Female Patient Intake Form

Basic Information

Lewerenz Medical Center

PATIENT'S NAME ______________________ DATE ______________

STREET ADDRESS ______________________

CITY, STATE, ZIP ______________________

HOME PHONE ______________ ALTERNATE PHONE ______________

EMAIL ADDRESS ______________________

HOW DO YOU PREFER TO BE CONTACTED? ○ *EMAIL* ○ *PHONE* BIRTH DATE ______________

MARITAL STATUS ○ *SINGLE* ○ *MARRIED* ○ *WIDOWED* ○ *DIVORCED*

REFERRED BY ______________________

EMERGENCY CONTACT ______________________

RELATIONSHIP ______________ PHONE NUMBER ______________

Female Patient Intake Form

Social and Family History

Lewerenz Medical Center

PATIENT'S NAME ______________________ **DATE** ______________

OCCUPATION AND HOURS ______________________ **LEVEL OF STRESS (RATE FROM 0 TO 10)** ________

ALCOHOL USE ○ *NEVER* ○ *OCCASIONALLY* ○ *3-4 TIMES PER WEEK* ○ *DAILY*

TOBACCO USE ○ *NEVER* *QUIT DATE:* __________ ○ *OCCASIONALLY* *PACKS PER DAY:* ______

AEROBIC EXERCISE ○ *NEVER* ○ *1-2 TIMES PER WEEK* ○ *3-4 TIMES PER WEEK* ○ *DAILY*

STRENGTH TRAINING ○ *NEVER* ○ *1-2 TIMES PER WEEK* ○ *3-4 TIMES PER WEEK* ○ *DAILY*

MEALS OR SNACKS ○ *2 TIMES A DAY* ○ *3-4 TIMES A DAY* ○ *5-6 TIMES A DAY*

VEGETABLE INTAKE ○ *LESS THAN 10%* ○ *BETWEEN 20 AND 40%* ○ *BETWEEN 41 AND 60%* ○ *MORE THAN 60%*

HOBBIES AND INTERESTS ______________________________

FAMILY HEALTH HISTORY *Please include: Cancer, Stroke, High blood pressure, Heart attacks, Diabetes, Alzheimer's, Osteoporosis, Thyroid. Indicate disease history. Indicate age or cause of death.*

