (in our sole discretion), we will not continue working with you.

Payment in full is expected prior to your consultation. The Anabolic Clinic, SC, does not accept insurance for any of our services.

At the time of your consultation, based upon the responses provided in your questionnaire, a proposed treatment and/or testing program will be offered and explained to you. This may be modified depending upon the information you provide during your consultation and/or the results of subsequent testing.

Other material will be presented for you to sign at your consultation. If you decline to sign any of the forms, we will not work with you.

Thank you for your interest in The Anabolic Clinic, SC.

Personal Demographics

First Name: _____
Last Name: _____
Middle Name / Initial: _____
Age: _____
Race: _____
Place of Birth: _____

Social Security Number: _____

(if you are not a citizen, permanent resident or temporary working resident of the USA):
Passport Number: _____
Issuing Country: _____)

Home Address 1: _____
Home Address 2: _____
Home City: _____
Home State / Province: _____
Home Zip: _____
Home Country: _____
Home Phone: _____
Personal Mobile Phone: _____
Home Fax: _____

If we want to contact you, possibly with personal information: (circle one)

May we leave a message for you on your home phone?	Yes	No
May we leave a message for you on your personal mobile phone?	Yes	No
May we send a fax to your home fax?	Yes	No
Is your home fax always available?	Yes	No

Years of Education/highest degree: _____

Marital Status: (circle one)

Single Married Divorced Widowed/Widowered

Spouse's/Partner's Name: _____

Number of children/ages: _____

Who lives at home with you? _____
_____
_____

Occupation: _____
Employer: _____
Work Address 1: _____
Work Address 2: _____
Work City: _____
Work State / Province: _____
Work Zip: _____
Work Country: _____
Work Phone: _____
Work Mobile Phone: _____
Work Fax: _____

If we want to contact you, possibly with personal information: (circle one)

May we leave a message for you on your work phone?	Yes	No
May we leave a message for you on your work mobile phone?	Yes	No
May we send a fax to your work fax?	Yes	No
Is your work fax always available?	Yes	No

E-mail address 1: _____
E-mail address 2: _____
E-mail address 3: _____

If we want to contact you, possibly with personal information: (circle one)

May we send an email message to Email Address 1?	Yes	No
May we send an email message to Email Address 2?	Yes	No
May we send an email message to Email Address 3?	Yes	No

Do you understand that <u>we will not respond to emails sent to us</u>? Yes (you must circle "Yes")

We require that all clients provide us a phone number with an answering machine or voice mail where we can leave a message containing personal information at any time. If you have indicated that none of the above is acceptable for leaving such a message, please provide us with a phone number with an answering machine or voice mail where we can leave personal information for you at any time:

_____
_____
_____

Medical Information

Primary Physician Information

Physician Name: _____
Physician Address 1: _____
Physician Address 2: _____
Physician City: _____
Physician State / Province: _____
Physician Zip: _____
Physician Country: _____
Physician Phone (voice): _____
Physician Fax: _____

Which of the following do you hope to have improved at The Anabolic Clinic, SC?
(please place a check mark (√) or an "X" in the column to the right of the item)

Cold or heat intolerance		Increasing wrinkles	
Decreased desire and ability to exercise		Increasingly stressed	
Decreased energy or endurance		Loss of activity	
Decreasing bone mass		Loss of concentration	
Decreasing memory		Loss of height	
Decreasing muscle strength		Loss of interest in sex	
Decreased sense of well-being		Loss of sociability	
Decreasing size of testicles		Muscle loss	
Depression		Progressive osteoporosis	
Difficulty sleeping		Sagging or loosening of skin	
Fatigue		Softening of testicles	
Headaches/ Migraines		Stooped posture	
Hot flashes/flushes		Thinning or loss of hair	
Hot sweats		Thinning skin	
Increased lack of drive		Vaginal dryness	
Increasing fat deposits about abdomen and/or thighs		Weakness	
Increasing mood swings		Weight gain – Unexplained	
Increasing sagging muscles or breasts		Weight loss – Unexplained	

Other: Please use this space to explain "other" and write any additional information:

_____
_____
_____

Do you intend to get pregnant? Yes No Does Not Apply

Are you currently pregnant? Yes No Does Not Apply

FAMILY HISTORY

Please indicate with a check (√**)** family members who have had any of the following conditions:

