LEVIN 道 THERAPEUTICS

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Confidential Health History & Self-Reflection Inventory

GENERAL INFORMATION **Date:** _____

Patient's Name: _____ Age: _____ Date Of Birth _____

Email Address: _____

Phone #:_____ Cell #:_____ Work #: _____

Home Address:

_____

STREET CITY STATE ZIP

Mailing Address (if different from above):

_____

STREET CITY STATE ZIP

Educational Background: _____ Occupation: _____

Living Situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parents ☐ Children, # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Prefer to describe _____

EMERGENCY CONTACT

In case of emergency, please notify: _____ Phone #: _____

Relationship to patient: _____

How did you hear about Levin Therapeutics? Is there someone we can thank for referring you?

_____

FINANCIAL AGREEMENT

I claim full financial responsibility for services rendered at the Levin Therapeutics for:

(PATIENT NAME) _____ and understand that payment is required in full at the time of service. Should an appointment be missed with less than 24-hour's notice, patient may be charged the ***full fee*** of their appointment.

SIGNED: _____ DATE: _____

SIGNATURE (PATIENT, OR PARENT/LEGAL GUARDIAN OF PATIENT)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:

I hereby authorize the release of any medical information necessary in the processing of my claim. I also authorize payment directly to Levin Therapeutics for medical benefits.

SIGNED: _____ DATE: _____

SIGNATURE (PATIENT, OR PARENT/LEGAL GUARDIAN OF PATIENT)

SIGNATURE ACKNOWLEDGE RECEIPT OF THE INFORMATION AND ACCEEPTANCE OF THE INFORMATION OF HIPAA AND PATIENT PRIVACY PRACTICES FORM

I hereby acknowledge receipt of the information and acceptance of the information provided by Levin Therapeutics regarding HIPAA and Patient Privacy Practices:

SIGNED: _____ DATE: _____

SIGNATURE (PATIENT, OR PARENT/LEGAL GUARDIAN OF PATIENT)

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MEDICAL HISTORY

Current and/or recent healthcare providers:

Provider Name _____ Date of Care: _____

Provider Name _____ Date of Care: _____

Provider Name _____ Date of Care: _____

Do any healthcare providers request follow-up on your visit here? If yes, please indicate:

Provider Name _____ Phone #:_____

Provider Address:

_____

STREET CITY STATE ZIP

ALLERGIES

Drug Allergies (Penicillin, etc.):

_____

_____

Other Allergies (Food, Animals, Pollens, etc.):

_____

_____

MEDICAL STATUS

Overall General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

HOSPITALIZATIONS/OPERATIONS

Operation/Diagnosis: _____ Date: _____

Operation/Diagnosis: _____ Date: _____

Operation/Diagnosis: _____ Date: _____

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REVIEW OF SYMPTOMS

Please check no or yes for the following **current** symptoms (**within past 3 months**)

	Yes	No
GENERAL		
Fever		
Sweats at night		
Hot flashes		
Temperature intolerance		
Excessive thirst		
Fatigue		
Sleep difficulties		
Daytime sleepiness		
Unplanned weight change		
SKIN		
Rash		
New or changing moles		
EYES		
Pain		
Redness		
Vision change		
EAR, NOSE, THROAT		
Hearing loss		
Ringing in ears		
Dizziness or vertigo		
Bleeding gums		
Nosebleeds		
BREAST		
Breast Pain		
Masses and or Lumps		
Nipple discharge		
Skin changes		
CARDIOVASCULAR		
Chest pain		
Heart murmur		
Irregular heart beat (palpitations)		
Leg swelling or edema		
PULMONARY		
Wheezing or shortness of breath		
Chronic cough		
HEMATOPOIETIC		
Swollen lymph glands		
Blood clots		
Excessive bleeding		
Anemia		

	Yes	No
GASTROINTESTINAL		
Diarrhea/Constipation		
Indigestion/heartburn		
Nausea		
Blood in stool		
GENITOURINARY		
Pain or burning on urination		
Frequent urination		
Waking to urinate more than once at night		
Excessive urination		
Difficulty emptying bladder		
Urinary incontinence		
Decreased sexual desire		
Pain with intercourse		
Sexually Transmitted Diseases		
Fertility issues		
Men:		
Erectile dysfunction		
Women:		
Heavy vaginal discharge		
Heavy menstrual bleeding		
Painful menstrual periods		
Irregular menstrual bleeding		
MUSCULOSKELETAL		
Generalized or all-over pain		
Joint pain		
Stiffness		
Joint swelling		
Joint redness		
Back or neck pain		
NEUROLOGICAL		
Abnormal gait (Trouble Walking) or falls		
Headache severe and/or frequent		
Seizures		
Muscle weakness, TIA or stroke		
Fainting or loss of consciousness		
Localized numbness, tingling, neuropathy		
PSYCHOLOGICAL		
Anxiety		
Depression		
Memory loss		
Mood swings		

