Linchitz Medical Wellness, PLLC

265 Post Ave. Suite 380
Westbury, NY 11590
Phone: (516) 759-4200 Fax: (516) 759-7600

Patient Intake

Patient's Name:_____
Last First Middle

Address:_____
Street City State Zip

Home Phone:_____Work:_____Cell:_____

Email Address:_____

Birthdate:_____Marital Status:_____ # Of Children:_____

Height:_____Weight:_____lbs.

If patient is a minor, give the parent or guardian's name_____

How did you hear about us:_____

Current Physician/Care Provider:_____

Address:_____Phone Number:_____

Have you seen any specialist in the last 3 years? And why_____

The reason I am seeking alternative care and treatment.
_____

Have you refused conventional care ? Yes_____ No_____

Medical Information

1. Are you having pain or discomfort at this time? Yes___No___

2. Have you been under the care of medical doctor during the past 2 years? Yes___No___

3. Have you had any surgery or infectious disease? Yes___No___
   If yes please list

_____

4. A. Are you taking any medications or drugs? Yes___No___

If yes, please list:_____

B. Are you taking supplements, Vitamins or homeopathic remedies Yes___No___

If yes, please list:_____

5. Are you sensitive or allergic to any medications or anesthetics? Yes___No___

If yes, Please List_____

6. Do you have food allergies? Yes___No___

If yes, Please List_____

7. Indicate which of the following you have had or have at present

Heart Failure	Yes____No____	Artificial Joints	Yes____No____
Heart Disease	Yes____No____	Kidney Trouble	Yes____No____
Heart Attack	Yes____No____	Ulcers	Yes____No____
Angina Pectoris	Yes____No____	Diabetes	Yes____No____
Congenital Heart Disease	Yes____No____	Thyroid Problems	Yes____No____
Heart Murmur	Yes____No____	Glaucoma	Yes____No____
High Blood Pressure	Yes____No____	Cancer	Yes____No____
Arteriosclerosis	Yes____No____	Emphysema	Yes____No____
Arterial Valve Prolapse	Yes____No____	Chronic Cough	Yes____No____
Artificial Heart Valve	Yes____No____	Tuberculosis	Yes____No____
Heart Pacemaker	Yes____No____	Asthma	Yes____No____

Initial_____

Heart Surgery	Yes____No____	Hay Fever	Yes____No____
Rheumatic Heart Valve	Yes____No____	Allergies or Hives	Yes____No____
Arthritis	Yes____No____	Sinus Trouble	Yes____No____
Rheumatic Fever	Yes____No____	Radiation Therapy	Yes____No____
Adrenal Issues	Yes____No____	Chemotherapy	Yes____No____
Drug Addiction	Yes____No____	Hepatitis A (Infectious)	Yes____No____
Stroke	Yes____No____	Venereal Disease	Yes____No____
Hepatitis B (Serum)	Yes____No____	H.I.V. Positive	Yes____No____
A.I.D.S.	Yes____No____	Blood Transfusion	Yes____No____
Cold Sores/Fever Blisters	Yes____No____	Anemia	Yes____No____
Hemophilia	Yes____No____	Bruise Easily	Yes____No____
Sickle Cell Disease	Yes____No____	Yellow Jaundice	Yes____No____
Liver Disease	Yes____No____	Fainting/Dizzy Spells	Yes____No____
Epilepsy or Seizures	Yes____No____	Tumors	Yes____No____
Nervousness	Yes____No____		

8. When you walk upstairs or take a walk, do you ever stop because of pain in your chest, shortness of breath, or because you are very tired? Yes___No____

9. Do your ankles swell during the days? Yes___No____

10. Do you use more than two pillows to sleep? Yes___No____

11. Have you gained more than 10 pounds in the past years? Yes___ No___

12. Do you ever wake up from sleep short of breath? Yes___ No___

13. Are you on a special Diet? Yes___No___

Social History and Personal Health Habits

General

My Health is: _____Excellent_____Good_____Fair_____Poor

My Physical Fitness is: _____Excellent_____Good_____Fair_____Poor

Initial _____

_____I am under a lot of stress _____ I am fatigued all the time ____ I am having difficulty dealing with stress _____ I practice meditation or other relaxing techniques _____ I am often sad and blue