Medical Condition	**Mom**	**Dad**	**Sister**	**Brother**	**Daughter**	**Son**	**Other close relatives**
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Autoimmune disorder							
Birth Defects							
Bleeding or Clotting problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, skin (except melanoma)							
Cancer, Ovary							
Cancer, Prostate							
Cancer (other)							
Colitis							
Depression							
Diabetes, Type 1							
Diabetes, Type 2							
Eczema							
Emphysema							
Endocrine disorder							
Epilepsy(seizures)							
Genetic diseases							
Glaucoma							
Gout							
Hay fever (Allergic Rhinitis)							
Hearing problems							
Heart Attack (Coronary Artery Disease)							
Heart Disease, congenital							

Heart Disease, other							

High Blood Pressure (Hypertension)							
High cholesterol (Hyperlipidemia)							
Kidney diseases							
Lipid Disorder							
Lupus (Systemic Lupus Erythematosis)							
Mental illness							
Mental retardation							
Migraine headaches							
Mitral Valve Prolapse							
Obesity/Overweight							
Osteoarthritis							
Osteoporosis							
Reproductive problems							
Rheumatoid Arthritis							
Seizures							
Stroke							
Suicide							
Thyroid disorders							
Tuberculosis							
Ulcers							

Other: Please use this space to explain “other” and write any additional information:

_____

_____

_____

PERSONAL MEDICAL HISTORY

Date of Birth: _____

Gender: (circle one) Male Female

Height: _____

Weight: _____

REVIEW OF SYSTEMS: Please check (√) any current problems you have on the list below.

Constitutional
___Excessive thirst or urination
___Fatigue/weakness
___Fevers/chills/sweats
___Sleep apnea
___Unexplained weight loss/gain

Eyes
___Change in vision

Ears/Nose/Throat/Mouth
___Congestion
___Difficult hearing/ringing in ears
___Hay fever/allergies
___Problems with teeth/gums

Cardiovascular
___Air hunger (getting up at night feeling as if you need more air)
___Ankle swelling
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations
___Shortness of breath with exertion

Chest (breast)
___Breast lump
___Nipple discharge

Respiratory
___Cough/wheeze
___Difficulty breathing
___Coughing up blood

Gastrointestinal
___Abdominal pain
___Blood in bowel movement
___Change in bowel habits
___Change in bowel movements
___Heartburn/reflux
___Nausea/vomiting/diarrhea

Genitourinary
___Nighttime urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina
___Sexual function problems
___Painful urination
___Bloody urination
___Loss of libido (sexual desire)
___Vaginal dryness
___Painful intercourse

Musculo-skeletal
___Muscle/joint pain
___Recent back pain
___Morning joint stiffness

Skin
___Rash
___New or change in mole

Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination
___Fainting

Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression

Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding

*Other (please specify)*_____
_____
_____

Do you have breast cancer or prostate cancer or liver disease? Yes No
If "Yes," please explain:

_____

_____

PRESCRIPTION MEDICATIONS: Prescription medicines, including birth control pills, anti-coagulants, diabetes medications, drugs for your heart, high blood pressure medications, performance-enhancing drugs by prescription. List ALL. Add additional sheets if needed:

Medication	Dose	Times per day

Approximately how much do you spend monthly on prescription medications? _____

NON-PRESCRIPTION MEDICATIONS: Non-prescription drugs, vitamins, home remedies, herbs, street drugs, supplements, performance-enhancing drugs (w/o prescription), etc. Add additional sheets if needed:

Medication	Dose	Times per day

Approximately how much do you spend monthly on non-prescription medications? _____

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medicine, Food, Other	Reaction or Side Effect

MEDICATIONS and DRUGS: Do you take any of the following medications or drugs? If so, please provide the dose and frequency. In the case of opiates or psychotropic drugs, please provide the name(s).

Medication or Drug	Dose	Times per day
Corticosteroids (e.g., Aristocort, Atolone, Celestone, Celestone, Cortan, Cortizone, Cortone, Deltasone, Entocort EC, Kenacort, Kenalog, Liquid Pred, Meticorten, Orapred, Orasone, Panasol-S, Pediapred, Prednicen-M, Prelone, Soluspan, Sterapred)		
Ketoconazole (e.g., Nizoral, Extina, Xolegel, Kuric)		
Finasteride (e.g., Proscar, Propecia)		
Spironolactone (e.g., Aldactone, Novo-Spiroton, Aldactazide, Spiractin,Spirotone, Verospiron orBerlactone)		
Flutamide (e.g., Eulexin, Flutamide)		
Cimetidine		
Cyproterone		
GnRH analogs (e.g., Lupron)		
Estrogens (e.g., Premarin, Cenestin, Enjuvia)		
Metoclopramide (e.g., Metoclopramide, Reglan)		
Ethanol (e.g., beer, wine, spirits)		
Opiates _____		
Psychotropic drugs _____		

Do you currently have or have you ever had any of the following? If "YES," please explain.