OTHER PAST MEDICAL CONDITIONS

Childhood diseases: ☐ German measles ☐ Chicken Pox ☐ Other: _____

☐ Heart Trouble: _____ ☐ High Blood Pressure ☐ Stroke ☐ Varicose Veins ☐ Phlebitis

☐ Clotting Defects ☐ Bleeding Tendencies ☐ Blood Transfusion ☐ Diabetes ☐ Kidney Trouble

☐ Rheumatic Fever ☐ Jaundice/Hepatitis ☐ Epilepsy ☐ Arthritis ☐ Colitis ☐ Asthma

☐ Eating Disorder ☐ Chronic Fatigue/Epstein Barr ☐ Fractures: _____ ☐ Cancer: _____

☐ Other: _____

FAMILY MEDICAL HISTORY

Have your close relatives (parent, brother or sister, child, grandparent) had the following?

	No	Yes	If yes, which relative	Age at Diagnosis
Heart attack, angina				
Stroke				
High blood pressure				
High Cholesterol				
Diabetes				
Thyroid disease				
Breast cancer				
Other Cancer–what type?				
Kidney Disease				
Osteoporosis				
Rheumatoid Arthritis				
Asthma				
Mental Health disorder				
Substance Abuse				

TRAUMA HISTORY

Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ☐ No ☐ Yes

If yes, is this an active issue in your life that you would like to address while you are here? ☐ No ☐ Yes

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HABITS

Tobacco use? ☐ No ☐ Yes – Type: _____ How much? _____ How long? _____

Alcohol use? ☐ No ☐ Yes – Type: _____ How much? _____ How long? _____

Caffeine use? ? ☐ No ☐ Yes – How much? _____ How long? _____

Other mood altering substance use (i.e. marijuana, cocaine—past and present):

_____

PHYSICAL ENVIRONMENT

Do you have specific health concerns about your current home or environment (quality of air, water, etc.)?

_____

Have you had hazardous environmental or occupational exposures? If yes, please describe:

_____

MOVEMENT, EXERCISE AND REST

What forms of exercise and movement do you enjoy?

_____

Please describe your usual physical activity:

Activity	How often	How long each time

Average hours of sleep each night: _____ Do you have any sleep issues? ☐ No ☐ Yes, please describe:

_____

SEXUAL HISTORY

Are you sexually active? ☐ No ☐ Yes – How often: _____

Diagnosis of HIV or other STD(s)? ☐ No ☐ Yes – Please describe: _____

_____

SPIRITUALITY

What things or activities bring you greatest joy and meaning? What inspires you?

_____

What things create the greatest challenges for you?

_____

What makes you feel connected to the larger world? Describe your spiritual or religious practices if any.
(i.e.,meditation, prayer, time in nature, worship attendance, etc.).

_____

If time and money were not an issue, describe the things you would do in your life:

_____

MIND-BODY CONNECTION

Rate the amount of stress in your life: ☐ None ☐ A Little Bit ☐ Moderate ☐ Quite a Lot ☐ Extreme

How well do you manage stress: ☐ Not at all ☐ A Little Bit ☐ Moderate ☐ Quite Well ☐ Excellent

What are the main sources of stress in life? (Personal, professional, financial etc.)

_____

What are your methods of coping with the stress in your life?

_____

Do you have a Racial/Culture heritage that is important to you? _____

Are you happy with your sexual life? _____

Which relationship(s) fulfill and/or empower you? _____

HEALTH GOALS:

What are your overall goals for improving your health and life?

