PRO HEALTH GROUP, INC.
NEW PATIENT FORMS

MEDICAL QUESTIONNAIRE **TODAY'S DATE** _____

PATIENT INFORMATION:		
NAME:		**DATE OF BIRTH:**
AGE:	SEX:	MARITAL STATUS:
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE: ( )		**CELL: ( )**
EMAIL:		FAX: ( )
PHARMACY:		
NAME:	PHONE: ( )	FAX: ( )
NEXT OF KIN / PERSON TO CONTACT IN CASE OF EMERGENCY:		
NAME:	RELATIONSHIP:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE: ( )		CELL: ( )
REFERRING PHYSICIAN:		
NAME:		
ADDRESS:	CITY/STATE:	ZIP CODE:
PHONE: ( )	FAX: ( )	
OTHER PHYSICIANS:		
NAME: (PHYSICIAN 1)		SPECIALITY:
PHONE: ( )	FAX: ( )	
NAME: (PHYSICIAN 2)		SPECIALITY:
PHONE: ( )	FAX: ( )	
NAME: (PHYSICIAN 3)		SPECIALITY:
PHONE: ( )	FAX: ( )	

PLEASE BRIEFLY STATE THE REASON FOR YOUR VISIT TO OUR OFFICE:

MEDICAL HISTORY (CHRONIC ILLNESSES AND INJURIES):

DATE:	ILLNESS:	TREATMENT:

HAVE YOU HAD COVID-19? **YES** **NO** **DATE:**

SURGICAL HISTORY (OPERATION AND PROCEDURES):
PLEASE LIST IN CHRONOLOGICAL ORDER, FROM THE OLDEST TO THE MOST RECENT

MONTH & YEAR:	TYPE OF SURGERY:

HAVE YOU BEEN VACCINATED: **YES** **NO**

WHICH VACCINE: **DATE:**

HAVE YOU EVER NEEDED A TRANSFUSION OF BLOOD OR BLOOD PRODUCT: **YES** **NO**

IF YES, BRIEFLY EXPLAIN WHY:

PLEASE EXPLAIN ANY ADVERSE REACTIONS:

MEDICATIONS: PRESCRIPTION AND COMPOUNDED **PATIENT NAME:**

PLEASE LIST ALL MEDICATIONS (PRESCRIPTIONS) YOU ARE TAKING FOR LYME

MEDICATION:	DOSAGE:	START DATE:	REASON FOR TAKING:

PLEASE ANSWER THE FOLLOWING QUESTIONS: IF MORE SPACE IS NEEDED PLEASE ATTACH SEPARATE SHEET

Present well-being (circle one): Poor Below average Average Fairly good Good

Overall how do you feel today?_____

Have you been diagnosed with Lyme disease? Yes No

If yes, by whom?_____

Most prominent symptoms: _____

_____

_____

LIST ANY MEDICATION ALLERGIES: _____

LIST ANY OTHER ALLERGIES: _____

Are you pregnant? Yes No If yes, how many months?

Have you had problems with previous pregnancies? Yes No

If yes, please explain:_____

Are you taking contraceptives? Yes No

Do you smoke? Yes No If yes, how long?_____ Quantity?_____

Do you exercise? Yes No If yes, what type:_____

Diet / eating habits (circle if applies): Gluten-free / Sugar-free / Dairy-free _____

Outdoor activities:_____

Do you have pets? Yes No If yes, what type: _____

How long? _____ Are they sick? Yes No

If yes, please explain: _____

States previously visited: _____

Areas travelled to outside of the United States:_____

Do you remember getting a bite from the following? Tick_____ Spider_____ Mosquito_____

If you don't remember getting a bite please check here:_____

Date of bite?_____ State where bitten? _____

Was the tick attached to your body when found? Yes No

How long before it was removed?_____

Was the tick identified? Yes No If yes, type of tick?