(Abnl. = abnormal)	Please circle one		Explain
Abnl. chest x-ray	Yes	No	_____
Abnl. EKG/ECG	Yes	No	_____
Abnl. mammogram	Yes	No	_____
Alcoholism	Yes	No	_____
Allergies to foods	Yes	No	_____
Allergies to medications	Yes	No	_____
Angina pectoris	Yes	No	_____
Ankle swelling	Yes	No	_____
Any known deficiency including minerals, vitamins and electrolytes	Yes	No	_____
Asthma	Yes	No	_____
Atherosclerosis	Yes	No	_____
Back problems	Yes	No	_____
Bladder infection	Yes	No	_____
Blanching of the fingers or toes	Yes	No	_____
Bleeding tendency	Yes	No	_____
Blood clots in legs	Yes	No	_____
Blood clots in lungs	Yes	No	_____
Blood disorder	Yes	No	_____
Blood transfusion	Yes	No	_____
Breast insensitivity	Yes	No	_____
Bronchitis	Yes	No	_____
Broken bones	Yes	No	_____
Cancer	Yes	No	_____
Cataracts	Yes	No	_____
Carpal Tunnel syndrome	Yes	No	_____
Chemical Dependency	Yes	No	_____
Chickenpox	Yes	No	_____
Chronic fatigue	Yes	No	_____
Cirrhosis	Yes	No	_____
Congenital heart disease	Yes	No	_____
Congestive heart failure	Yes	No	_____

Contact lenses	Yes	No	_____
Convulsions	Yes	No	_____
COPD	Yes	No	_____
Decreasing enjoyment of life	Yes	No	_____
Dentures	Yes	No	_____
Depression	Yes	No	_____
Deteriorating work performance	Yes	No	_____
Diabetes – Type 1	Yes	No	_____
Diabetes – Type 2	Yes	No	_____
Difficulty achieving orgasm	Yes	No	_____
Difficulty perceiving smells or fragrances	Yes	No	_____
Diphtheria	Yes	No	_____
Easy bruising	Yes	No	_____
Easy fatigability	Yes	No	_____
Ear Infections	Yes	No	_____
Eczema	Yes	No	_____
Edema / excess fluid retention	Yes	No	_____
Emotional disorders	Yes	No	_____
Emphysema	Yes	No	_____
Endocrine disorder	Yes	No	_____
Epilepsy	Yes	No	_____
Erectile dysfunction	Yes	No	_____
Failure to achieve orgasm	Yes	No	_____
Fibroids	Yes	No	_____
Fibromyalgia	Yes	No	_____
Fractures	Yes	No	_____
Genital – Urinary disorder	Yes	No	_____
Glaucoma	Yes	No	_____
Goiter	Yes	No	_____
Gout	Yes	No	_____
Grumpiness	Yes	No	_____
Heart attack	Yes	No	_____
Heart failure	Yes	No	_____
Heart murmur	Yes	No	_____
Heart rhythm abnormality	Yes	No	_____
Hepatitis	Yes	No	_____

