DR. SHANNON LEON

FELLOW OF THE AMERICAN COLLEGE OF FUNCTIONAL NEUROLOGY
FELLOW OF THE AMERICAN BOARD OF VESTIBULAR REHABILITATION

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ANTI-AGING | NUTRITION | WELLNESS

Complex Health History Assessment

Patient Name:_____ **Date**_____
Date of Birth:_____ **Handedness: R L**
E-mail address:_____
Address:_____
City_____ **State**_____ **Zip code**_____
Home phone_____ **Work**_____
Cell phone_____ **Spouse**_____
Emergency Contact Person:_____
Relationship_____ **Phone**_____
Social Security Number_____/____/____
Who may we thank for the referral? Referred by:_____
Who other than you can we discuss any medical conditions, test results and treatments with? Please list full names:_____
I will be paying for today by: Cash, Check, or Credit Card (circle choice)

Signature of Patient:_____ **Date:**_____
Parent's signature if patient is a minor:_____

What are your chief complaints that you want Dr. Leon to know about and evaluate for today?_____
_____
_____

Relevant Medical history:

Have you ever been treated for this condition in the past?_____
If yes, by whom?_____
Relate outcome of therapy….. better, worse, same, details:_____
List other doctors seen for this condition in past three years:
Name_____ **email**_____
Name_____ **email**_____
Name_____ **email**_____
List current medications, dosage schedule and dose strength:

_____ _____
_____ _____
_____ _____
_____ _____

List any Allergies: _____

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Have you ever had Botox? Yes/ No
If yes, describe location, how often, and total sessions to date: _____
_____

Have you experienced any changes in vision, eye alignment, headache, anxiety or migraine since you began using Botox (circle all that apply)?_____

Relevant Family History:_____
_____
_____

Social History:

Employment:_____
List some typical daily activities:_____
_____
Sleep quality:_____
Alcohol consumption:_____
Tobacco consumption:_____
Recreational drugs in past 5 years:_____
Have you ever been exposed to toxic substances?_____

Instructions: Place a **Y** in the left column next to those questions that are **YES** and apply to you currently. If NO, leave blank.

FL:

Do you have any changes in mood or affect?
Have you had any mood swings or changes in personality?
Are you more emotional now than in the past, to similar events?
Have you noticed a difference in your outlook towards life?
Are you more aggressive now than in the past?
Are you currently depressed?
Do you have any changes in concentration or your ability to pay attention?
Are you easily distracted or bored?
Have you noticed any cognitive deficits?
Do you currently lack motivation?
Are you sensitive to light?
Do you have difficulty slowing or initiating movement?
Do you have any difficulties initiating stream or controlling your urine flow?
Do you stutter or have any problems speaking or getting words out?

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PL:

Do you have difficulty with right and left orientation?
Do you say the wrong thing at the wrong time?
Have you lost empathy to others?
Do you stub your toes often or bang into things often? On which side? R or L
Do you only write on one side of the page?

TL:

Have you noticed any changes in memory?
Short term memory?
Long term memory?
Do you have difficulties recalling new memories and events (R)?
Do you have difficulties learning new tasks? (L)
Do you have any hearing deficits? To Low pitch tones or High pitch tones?
Do you have tinnitus? If yes, what side? R L
If yes, high pitch (TL) or low pitch (VL)?
Do you hear unknown voices or experience Déjà vu?
Do you ever experience mysterious smells or have metal tastes in your mouth?
Wernicke's:
Do you have any problems choosing words when speaking? (L)
Do you have difficulties comprehending speech that is spoken to you?
Has your voice changed in tone recently to Monotone? (R)

LL:

Are you experiencing changes in anger, irritability, or feeling fear or paranoia?
Has your personality become flat?
Have you become less caring for others and lost empathy to those around you?
Have you noticed any changes in smell, taste or their intensity?
Ant cingulate:
Do you inflict damage to those individuals, pets, or plants around you?

OL:

Have you recently had any changes in your vision?
Do you ever have any blind spots within your field of vision?
Do you ever have double vision?
Do you wear contacts or corrective lenses?

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Cb:

Do you have difficulty paying attention?
Do you trip and fall often? Do you frequently fall to one side? R or L
Do you lack coordination while moving?
Do you experience motion sickness when traveling?
Do you experience nausea and/or vomiting with head or body positional changes?
Do you get nauseated often and to what stimuli?
Do you have gut dysfunction?
Do you have any balance problems?
Do you perceive any spin with your eyes closed? If yes, describe the direction that you feel yourself moving/spinning when your eyes are closed_____
Do you ever feel dizzy?

BG:

Do you have any body parts that tremor, tick, or jump for no reason?
Do you notice any slowing of movement?
Do you have any difficulty initiating movement?
Do you have increased tone and or cramps in your leg muscles?
Do you notice if your handwriting has become small and crunched together?