Symptoms following tick bite:_____

_____

_____

Generalized date of onset of symptoms?_____

Was there a rash at the bite site? Yes No

If yes, describe the rash: _____

How long after the bite did the rash occur? _____

Duration of rash? _____

Was there a "bullseye" lesion? Yes No Duration? _____

Have you been diagnosed with any of the following?

Please circle all that pertain to you:

ALS
Alzheimer's Disease
Asthma
Bakers Cyst (behind knee)
Bell's Palsy
Bursitis (where? _____)
Carpel Tunnel Syndrome
Depression
Diabetes
Encephalitis
Fibromyalgia
Iritis Anemia
Meningitis
Multiple Sclerosis
Polymyalgia Rheumatica
Prostatitis
Psoriasis/eczema
Stroke: Permanent Temporary
Tendonitis
TMJ

Special children's questions:

Decreased interest in playing? Yes No
Poor school performance? Yes No
When did he/she start whimpering or whining? _____

Clinical signs and symptoms:

Please circle all that pertain to you:

General
Fatigue
Fevers: High Low
Flu-like symptoms
Loss of voice/hoarseness
Loss of appetite
Hair loss
Sore throats
Night sweats
Unexplained chills
Unexplained weight change
Other _____

Heart and Lung
Abnormal echocardiogram
Chest: Pain Tightness
EKG abnormalities
Heart attack
Heart palpitations
Skipped heart beats
Increased blood pressure
Mitral valve prolapse
Shortness of breath
Cough: Dry Productive
Other _____

Eye and Ear
Blind spots
Blurred vision
Conjunctivitis
Diminished peripheral vision
Double vision: Horizontal Vertical
Drooping eyelids
Flashing lights
Floaters
Lazy eye
Light sensitivity
Optic atrophy
Pressure behind the eyes
Retinal damage
Uveitis (inflammation of eye)
Vision loss/blindness
Ringing in the ears (one / both)
Hearing loss/deafness one ear both ears
Other_____

Musculoskeletal
Muscle: Pain Aching
Muscle: Cramps Stiffness
Loss of muscle tone
Jaw: Pain Stiffness
Back: Pain Stiffness
Neck pain
Joint: Pain Stiffness
Hand: Pain Stiffness
Elbow: Pain Stiffness
Shoulder: Pain Stiffness
Hip(s): Pain Stiffness
Knee: Pain Stiffness
Feet/ankle: Pain Stiffness
Leg aches
Other _____

Neurological
Abnormal EEG
Anxiety attacks
Burning sensation external internal
Change in: smell taste
Confusion
Decreased concentration
Dementia
Depression
Difficulty: Chewing Swallowing
Dizziness Fainting
Fatigue
Hallucinations
Headache: Mild Severe
Involuntary jerking
Irritability
Memory Problems
Meningitis
Mood swings
Motion sickness
Muscle twitching
Nightmares
Numbness (where? _____)
Obsessive/compulsive behavior
Panic attacks
Paranoia
Partial paralysis (where?_____)

Gastrointestinal and Urinary
Abdominal pain
Constipation
Diarrhea
Diverticulosis
Irritable bladder
Liver enlargement
Nausea
Spleen enlargement
Tenderness in abdomen
Urinary frequency retention
Vomiting
Other _____

Reproductive
Breast: infections discharge from breasts
Loss of libido (sex drive/decreased activity)
Menstrual irregularities
Worsening symptoms around menstruation
Pelvic pain
PMS
Other _____

Personality change
Poor balance or difficulty walking
Seizures
Sleep disturbances: falling asleep, waking frequently
Suicidal
Tearfulness _____
Tingling (where? _____)
Tremors or shaking
Weakness of limbs
Unusual clumsiness

Abnormal lab results:

Please circle all that apply and document date and lab:

	Date	Lab
Positive Lyme ELISA		
Positive Lyme Western Blot		
Positive Lyme Immunoblot		
Positive Lyme IGX Spot		
Positive Lyme PCR		
Positive Lyme Urine Antigen (LUAT)		
Positive Tick Borne Relapsing Fever Test		
Positive Babesia test		
Positive Bartonella test		
Positive Ehrlichea test		
Positive Anaplasma test		
Positive Rickettsia test		
Elevated ANA Elevated		
Anticardiolipin		
Elevated Rheumatoid Factor		
VDRL (Syphillis)		
List all other tests to substantiate diagnosis:		