Hernia	Yes	No	_____
Herpes - genital	Yes	No	_____
Herpes - shingles	Yes	No	_____
High blood pressure	Yes	No	_____
High cholesterol	Yes	No	_____
HIV/AIDS	Yes	No	_____
Hives	Yes	No	_____
Hot flashes/flushes	Yes	No	_____
Hot sweats	Yes	No	_____
Hyperlipidemia	Yes	No	_____
Hypertension	Yes	No	_____
Immune disorder	Yes	No	_____
Indigestion	Yes	No	_____
Infertility	Yes	No	_____
Influenza	Yes	No	_____
Insulin resistance	Yes	No	_____
Jaundice	Yes	No	_____
Joint disorders	Yes	No	_____
Kidney disease	Yes	No	_____
Kidney infection	Yes	No	_____
Kidney stones	Yes	No	_____
Leg cramps	Yes	No	_____
Liver problems	Yes	No	_____
Loss of height	Yes	No	_____
Loss of libido	Yes	No	_____
Low blood pressure	Yes	No	_____
Low energy	Yes	No	_____
Lower respiratory tract disease	Yes	No	_____
Lung disorder	Yes	No	_____
Malaria	Yes	No	_____
Measles	Yes	No	_____
Memory loss	Yes	No	_____
Meningitis	Yes	No	_____
Metabolic Syndrome	Yes	No	_____
Mono	Yes	No	_____
Mumps	Yes	No	_____
Muscle condition	Yes	No	_____
Nervous condition	Yes	No	_____
Neurological disorder	Yes	No	_____
Numbness	Yes	No	_____
Orthopedic disorder	Yes	No	_____
Painful intercourse	Yes	No	_____

Paralysis	Yes	No	_____
Phlebitis	Yes	No	_____
Pleurisy	Yes	No	_____
Poliomyelitis	Yes	No	_____
Poor wound healing	Yes	No	_____
Psychiatric condition	Yes	No	_____
Raynaud's Disease/Phenomenon	Yes	No	_____
Renal disease	Yes	No	_____
Respiratory problems	Yes	No	_____
Rheumatic Fever	Yes	No	_____
Rheumatoid Arthritis	Yes	No	_____
Rubella (German Measles)	Yes	No	_____
Sadness	Yes	No	_____
Scarlet Fever	Yes	No	_____
Scleroderma	Yes	No	_____
Seizures	Yes	No	_____
Sensitivity to cold	Yes	No	_____
Sleepiness after dinner	Yes	No	_____
Stomach problems	Yes	No	_____
Suicide attempt	Yes	No	_____
Thyroid Disease	Yes	No	_____
Tonsillitis	Yes	No	_____
Tropical disease	Yes	No	_____
Tuberculosis	Yes	No	_____
Typhoid	Yes	No	_____
Ulcer	Yes	No	_____
Uncomfortable intercourse	Yes	No	_____
Upper respiratory tract disease	Yes	No	_____
Vaginal dryness	Yes	No	_____
Venereal disease	Yes	No	_____
Weak orgasms	Yes	No	_____
Weight gain (recent and unintended)	Yes	No	_____
Weight loss (recent and unintended)	Yes	No	_____
Whooping Cough	Yes	No	_____
Yellowing of the eyes	Yes	No	_____

Other illnesses:
(Please Explain): Yes No _____
_____
_____
_____

SURGICAL HISTORY (Please list all prior operations or procedures and dates)**:**

Operation or Procedure	Date

MEN'S HISTORY:

Are you trying to have children? YES NO

Do you intend to have children? YES NO

Have you ever had a PSA (prostate specific antigen) test? YES NO

If so, when?_____

If so, was it abnormal? YES NO

If it was abnormal, what was the value?_____

If you had a PSA test, please provide a copy of the latest result and include it with this questionnaire.

If you have not had a PSA test within the last 3 months, we may request that you have one before offering you treatment. Do you understand? YES (you must circle "Yes")

WOMEN'S HISTORY:

Are you pregnant? YES NO

Do you intend to get pregnant? YES NO

Number of pregnancies: _____

Number of deliveries: _____

Number of C-sections: _____

Number of therapeutic abortions (by choice): _____

Number of miscarriages: _____

1st day, most recent period: (provide date) _____

Age at 1st period: _____

Length of period: (actual bleeding - e.g., 5 days) _____

Length of menstrual cycle: (e.g., 28 days; if irregular state range, e.g., 22-38 days)
_____

Do you have any concerns about your periods? YES NO
_____
_____
_____

Do you have any concerns about menopause? YES NO
_____
_____
_____

Have you ever had a mammogram? YES NO

If so, when?_____

If so, was it abnormal? YES NO

If it was abnormal, what was the result?_____
_____

If you had a mammogram, please provide a copy of the latest result and include it with this questionnaire.