MOTHER ______________________________

MATERNAL GRANDMOTHER ______________________________

MATERNAL GRANDFATHER ______________________________

FATHER ______________________________

PATERNAL GRANDMOTHER ______________________________

PATERNAL GRANDFATHER ______________________________

AUNTS / UNCLES ______________________________

SIBLINGS ______________________________

CHILDREN ______________________________

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Female Patient Intake Form

Female patient questionnaire

Lewerenz Medical Center

PATIENT'S NAME ____________________ DATE ____________________

DATE OF LAST MENSTRUAL PERIOD ____________________

ARE YOUR PERIODS REGULAR? __________ HEAVY? __________ LENGTH OF CYCLE __________

TOTAL # PREGNANCIES __________ LIVING CHILDREN __________ #VAGINAL __________ #C-SECTION __________

ARE YOU SEXUALLY ACTIVE? __________ NUMBER OF TIMES PER WEEK __________ PROBLEMS ____________________

SEXUAL ORIENTATION ○ *HETEROSEXUAL* ○ *BISEXUAL* ○ *HOMOSEXUAL*

CURRENT METHOD FOR BIRTH CONTROL ____________________ BIRTH CONTROL METHODS USED IN THE PAST ____________________

ARE YOU IN AN ABUSIVE RELATIONSHIP? __________ HAVE YOU BEEN SEXUALLY ABUSED? __________

DATE OF LAST PAP SMEAR __________ PAST ABNORMALITIES ____________________

DATE OF LAST MAMMOGRAM __________ PAST ABNORMALITIES ____________________

DATE OF LAST BONE DENSITY SCREENING __________ PAST ABNORMALITIES ____________________

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Female Patient Intake Form

Health Conditions

Lewerenz Medical Center

PATIENT'S NAME ______________________ DATE ______________

HEALTH CONDITIONS Check all that apply

Condition				
SLEEP DISORDER	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
ANXIETY / NERVOUSNESS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
IRRITABILITY	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
DEPRESSION / EMOTIONAL SWINGS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
FOOD CRAVINGS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
HOT FLASHES	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
NIGHT SWEATS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
VAGINAL DRYNESS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
URINE LEAKAGE	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
DRY SKIN / WRINKLES	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
DRY HAIR	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
FATIGUE	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
MEMORY LOSS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
CONCENTRATION LOSS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
HAIR LOSS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
LOSS OF LIBIDO / ORGASM	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
MUSCLE WEAKNESS / LOSS	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
MUSCLE AND JOINT PAIN	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*
LOSS OF PUBIC HAIR	◯ *NONE*	◯ *MILD*	◯ *MODERATE*	◯ *SEVERE*

Female Patient Intake Form

Symptom History

Lewerenz Medical Center

PATIENT'S NAME ________________________ DATE ______________

SYMPTOM HISTORY Fill all that apply

GENERAL PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ○ **HAVE YOU SEEN AN INTERNIST?** ______________________
- ○ **FEVERS / CHILLS** ______________________
- ○ **HEADACHE** ______________________
- ○ **DIZZINESS** ______________________
- ○ **EXCESS FATIGUE** ______________________
- ○ **INSOMNIA** ______________________
- ○ **WEIGHT LOSS / WEIGHT GAIN** ______________________
- ○ **ENLARGED LYMPH NODES** ______________________
- ○ **FREQUENT BRUISING** ______________________

EYES / EARS / NOSE / MOUTH PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ○ **HAVE YOU SEEN AN EAR, NOSE, THROAT DOCTOR?** ______________________
- ○ **BLURRY VISION** ______________________
- ○ **RINGING IN EARS** ______________________
- ○ **DIFFICULTY WITH VISION** ______________________
- ○ **DIFFICULTY WITH HEARING** ______________________
- ○ **MOUTH SORES** ______________________
- ○ **SINUS PROBLEMS** ______________________
- ○ **WEIGHT LOSS / WEIGHT GAIN** ______________________

Female Patient Intake Form

Symptom History

Lewerenz Medical Center

PATIENT'S NAME ______________________ DATE ______________

SYMPTOM HISTORY Continued Fill all that apply

CARDIOVASCULAR PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ◯ **HAVE YOU SEEN A CARDIOLOGIST?** ______________________
- ◯ **CHEST PAIN AT REST OR EXERCISE** ______________________
- ◯ **SHORTNESS OF BREATH** ______________________
- ◯ **COLD HANDS OR FEET** ______________________
- ◯ **SWELLING OF LEGS** ______________________
- ◯ **PALPITATIONS** ______________________

GASTROINTESTINAL PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ◯ **HAVE YOU SEEN A SPECIALIST?** ______________________
- ◯ **CONSTIPATION** # BOWEL MOVEMENTS A DAY ______________________
- ◯ **DIARRHEA** ______________________
- ◯ **BLOATING** ______________________
- ◯ **EXCESSIVE BELCHING** ______________________
- ◯ **GAS / ACIDITY** ______________________
- ◯ **BLOOD IN STOOL** ______________________
- ◯ **THIRST: LACK OF / TOO MUCH** # GLASSES OF FLUID A DAY ______________________

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Female Patient Intake Form

Symptom History

Lewerenz Medical Center

PATIENT'S NAME ______________________ **DATE** ______________

SYMPTOM HISTORY Continued Fill all that apply

GENITOURINARY PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ○ **HAVE YOU SEEN AN UROLOGIST?** ______________________
- ○ **PAIN DURING URINATION** ______________________
- ○ **CLOUDY / BLOODY URINATION** ______________________
- ○ **URINATING TOO MANY TIMES** # OF TIMES PER DAY ______________________
- ○ **DIFFICULTY URINATING** ______________________
- ○ **LOSS OF URINE** ______________________

MUSCULOSKELETAL PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ○ **HAVE YOU SEEN A CHIROPRACTOR?** ______________________
- ○ **DO YOU GET REGULAR BODY TREATMENT / MASSAGE?** ______________________
- ○ **BACK PAIN** ______________________
- ○ **NECK PAIN** ______________________
- ○ **SHOULDER PAIN** ______________________
- ○ **KNEE PAIN** ______________________
- ○ **JOINT PAIN** ______________________