Other information pertinent to your symptoms or diagnosis:

CONSENT TO TREAT CHRONIC PERSISTENT LYME DISEASE

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program for Lyme disease is universally successful or accepted. Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two schools of thought is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

My Diagnosis. The diagnosis of Lyme disease is primarily a clinical determination made by my doctor based on my exposure to ticks, my report of symptoms, and my doctor's observation of signs of the disease, with diagnostic tests playing a supportive role.

Doctors differ in how they diagnose Lyme disease.

- Some physicians rely on the narrow surveillance case criteria of the CDC for clinical diagnosis even though the CDC itself cautions against this approach. These physicians may fail to diagnose some patients who actu ally have Lyme disease. For these patients, treatment will either not occur or will be delayed.

- Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. These physicians sometimes use the antibiotic responsiveness of a patient to assist in their diagnosis. Since no treatment is risk-free, use of broader clinical criteria to diagnose disease could in some cases expose patients to increased treatment complications. This approach may result in a tendency to over diagnose and over treat Lyme disease.

My Treatment Choices. The medical community is divided regarding the best approach for treating persistent Lyme disease. At this time, many physicians follow the treatment guidelines of the Infectious Diseases Society of America (IDSA) that recommend short term treatment only and view the long-term effects of Lyme disease as an autoimmune process or permanent damage that is unaffected by antibiotics.[1] Other physicians believe that the infection persists, is difficult to eradicate, often associated with "co infections" or additional organisms and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination doses. In fact, there have been questions as to the validity of the aforementioned (IDSA) guidelines, that have been published in the peerreviewed literature [2-4]. Alternative guidelines promoted by the International Lyme and Associated Diseases Society (ILADS) [5] support the concepts that diagnostic technology and criteria for the diagnosis of Lyme disease are often too INSENSITIVE. That the clinical judgment in the appropriate setting as described above, ought to provide the clinician at the point of care with the ability to diagnose and clinically determine the activity of this infectious process. That this approach supports the concepts that this complex may be difficult to treat and may require longer courses of antibiotics, in protocols such as pulsing or cycling. That while doing all we can to "do no harm," the perspective remains that oftentimes quite ill patients would often benefit from these "alternative" approaches to the management of this most complex process [6]

Potential Benefits of Treatment. Some clinical studies support longer term treatment approaches, while others do not. The experience in this office is that although most patients improve with continued treatment, some do not.

Risks of treatment. There are potential risks involved in using any treatment, just as there are in foregoing treatment entirely. Some of the problems with antibiotics may include (a) allergic reactions, which may manifest as rashes, swelling, and difficulty with breathing, (b) stomach or bowel upset, or (c) yeast infections. Severe allergic reactions may require emergency treatments, while other problems may require suspension of treatment, or adjustment of medication. Other problems such as adverse effects on liver, kidneys gallbladder, or other organs may occur.

Factors to consider in my decision. No one knows the optimal treatment of symptoms that persist after a patient is diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, potentially herbal/complimentary supplements may be warranted. Or, the appropriate treatment might be additional antibiotic therapy, either oral or intravenous. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the a therapy. By taking antibiotics for longer periods of time, I place myself at greater risk of developing side effects.

By stopping antibiotic treatment, I place myself at greater risk that a potentially serious infection will progress [7]. Not all patients respond to antibiotic therapy. There is no currently available diagnostic test that can demonstrate the eradication of the Lyme bacteria from my body [8]. Other forms of treatment designed to strengthen my immune system also may be important. Some forms of treatment are only intended to make me more comfortable by relieving my symptoms and do not address any underlying infection.

