



longevity health institute

MALE 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 _____

Lewerenz Medical Center : Crown Office Village
1467 East Twelve Mile Road. Madison Heights, MI 48071
Phone: 248 548 3060 Fax: 248 548 3078

Longevity Health Institute
1555 E. South Blvd. Suite 340. Rochester Hills, MI 48307
Phone: 248 289 6643 Fax: 248 289 6949



longevity health institute

MALE 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 _____

Lewerenz Medical Center : Crown Office Village
1467 East Twelve Mile Road. Madison Heights, MI 48071
Phone: 248 548 3060 Fax: 248 548 3078

Longevity Health Institute
1555 E. South Blvd. Suite 340. Rochester Hills, MI 48307
Phone: 248 289 6643 Fax: 248 289 6949



longevity health institute

MALE PATIENT INTAKE FORM

MALE PATIENT QUESTIONNAIRE



LEWERENZ
MEDICAL
CENTER

PATIENT'S NAME _____ DATE _____

LIVING CHILDREN _____

ARE YOU SEXUALLY ACTIVE? _____ NUMBER OF TIMES PER WEEK _____ PROBLEMS _____

SEXUAL ORIENTATION HETEROSEXUAL BISEXUAL HOMOSEXUAL

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

DATE OF LAST PHYSICAL EXAM _____ PAST ABNORMALITIES _____

DATE OF LAST PROSTATE EXAM _____ PAST ABNORMALITIES _____

DATE OF LAST P.S.A. _____ PAST ABNORMALITIES _____

DATE OF LAST BONE DENSITY SCREENING _____ PAST ABNORMALITIES _____

Lewerenz Medical Center : Crown Office Village

1467 East Twelve Mile Road. Madison Heights, MI 48071

Phone: 248 548 3060 Fax: 248 548 3078

Longevity Health Institute

1555 E. South Blvd. Suite 340. Rochester Hills, MI 48307

Phone: 248 289 6643 Fax: 248 289 6949



longevity health institute

MALE PATIENT INTAKE FORM

HEALTH CONDITIONS



LEWERENZ
MEDICAL
CENTER

PATIENT'S NAME _____ DATE _____

HEALTH CONDITIONS Check all that apply

DRY SKIN NONE MILD MODERATE SEVERE

DRY HAIR NONE MILD MODERATE SEVERE

SLEEP DISORDERS NONE MILD MODERATE SEVERE

FATIGUE NONE MILD MODERATE SEVERE

MEMORY LOSS NONE MILD MODERATE SEVERE

CONCENTRATION LOSS NONE MILD MODERATE SEVERE

ANXIETY / NERVOUSNESS NONE MILD MODERATE SEVERE

IRRITABILITY NONE MILD MODERATE SEVERE

DEPRESSION NONE MILD MODERATE SEVERE

LOSS OF LIBIDO / ORGASM NONE MILD MODERATE SEVERE

DIFFICULTY MAINTAINING AN ERECTION NONE MILD MODERATE SEVERE

DIFFICULTY ACHIEVING AN ERECTION NONE MILD MODERATE SEVERE

PREMATURE EJACULATION NONE MILD MODERATE SEVERE

MUSCLE WEAKNESS NONE MILD MODERATE SEVERE

MUSCLE LOSS NONE MILD MODERATE SEVERE

MUSCLE AND JOINT PAIN NONE MILD MODERATE SEVERE

LOSS OF MASCULINITY / CONFIDENCE / AGRESSIVENESS NONE MILD MODERATE SEVERE

Lewerenz Medical Center : Crown Office Village
1467 East Twelve Mile Road. Madison Heights, MI 48071
Phone: 248 548 3060 Fax: 248 548 3078

Longevity Health Institute
1555 E. South Blvd. Suite 340. Rochester Hills, MI 48307
Phone: 248 289 6643 Fax: 248 289 6949



longevity health institute

MALE 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 _____

Lewerenz Medical Center : Crown Office Village
1467 East Twelve Mile Road. Madison Heights, MI 48071
Phone: 248 548 3060 Fax: 248 548 3078

Longevity Health Institute
1555 E. South Blvd. Suite 340. Rochester Hills, MI 48307
Phone: 248 289 6643 Fax: 248 289 6949



longevity health institute

MALE 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 _____



longevity health institute

MALE 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 _____



longevity health institute

MALE PATIENT INTAKE FORM

SYMPTOM HISTORY



LEWERENZ
MEDICAL
CENTER

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 _____



longevity health institute

MALE PATIENT INTAKE FORM

MEDICATION HISTORY



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.



longevity health institute

MALE PATIENT INTAKE FORM

CONSENT



LEWERENZ
MEDICAL
CENTER

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, masotherapy, Botox cosmetic, Juvederm, Velasmoth, 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

Lewerenz Medical Center : Crown Office Village
1467 East Twelve Mile Road. Madison Heights, MI 48071
Phone: 248 548 3060 Fax: 248 548 3078

Longevity Health Institute
1555 E. South Blvd. Suite 340. Rochester Hills, MI 48307
Phone: 248 289 6643 Fax: 248 289 6949



longevity health institute

MALE 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** _____



longevity health institute

MALE 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 _____



longevity health institute

MALE PATIENT INTAKE FORM

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.



LEWERENZ
MEDICAL
CENTER

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

Lewerenz Medical Center : Crown Office Village
1467 East Twelve Mile Road. Madison Heights, MI 48071
Phone: 248 548 3060 Fax: 248 548 3078

Longevity Health Institute
1555 E. South Blvd. Suite 340. Rochester Hills, MI 48307
Phone: 248 289 6643 Fax: 248 289 6949