Female Patient Intake Form

Symptom History

PATIENT'S NAME ______________________ DATE ______________

SYMPTOM HISTORY Continued Fill all that apply

SKIN PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ○ **HAVE YOU SEEN A DERMATOLOGIST?** ______________________
- ○ **ACNE** ______________________
- ○ **DRY SKIN** ______________________
- ○ **OILY SKIN** ______________________
- ○ **LOSS OF COLLAGEN LOSS OF FIRMNESS** ______________________
- ○ **WRINKLES** ______________________
- ○ **PIGMENTATION / SCARRING** ______________________

EMOTIONAL PLEASE DESCRIBE Include a the Doctor's name, the condition and its duration.

- ○ **DO YOU HAVE A COUNSELOR?** ______________________
- ○ **DEPRESSION** ______________________
- ○ **ANXIETY** ______________________
- ○ **STRESS** ______________________

BY SIGNING BELOW YOU DECLARE THAT YOU HAVE ANSWERED TO THE BEST OF YOUR KNOWLEDGE

PATIENT SIGNATURE ______________________

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longevity health institute

Female Patient Intake Form

Medication History

LMC
Lewerenz Medical Center

PATIENT'S NAME ______________________ **DATE** ______________

DRUG ALLERGIES AND TYPE OF REACTIONS ______________________

MEDICATION HISTORY List dosage and how many times a day, start and stop date and reason for taking the medication.

SUPPLEMENTS HISTORY List dosage and how many times a day, start and stop date and reason for taking the supplement.

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Female Patient Intake Form

Lewerenz Medical Center

Consent

I hereby request and consent to the performance of medical treatment and other procedures within the scope of practice afforded by the licensed healthcare professionals and other clinical staff members of Longevity Health Institute (LHI) and Lewerenz Medical Center (LMC) on me or patient named below, for whom I am legally responsible for.

I understand that any recommendations and care received at Longevity Health Institute or Lewerenz Medical Center are supportive only and do not substitute for regular medical care. I understand that I must continue to see my regular treating healthcare providers as directed by them and take my regular medications as prescribed.

I understand that the methods of treatment provided by LHI/LMC include, but are not limited to, Bio-identical hormone restoration, gynecology services, chiropractic care, acupuncture, oriental and homeopathic medicine, weight loss, detoxification, nutritional restoration, facials and peels, massages, body treatments, hydrotherapy, spa services, hair removal, leg veins, masotheraphy, Botox cosmetic, Juvederm, Velasmooth, Fotofacial RF, dermal fillers, electrical stimulation, moxibustion, cupping, Tul-Na, Oriental herbs, teas and/or nutritional supplements to promote health and well-being, dietary and lifestyle counseling. I understand that some of the herbs and supplements recommended by LHI/LMC may have occasional side effects, I will immediately notify LHI/LMC by telephone or in person of any side effects associated with my use of these herbs and or supplements.

I understand that methods of treatment may involve insertion of various sized needles into different areas of my body, along with stimulation of these needles either by hand or with an approved electrical device, and that there may be some discomfort and/or bruising during or following treatment.

I understand that I have the right to question any therapy proposed and/or provided by LHI/LMC and that all of my questions will be answered prior to receiving such treatment. I understand that I have not been given a guarantee of beneficial or specific results. I affirm that I have and/or always, to the best of my ability, disclose my complete current and past medical history to LHI/LMC. I understand that history is essential for LHI/LMC to be able to assess and provide competent care and treatment to me. I understand that the treatment I receive from LHI/LCC and its health care professionals is in large part based upon my disclosures to them.

I consent to the use or disclosure of my protected health information to LHI/LMC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bill or to conduct healthcare operations. I understand that treatment by LHI/LMC may be conditioned upon my authorization as evidenced by my signature on the Consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of LHI/LMC. LHI/LMC is not required to agree to any restrictions I may request. However, if LHI/LMC agrees to any such restriction, restriction is binding on LHI/LMC.