My decision about continued treatment may depend on a number of factors that may be important to me. Some of these factors include (a) the severity of my illness and degree to which it impairs my quality of life, (b) whether I have coinfections, which can complicate treatment, (c) my ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment, (d) whether I have been responsive to antibiotics in the past, (e) whether I relapse or my illness progresses when I stop taking antibiotics, and (f) my willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse.

For example, if my illness is severe, significantly affects the quality of my life, and I have been responsive to antibiotic treatment in the past, I may wish to continue my treatment. However, if I am unresponsive to antibiotics, I may wish to terminate treatment. I will ask my doctor if I need any more information to make this decision and am aware that I have the right to obtain a second opionion at any time if I think this would be helpful.

I realize that the choice of treatment approach to use in treating my condition is mine to make in consultation with my physician. After weighting the risks and benefits of the two treatment approaches, I have decided: (CHECK ONE)

☐	To treat my Lyme disease through a treatment approach that relies heavily on clinical judgment and may use antibiotics either oral or IV, depending upon my doctor's clinical judgment, until my clinical symptoms resolve. I recognize that this treatment approach does not conform to IDSA guidelines and that insurance companies may not cover the cost of some or all of my treatment.	☐	Not to pursue antibiotic therapy
☐	Only to treat my Lyme disease with antibiotics for thirty days, even if I still have symptoms.		I may obtain a copy of IDSA guidelines by going to: http://www.cdc.gov/ncidod/dvbid/lyme/IDSA_2000.pdf ILADS guidelines by going to: http://www.ilads.org/files/ILADS_Guidelines.pdf

I understand the benefits and risks of the proposed course of treatment, and of the alternatives to it, including the risks and benefits of foregoing treatment altogether. My questions have all been answered in terms I understand. All blanks on this document have been filled in as of the time of my signature.

Signature: _____ Date: _____

Print Name: _____ Witness: _____

1. Wormser GP, RJ Dattwyler, ED Shapiro, AJ Halperin, AC Steere, MS Klempner, PJ Krause, JS Bakken, F Strle, G Stanek, L Bockenstedt, D Fish, JS Dumler, and RB Nadelman. The clinical assessment, treatment, and prevention of Lyme disease, Human Granulocytic Anaplasmosis, and Babesiosis: Clinical practice guidelines by the Infectious Diseases Society of America. Clin Infect Dis. 2006; 41(1 November): 1089. Available at hhttp://www.idsociety.org/content.aspx-?id=4432#ld

2. Khan AR, Khan S, Zimmerman V, Baddour LM,and Tleyjeh IM Quality and Strength of Evidence of the Infectious Diseases Society of America Clinical Practice Guidelines CID (15 November) 2010:51

3. Deresinski S Guiding Clinical Care through Evidence-Free Zones CID (15 November) 2010:51 1157-1159

4. Johnson L and Stricker RB The Infectious Diseases Society of America Lyme guidelines: a cautionary tale about development of clinical practice guidelines Philosophy, Ethics, and Humanities in Medicine 2010, 5:9 doi:10.1186/1747-5341-5-9

5. The International Lyme and Associated Diseases Society. ILADS Evidence-based guidelines for the management of Lyme disease. Expert Rev. Anti-infect. Ther. 2004; 2(1): S1–S13. Available at w.ilads.org

6. Shor, S Retrospective analysis of a cohort of Internationally Case Defined Chronic Fatigue Syndrome patients in a Lyme endemic area Bulletin of the IACFS/ME.2011;18(4):109-123

7. Virginia Governor McDonnell's task force on Lyme disease 2010-2011, position paper published June 30, 2011

8. Cameron DJ Consequences of treatment delay in Lyme disease Journal of Evaluation in Clinical Practice 13 (2007) 470–472

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury. And instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a backup for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims of monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive related, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and the fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law(Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.
Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example emergency treatment) patient should initial here, . Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable. The remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE; BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUES OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature: _____ Date: _____

(Or Patient Representative) _____ (Indicate relationship if signing for patient _____)

Office Signature: _____ Date: _____

PRO HEALTH GROUP, INC.
PATIENT CONSENT TO RELEASE MEDICAL INFORMATION

This form allows other medical providers to release your medical information to Pro Health Group, Inc. in the event you require us to have your historical medical information.