Mes/Pons/MO:

Do you have dry eyes often? Do you get dry mouth often?
Do you have any problems chewing food or difficulty swallowing food or water?
Do you bite your tongue often?
Do you notice your pupils to be different sizes?
Do you have any problems sleeping?
Are your palms often sweaty or moist and clammy?
Are your feet often sweaty or very cold?
Do you have hypertension?
Do you have any cardiac complaints (e.g. palpitations or arrhythmias)?
Do you ever faint? Or near faint?
Do you have any respiratory problems e.g. asthma?
Do you have difficulty breathing slowly and deeply)?
Are you often bloated? Constipated?
Do you notice any problems with the sensation to your face (e.g. numbness)?
Do you have any difficulties with shrugging your shoulders or turning your head?

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SC:

Have you noticed any bladder changes recently?
Do you have incontinence?
Can you hold your stool properly?
Do you experience pain/difficulty reaching climax?
Do you have cramps on one side of your body? Which side? R or L
Do you experience weakness only on one side of your body? Which side R or L?

PN:

Have you noticed any muscles getting smaller (atrophy/wasting)? Where?
Do you have any muscle twitching in your arms or legs? Where?
Do you have any shock-like or pins and needle sensation anywhere?

Rec:

Do you have any metabolic diseases (e.g. Diabetes)?
Do you have any genetic diseases (Myasthenia Gravis, Hoshimoto's Thyroiditis)?
Have you ever been severely burned? Location?_____

ROS:

Do you suffer from any symptoms not yet addressed, that you would like the doctor to know about? If yes, please list them below:_____

_____
_____
_____
_____
_____

Please describe your Treatment Goals:_____

_____
_____
_____
_____
_____

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How Healthy Are You Questionnaire?

If you answered NO to more than 5 of the questions below in Section 1 you can benefit from my wellness lifestyle modifications, including: improved food choices, regular exercise, daily vitamin therapy, and cognitive fitness.

Section 1

1. Do you think you are currently healthy?	Y	N
2. Do you take vitamins daily?	Y	N
3. Do you drink 8 glasses of water per day?	Y	N
4. Do you eat 3+servings of fruits and vegetables per day?	Y	N
5. Do you eat 2 servings of leafy greens per day?	Y	N
6. Do you prepare most of your food at home?	Y	N
7. Do you eat mostly organic whole foods?	Y	N
8. Do you avoid fast food and processed foods?	Y	N
9. Do you avoid soda and sugar filled drinks?	Y	N
10. Do you connect with nature regularly?	Y	N
11. Do you exercise 3 or more times per week for 30 min+?	Y	N
12. Are you happy with your current level of fitness?	Y	N
13. Do you get 6-8 hours of quality sleep each night?	Y	N
14. Is your mind calm with inner dialogue quiet?	Y	N
15. Are you properly coping with daily stressors?	Y	N

Section 2: If you answered YES to more than 3 of the questions below you can benefit from my nutrition, vitamin and wellness lifestyle modifications.

16. Do you constantly feel run down or tired?	Y	N
17. Are you frequently stressed and feeling burned out?	Y	N
18. Are you frequently anxious or nervous?	Y	N
19. Are you always rushing?	Y	N
20. Do you suffer aches and pains twice or more weekly?	Y	N
21. Do you regularly eat junk food?	Y	N
22. Are you overweight?	Y	N
23. Do you experience indigestion or heartburn?	Y	N
24. Do you have irregular or painful bowel movements?	Y	N
25. Do you have high blood pressure?	Y	N
26. Do you experience heart palpitations on occasion?	Y	N
27. Are you at risk for type-2 diabetes or heart disease?	Y	N
28. Do you toss-and turn in bed once or more per week?	Y	N

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Financial Policy and Agreement

Please be advised, that the only portion of your functional neurology treatment sessions that is recognized by your insurance carrier is the physical adjustment of the spine and the extremities. If you have out of network chiropractic coverage, we will happily generate for you a completed insurance claim form for submittal of this portion of your visits. All payment is due at time services are rendered. You are expected to be reimbursed by the provisions of your health coverage. All other individual aspects of your treatment sessions will fall under the realm of un-reimbursed medical expenses, for which you the patient are responsible for. I understand and agree to the terms of this policy, and choose to be evaluated and treated by Dr. Shannon Leon.

_____ _____

Print name Signature Date

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PATIENT CONSENT FORM

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care options.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose PHI for purposes of treatment, payment, and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your PHI. This refusal must be made in writing. Under the HIPPA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. If you give consent to disclose your PHI, by signing this document, you can at some future time request to refuse future disclosures of your PHI. The refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our Compliance Officer if you have any objections to this consent.

Signature: **Print Name:** **Today's Date:**

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