_____

_____

_____

_____

_____

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FERTILITY & GYNECOLOGICAL HISTORY (WOMEN ONLY)

Date last period began: _____ Date prior period began: _____

Date of last pelvic exam: _____ Date of last pap smear: _____

Were the above normal? _____

Have you ever had an abnormal Pap? ☐ No ☐ Yes – Date: _____ Results: _____

Treatment: _____

Are you sexually active? ☐ No ☐ Yes Do you practice safe sex? ☐ No ☐ Yes

Are you trying to get pregnant? ☐ No ☐ Yes – For how long? _____

Current birth control method: _____ For how long? _____

Any problems? ☐ No ☐ Yes: _____

Past birth control methods _____

Normally (when not on pills), how many days from the start of one period to the start of the next? _____

Number of days of flow: _____ Amount of bleeding: _____ Amount of cramps: _____

Premenstrual syndromes: _____

Starting when? _____

Any changes in your normal pattern? _____

Any bleeding between periods? ☐ No ☐ Yes – When: _____

Any unusual pelvic pain, pressure, or fullness? ☐ No ☐ Yes —When: _____

Describe: _____

Any unusual vaginal discharge or itching? ☐ No ☐ Yes — Describe: _____

For how long? _____ Past treatments: _____

Any sexual concerns to discuss? _____

Any history of tubal infection? _____

Any history of sexually transmitted disease? _____

Any history of DES exposure? *(DES was a drug taken by mothers during pregnancy to prevent miscarriage)* _____

AMH/FSH/LH levels? _____

Methods used to try and achieve conception? *(IVF, IUI, rhythm method, AI)* _____

Other information: _____

Preganancies / Miscarriages and/or Abortions *(please provide any details such as date, how far along, sex, weight)*

_____

_____

Other Problems? _____

_____

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DAILY LIVING PROFILE

Please indicate whether each statement does or does not describe your current life. **Circle answers to any statements, or concerns that bother you a great deal.**

NEIGHBORHOOD

1. My neighborhood is too noisy ..... ☐ Yes ☐ No
2. My neighborhood is too crowded ..... ☐ Yes ☐ No
3. My neighborhood is too quiet ..... ☐ Yes ☐ No
4. I do not have enough friends/neighbors ..... ☐ Yes ☐ No
5. I live in a dangerous neighborhood ..... ☐ Yes ☐ No
6. Having so many household tasks irritates me ..... ☐ Yes ☐ No
7. The weather here bothers me ..... ☐ Yes ☐ No
8. I am new to this area ..... ☐ Yes ☐ No
9. Other neighborhood problems ..... ☐ Yes ☐ No

If "Yes," please describe: _____

FAMILY

10. I recently married ..... ☐ Yes ☐ No
11. I recently divorced, or separated ..... ☐ Yes ☐ No
12. I recently moved, or am planning to move ..... ☐ Yes ☐ No
13. I am alone too much at home ..... ☐ Yes ☐ No
14. I am concerned about my relationship with my partner ..... ☐ Yes ☐ No
15. I am concerned about my relationship with another family member ..... ☐ Yes ☐ No
16. I feel I was raised in a dysfunctional environment ..... ☐ Yes ☐ No
17. There is a new baby in our family ..... ☐ Yes ☐ No
18. I, or one of my family members, is having legal problems ..... ☐ Yes ☐ No
19. There was a recent death of a family member, or close friend ..... ☐ Yes ☐ No
20. There is serious illness in my family ..... ☐ Yes ☐ No
21. I am worried about one of my family members, or close friends ..... ☐ Yes ☐ No
22. Someone close to me drinks too much ..... ☐ Yes ☐ No
23. One of my children has moved away from home recently ..... ☐ Yes ☐ No
24. I, or my partner, have recently retired ..... ☐ Yes ☐ No
25. Other family, or household problems ..... ☐ Yes ☐ No

If "Yes," please describe: _____

WORK

26. I am bored with the work I do ☐ Yes ☐ No
27. Other people make too many demands of me ☐ Yes ☐ No
28. I have too little control over my own work ☐ Yes ☐ No
29. I am not satisfied with the work I do ☐ Yes ☐ No
30. I often feel over whelmed by my responsibilities ☐ Yes ☐ No
31. There is not enough time to finish my work ☐ Yes ☐ No
32. I just began a new job ☐ Yes ☐ No
33. I just lost my job ☐ Yes ☐ No
34. I don't get along with my boss/co-workers ☐ Yes ☐ No
35. I am having problems with the people I work with ☐ Yes ☐ No
36. Other work-related problems ☐ Yes ☐ No

If "Yes," please describe: _____

PERSONAL

37. I worry about money a great deal ☐ Yes ☐ No
38. I feel lonely ☐ Yes ☐ No
39. I am bored with my life ☐ Yes ☐ No
40. I am generally concerned about my health ☐ Yes ☐ No
41. I think a lot about dying ☐ Yes ☐ No
42. I have particular concerns relating to my religion ☐ Yes ☐ No
43. Other personal problems ☐ Yes ☐ No