Patient Name: _____

Other Names Used: _____

Patient Date of Birth: _____ /_____/_____ (MM/DD/YYYY)

Social Security Number: _____- _____ -_____

Medical Record Number: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS OBTAINED IN THE COURSE OF MY DIAGNOSIS AND TREATMENT INCLUDING SUMMARIES, LABORATORY AND DIAGNOSTIC STUDIES, MEDICATIONS AND IMMUNIZATIONS TO:

PRO HEALTH GROUP, INC.
DR. ERICA LEHMAN
9001 WILSHIRE BLVD. #308
BEVERLY HILLS, CA 90211
ATTENTION: MEDICAL RECORDS
PHONE: (310) 504-3700 FAX: (310) 919-1199

A COPY OF THIS RELEASE IS AS EFFECTIVE AS THE ORIGINAL

Print Patient Name _____ Signature_____ Date_____

***If patient is a minor, all legal guardians must sign below

Print Guardian Name_____ Signature_____Date_____

Indicate relationship if signing for patient _____

Print Guardian name _____Signature _____Date_____

Indicate relationship if signing for patient _____

Print Guardian Name_____Signature _____Date_____

Indicate relationship if signing for patient _____

PRO HEALTH GROUP, INC.
IV PROCEDURE

As the IV treatment continues to grow and evolve, it has become necessary to formalize processes and procedures to ensure patient safety and privacy. Please read and sign this document.

- We will make every effort to keep to the appointment schedule but please understand that treatment can be complicated and some patients may require more time than others.
- Many patients have light and sound sensitivities. Please silence all cell phones and electronic devices.
- If you must make a call or receive a call, please go outside so you do not disturb other patients in the room.
- If you would prefer to be treated in a room away from other patients, please let us know and we will make every effort to accommodate you.
- Payment is due at the time of the service unless other arrangements have been made beforehand.

I have read the IV procedures and understand them:

Print Patient Name _____ Signature_____ Date_____

*****If patient is a minor, all legal guardians must sign below:**

Print Guardian Name_____ Signature_____Date_____

Indicate relationship if signing for patient _____

Print Guardian Name_____ Signature_____Date_____

Indicate relationship if signing for patient _____

Print Guardian Name_____Signature _____Date_____

Indicate relationship if signing for patient_____

PRO HEALTH GROUP, INC.
DR. ERICA LEHMAN
9001 WILSHIRE BLVD. #308
BEVERLY HILLS, CA 90211
PHONE: (310) 504-3700 FAX: (310) 919-1199

PATIENT AGREEMENT

PATIENT INFORMATION

PATIENT NAME: _____

NAME OF PARENT OR AUTHORIZED GUARDIAN AND RELATIONSHIP (IF APPLICABLE): _____

_____

ADDRESS: _____

_____

PHONE #: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ D.O.B. _____

PLEASE LIST ALL KNOWN ALLERGIES: _____

_____

_____

I HAVE PROVIDED THE FOLLOWING INFORMATION AND DOCUMENTS AS LISTED BELOW:

- ☐ MEDICAL QUESTIONNAIRE
- ☐ LIST OF MEDICATIONS
- ☐ LIST OF SUPPLEMENTS
- ☐ CURRENT SYMPTOMS CHECK LIST
- ☐ CONSENT TO DISCLOSE / RELEASE HEALTH INFORMATION TO DR. ERICA LEHMAN
- ☐ INFORMED CONSENT FOR TREATMENT OF PERSISTENT LYME DISEASE
- ☐ IV TREATMENT CONSENT FORM
- ☐ ARBITRATION AGREEMENT

CANCELLATION POLICY: A MINIMUM OF 48 HRS IS REQUIRED TO AVOID A CANCELLATION FEE (call for current rates)