Dietary Habits

_____ No special diet _____ avoid red meat _____ minimize fat _____

Vegetarian _____ I do not eat dairy/cheese ____

I commonly consume:____ Coffee ____ Regular soft drinks

Exercise Habits

___No special exercise habits____ routinely exercise ____ hr(s) ____ x/week

_____ Aerobic Exercise (jog/walk/treadmill)____ Lift weights ____ Swim_____ Stretch/ Yoga

Tobacco Use

_____ I do not use Tobacco Products _____I smoke ____ Cigarettes per day

Alcohol Use

____ I never drink alcohol ____ I regularly drink ____ 1-2 drinks/day ____ more than 2 drinks/day _____ more than 4 drinks/day

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Women Only: Gynecological History

Age at first menstrual period _____ Menses Frequency _____ Length _____

Pain? Yes___No___

Clotting? Yes___ No___

Has your period ever skipped? Yes___ No___ For how long? _____

Date of last menstrual period: _____

Number of pregnancies _____ # living Children _____ Caesarean? ___
Vaginal delivery?_____
Miscarriage? ____ Abortion? ____ Post partum depression? ____

Toxemia? ____ Gestational diabetes? ____

Breast-feeding ____ for how long _____

Are you pregnant now? Yes____ No____ If yes, what month are you in_____

Are you nursing? Yes____ No ____ Are you on any type of hormonal contraception? Yes____ No____ If yes, please list _____

If so, what type of Birth Control: Pills_____ Patch _____ Nuva Ring_____

Are you in menopause? Yes_____ No _____

Are you taking any hormone replacements? Yes_____ No _____
If yes, please list _____

Mood Swings? _____ Hot Flashes?_____ Weight Gain? _____ Vaginal Dryness? ___Low Libido? _____ Headaches? _____ Sleep Problems? _____ Heavy Bleeding?____Palpitations?_____ Joint Pains?_____ Loss of control of Urination? _____

Do you perform regular self-breast examinations? Yes _____ No _____

Last Mammogram:_____

Date of Last:

Pap Smear:_____
Bone Density:_____

Men Only:

Date of last prostate exam:_____

Have you had a PSA done?_____Level:_____

Are you concerned about loss of muscle mass or strength? Yes____ No____

Change in libido? Yes_____No_____

Have you had problems with urination? Yes_____No_____

Urgency? Yes_____ No_____ Loss of control? Yes_____ No_____

Getting an erection? Yes____No____ Maintaining an erection? Yes___No____

Do you preform periodic testicular self-examinations? Yes____ No____

_____

I understand the information above is necessary to provide me with medical care in a safe and effective manner. I have answered all the questions truthfully and to the best of my knowledge.

Patients Signature_____Date:_____

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As a result of the Health Insurance Portability and the Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office of Civil Rights, we are not permitted to release patient information except as stated in the notice of privacy practices, or in accordance with your wishes as stated below.

This waiver authorizes Linchitz medical Wellness to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my Home/Cell phone:

Yes_____ No _____

Speak to a family member of my choosing, also known as, Personal Representative, regarding my Personal Health Information:

Yes_____ No_____

Name of Personal Representative:_____

Relationship/Phone Number:_____

The authorizations made above will remain effective until such times as I notify Linchitz Medical Wellness in Writing, by certified mail, of requested changes

Patient Signature:_____Date:_____

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Our belief is that our treatment is vital to your overall health. Some insurers do not agree with our approach and prefer doctors who recommend drugs/surgery-standard, conventional treatment. We do not agree with them. While conventional medicines may be appropriate in some cases, it is our belief that most chronic disease are the result of an unbalanced lifestyle. These can be very responsive to diet and lifestyle changes and we prefer to treat patients by first trying these methods which have no side effects.

We do not accept any assignment on any insurance plan. We wish to reclaim our freedom to practice medicine without oppressive government and bureaucratic meddling. The amount of time and energy spent on getting reimbursed is cost prohibitive and waste enormous amounts of time and resources. Their requirements frequently limit your test and treatment options. We prefer to spend out time caring for patients.

We are happy to provide you with the name of a medical insurance biller who can assist you, their contact with you is independent of this practice and we have no responsibility to assist with getting reimbursements. We do not provide codes and we make no representations about whether or not you will be reimbursed by your insurance company,

We will provide you with a bill that supplies you diagnosis, treatment/procedures and costs. However we will not be responsible for providing information regarding diagnosis codes, treatment/procedure codes, and standards of care, articles to support the treatments of letters to insurance companies. You are, of course, entitled to your medical records at any time and we will be happy to provide them to you at a cost of $.25 per page for copying and any additional mailing cost.

I understand that all responsibility for payment for services in this office for myself is mine and payable at the time services are rendered.

I understand that if I do not give 24 hour notice of cancellation, I will be charged the full price of my visit.

Patient Signature:_____Date:_____