If you have not had a mammogram within the last 6 months, we may request that you have one before offering you treatment. Do you understand? YES (you must circle "Yes")

SOCIAL HISTORY

Religion:

What is your religion: _____

Do you consider yourself observant of your religion? YES NO

Does the observance of your religion place any dietary restrictions on you? YES NO

If "Yes," please describe: _____

_____

Tobacco Use:

Cigarettes: Never _____ Started (age) _____ Quit Date _____

Current Smoker: packs/day _____

Other Tobacco (circle): Pipe Cigar Snuff Chew

Are you interested in quitting? YES NO

Alcohol Use:

Do you drink alcohol? YES NO

Number of drinks per week: _____

Is your alcohol use a concern for you or others? YES NO

Have you ever felt the need to cut down on drinking? YES NO

Have you ever felt annoyed by criticism of drinking? YES NO

Have you ever had guilty feelings about drinking? YES NO

Have you ever taken a drink first thing in the morning (Eye-openers) to steady your nerves or get rid of a hangover? YES NO

Drug Use:

Do you use any recreational (street) drugs? YES NO

What drug(s) do you use: _____

Have you ever used needles to inject drugs? YES NO

Sexual Activity:

Have you been sexually active? YES NO

Are you currently sexually active? YES NO

Current sex partner(s) is/are (circle all that apply): Male Female

Do you use birth control? YES NO

If you do not use birth control is that because none is needed? YES NO

Birth control method(s) used: _____

Have you ever had any sexually transmitted diseases (STDs)? YES NO

If "Yes," what STD(s)? _____

Are you interested in being screened for sexually transmitted diseases? YES NO

Caffeine Intake:

None: _____ (check or place an "X" if none)
Coffee cups/day: _____
Tea cups/day: _____
Soda cups/day: _____

Weight and Height:

Are you satisfied with your weight? YES NO

Current Height: _____
Current Weight: _____

Height one year ago: _____
Weight one year ago: _____

Height five years ago: _____
Weight five years ago: _____

Diet:

How do you rate your diet? (circle one) Good Fair Poor

Have you ever experienced an eating disorder? Yes No

If "Yes," please explain:

_____
_____
_____
_____

Are you pleased with your present eating habits? Yes No

If "No," please explain:

_____
_____
_____
_____

Are you following a special diet or have you changed your diet in any way(s) over the last year?

Yes No

If "Yes," what kind of diet? Check the one(s) that apply:

Atkins _____
Diabetic _____
High-calorie _____
High-carbohydrate _____
High-fiber _____
High-protein _____
Hypoglycemic _____
Low carb _____
Low-calorie _____
Low-cholesterol _____
Low-fat _____
Low-sodium _____
Vegan _____
Vegetarian _____
Other _____

If "Other," please describe:

_____
_____
_____
_____

Do you eat or drink four servings of dairy or soy daily or take calcium supplements?

YES NO

Exercise:

Do you "exercise" regularly? YES NO

What kind of "exercise"?_____
_____

How long (minutes)? How often?_____
_____

If you do not "exercise," why?_____
_____

Have you ever used performance enhancing drugs? YES NO

If "Yes," which, when, why?:_____
_____
_____

Safety:

Do you use a bike helmet? YES NO DNA

Do you use seatbelts consistently? YES NO

Is violence at home a concern for you? YES NO REFUSE TO ANSWER

If "Yes," please describe:_____

_____

_____

Have you ever been abused? YES NO REFUSE TO ANSWER

If "Yes," please describe:_____

_____

_____

Do you own a gun? YES NO REFUSE TO ANSWER

Do you have a gun in your home? YES NO REFUSE TO ANSWER

Associations:

Do you belong to a gang? YES NO REFUSE TO ANSWER

If "Yes," which gang?_____

Legal: (add additional sheets if necessary)

Have you ever sued a medical doctor or other health care worker?

YES NO REFUSE TO ANSWER

If "Yes": (if more than once, please add additional sheet)

Who?_____

Why?_____

When?_____

Where?_____

Did you prevail? YES NO

Have you ever been convicted of a violent crime?

YES NO REFUSE TO ANSWER

If "Yes":

When?_____

What?_____

_____

Have you ever been convicted of a sex offense?

YES NO REFUSE TO ANSWER

If "Yes":

When?_____

What?_____

_____

Have you ever been in jail? YES NO REFUSE TO ANSWER

If "Yes":

When?_____

Why?_____

_____

_____

Have you ever had a restraining order issued against you?

YES NO REFUSE TO ANSWER

If "Yes," please describe:_____

_____

_____

I hereby affirm that the above information is true and correct.

_____

Your Name Printed

_____ _____

Your Signature **Date**