If "Yes," please describe: _____

STRESS EFFECTS

44. I have difficulty falling asleep ☐ Yes ☐ No
45. I have difficulty staying asleep ☐ Yes ☐ No
46. I have difficulty staying awake ☐ Yes ☐ No
47. I feel tired when I wake up in the mornings ☐ Yes ☐ No
48. I feel nervous most of the time ☐ Yes ☐ No
49. I often feel depressed ☐ Yes ☐ No
50. I worry a lot ☐ Yes ☐ No
51. I am frequently ill ☐ Yes ☐ No

52. I have considered committing suicide ☐ Yes ☐ No
53. I have some sexual problems ☐ Yes ☐ No
54. I sometimes feel weak, or light-headed ☐ Yes ☐ No
55. I often have pains in my shoulders, neck, or back ☐ Yes ☐ No
56. I often feel like crying ☐ Yes ☐ No
57. I drink too much coffee ☐ Yes ☐ No
58. I smoke too much ☐ Yes ☐ No
59. I often drink too much alcohol ☐ Yes ☐ No
60. I eat much more than I used to ☐ Yes ☐ No
61. I eat much less than I used to ☐ Yes ☐ No
62. I am concerned about my weight ☐ Yes ☐ No
63. I lose my temper more than I use to ☐ Yes ☐ No
64. I think that I might be helped by counseling ☐ Yes ☐ No
65. Other stress-related problems ☐ Yes ☐ No

If "Yes," please describe: _____

_____

Do you have any personal matters you wish to discuss with us?

_____

_____

_____

Please use this space to add any other information about yourself that you think will be of help to us:

_____

_____

_____

_____

_____

_____

_____

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NUTRITIONAL PROFILE

How many times per week do you eat out, or bring home take-out food?_____

Do you eat packaged or frozen foods? ☐ No ☐ Yes – How often?_____

Do you typically eat breakfast? ☐ No ☐ Yes How many meals do you eat per day? _____

How many times a day do you snack? _____ What is a typical snack?_____

Please write down below what you have eaten in the past 24 hours. Be as specific as possible, stating amount and type of food (ex. 1/2 cup brown rice, instead of just "rice"). Use the back of this sheet if you need more space.

Morning	
Afternoon	
Evening	
Snacks	

Do you currently or have you ever had a problem with weight or eating? ☐ No ☐ Yes, please describe:

_____

Are you uncomfortable with your relationship with food? ☐ No ☐ Yes, please describe:

_____

Do you feel knowledgeable about your nutritional needs? ☐ No ☐ Yes

Who prepares your meals? _____

What are your favorite foods? _____

Do you have food cravings? ☐ No ☐ Yes – When? _____

Foods you typically crave: ☐ Sweet Salty ☐ Breads/ pastas ☐ Chocolate ☐ Coffee/ caffeine ☐ Other: _____

Do you frequently feel thirst? ☐ No ☐ Yes What beverage do you drink most in a given day? _____

How many glasses (8 oz.) of plain water do you drink a day?_____

Do you often feel hungry? ☐ No ☐ Yes Do you eat beyond feeling full? ☐ No ☐ Yes

Do you eat when you are not hungry? ☐ No ☐ Yes – What and why? _____

Are there any foods will you NOT eat? _____

What are the foods you eat most frequently? _____

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Please fill out the information below to help us to get a general idea of your eating habits.

I usually eat...	Every day	3-4x/ week	1 or 2x/ week	Almost never	Never
Breakfast					
Lunch					
Dinner					
Snacks					
Canned vegetables					
Frozen vegetables					
Leafy greens					
Yellow or orange veggies					
Fresh Fruit					
Cheese or yogurt					
Eggs					
Red meat					
Fish					
Chicken					
Beans, dried peas or lentils					
Tofu or tempeh					
Nuts, peanut butter, tahini…					
Other sources of protein?					
Whole grains, wheat noodles, corn tortillas, brown rice					

MEDICATION LOG

Please list all current medications, supplements, vitamins, herbal and homeopathic remedies. Use the back of this sheet if you need more space.

Medications, supplements, vitamins, herbal and homeopathic remedies	Dosage (how much, how many times/day)	Prescribed by practitioner or self-prescribed?	Any noticeable side effects?