I have the right to revoke this Consent in writing, at any time, except to the extent LHI/LMC has taken action in reliance of this Consent.

My “protected health information” means health information including demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review LHI/LMC’s Notice of Privacy Practices prior to signing this Consent. The Notice of Privacy Practices describes my rights and LHI/LMC’s duties with respect to my protected health information. The Notice of Privacy Practices describes the uses and disclosures of my protected health information that may occur during my treatment, payment of bills or in the performance of healthcare operations. A copy of LHI/LMC’s Notice of Privacy Practices is available at the reception desk.

LHI reserves the right to change the privacy practices described in the Notice of Privacy Practices by requesting a copy from LHI/LMC staff or by requesting a copy to be sent to me by mail.

Furthermore, I understand I am responsible for full payment of services at the time they are rendered and for any unpaid balances in the event of third party or insurance claims. I hereby acknowledge and accept full responsibility for any and all costs incurred.

By voluntarily signing below, I affirm that I have read and have read to me the above consent to treatment. I have been advised of the risks and benefits of the procedures provided to me and I have had the opportunity to ask cquestions regarding each such procedure. I undertsnd the Consent covers the entire course of treatment provided by LHI/LMC for my present condition and for any future condition(s) for which I seek treatment.

SIGNATURE OF PATIENT OR PERSON LEGALLY EMPOWERED TO EXECUTE THIS CONSENT FOR PATIENT WHO IS A MINOR OR PHYSICALLY OR MENTALLY INCOMPETENT

DATE

PRINTED NAME OF PATIENT OR PERSON LEGALLY EMPOWERED TO EXECUTE THIS CONSENT FOR A PATIENT WHO IS A MINOR OR PHYSICALLY OR MENTALLY INCOMPETENT

DATE

Female Patient Intake Form

Medical Information Release Form

Lewerenz Medical Center

PATIENT'S NAME ______________________ **DATE OF BIRTH** ______________________

RELEASE OF INFORMATION ○ I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS, EXAMINATION RENDERED TO ME AND CLAIMS OF INFORMATION.

THIS INFORMATION MAY BE RELEASED TO:

SPOUSE ○ ______________________

CHILD (REN) ○ ______________________

OTHER ○ ______________________

INFORMATION IS NOT TO BE RELEASED TO ANYONE ○ THIS *RELEASE OF INFORMATION* WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES PLEASE CALL:

MY HOME ○ ______________________

MY WORK ○ ______________________

MY CELL NUMBER ○ ______________________

IF UNABLE TO REACH ME:

○ **YOU MAY LEAVE A DETAILED MESSAGE**

○ **YOU MAY LEAVE A MESSAGE ASKING ME TO RETURN YOUR CALL**

SIGNED ______________________ **DATE** ______________________

WITNESS ______________________ **DATE** ______________________

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Female Patient Intake Form

Patient's HIPAA Acknowledgment Form

Lewerenz Medical Center

I, ______________________________, ACKNOWLEDGE THAT I RECEIVED AND REVIEWED THE OFFICE PRIVACY POLICY NOTICE FOR DR. JAMES LEWERENZ, D.O.

I GIVE PERMISSION TO DR. LEWERENZ AND HIS STAFF TO COMMUNICATE WITH MY FAMILY MEMBERS OR OTHER RESPONSIBLE ADULT REGARDING MY MEDICAL CARE.

PATIENT SIGNATURE: ______________________ DATE ______________________

IF A PERSONAL REPRESENTATIVE SIGNS THIS AUTHORIZATION ON BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME ______________________________

RELATIONSHIP TO INDIVIDUAL ______________________________

Female Patient Intake Form

Michigan Healthcare Professionals, P.C.

Acknowledgment of receipt of patient notice of privacy practices

I ACKNOWLEDGE THAT I READ AND / OR RECEIVED A COPY OF THE MICHIGAN HEALTHCARE PROFESSIONALS, P.C. PATIENT NOTICE OF PRIVACY PRACTICES EFFECTIVE SEPTEMBER 23, 2013.

PATIENT SIGNATURE: ______________________________ DATE ______________________________

OR GUARDIAN, IF APPLICABLE