I HEREBY AUTHORIZE AND ACCEPT PRO HEALTH GROUP INC. TO PROVIDE THE REQUIRED SERVICES AND PRODUCTS AND AGREE TO THEIR TERMS AND CONDITIONS:

PATIENT SIGNATURE: _____ DATE: _____

(Or Patient Representative) _____ (Indicate relationship if signing for patient _____)

OFFICE SIGNATURE: _____ DATE: _____

SYMPTOM CHECKLIST

NAME: _____ **DATE:** _____ **SEX:** ____ **DOB:** _____

SYMPTOM OR SIGN (Circle all that apply)	**CURRENT SEVERITY** NONE	MILD	MODERATE	SEVERE	**CURRENT FREQUENCY** NONE	MILD	MODERATE	SEVERE
Hearing: buzzing, ringing								
Decreased hearing								
Increased motion sickness, vertigo, spinning								
Off balance, "tippy" feeling								
Lightheadedness, wooziness, unavoidable need to sit or lie								
Tingling, numbness, burning or stabbing sensations, shooting pain								
Skin hypersensitivity								
Facial paralysis – Bell's Palsy								
Dental pain								
Neck creaks and cracks								
Stiffness, neck pain								
Fatigue, tired, poor stamina								
Insomnia, fractionated sleep								
Early awakening								
Excessive night time sleep								
Napping during the day								
Unexplained weight gain								
Unexplained weight loss								
Unexplained hair loss								
Pain in genital area								
Unexplained milk production								
Breast pain								
Irritable bladder or bladder dysfunction								
Erectile dysfunction								
Loss of libido								
Queasy stomach or nausea								
Heartburn, stomach pain								
Constipation								
Diarrhea								
Low abdominal pain, cramps								
Heart murmur or valve prolapse								
Heart palpitations or skips								
"Heart block" on EKG								
Chest wall pain or ribs sore								
Head congestion								
Breathlessness, "air hunger"								
Unexplained chronic cough								
Night sweats								

SYMPTOM OR SIGN (Circle all that apply)	**CURRENT SEVERITY** NONE	MILD	MODERATE	SEVERE	**CURRENT FREQUENCY** NONE	MILD	MODERATE	SEVERE
Exaggerated symptoms or worse hangover from alcohol								
Symptom flares every 4 weeks								
Degree of disability								
Persistent swollen glands								
Sore throat								
Fevers								
Sore soles, esp. in AM								
Joint pain								
Fingers, toes								
Ankles, wrists								
Knees, elbows								
Hips, shoulders								
Joint swelling								
Fingers, toes								
Ankles, wrists								
Knees, elbows								
Hips, shoulders								
Unexplained back pain								
Stiffness of joints or back								
Muscle pain or cramps								
Obvious muscle weakness								
Twitching of the face or other muscles								
Confusion, difficulty thinking								
Difficulty with concentration, reading								
Problem absorbing new information								
Word search, name block								
Forgetfulness, poor short term memory								
Poor attention								
Disorientation: getting lost								
Speech errors: wrong word, mis-speaking								
Mood swings, irritability, depression								
Anxiety, panic attacks								
Psychosis (hallucinations, delusions, paranoia, bipolar)								
Tremor								
Seizures								
Headache								
Light sensitivity								
Sound sensitivity								
Vision: double, blurry, floaters (circle)								
Ear Pain								

AUTHORIZATION FOR CREDIT CARD USE.
PROHEALTH GROUP INC.
DR. ERICA LEHMAN
9001 WILSHIRE BLVD. #308
BEVERLY HILLS, CA 90211

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____VISA _____MASTERCARD _____ DISCOVER _____AMEX

Credit Card Number: _____

Expiration Date: _____

Zip Code: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card OR 4 digits located on the front of AMEX card)

I authorize _____ to charge the credit card herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder - Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

RETURN THE COMPLETED AND SIGNED FORM TO THE FOLLOWING:

FAX: 310-919-1199 OR EMAIL: assistant@prohealthgroupinc.com