THE CLEANSING CLINIC

HCG DIET

INTAKE EVALUATION

Name:_____ **Date**: _____/_____/___

Address:_____

Phone: (_____)_____

Email: _____

HOW DID YOU FIND OUT ABOUT US? (Circle) **: Internet Search | Natural Awakenings Magazine | Signs | Car Ad | fax | referred by _____ | business card | other_____**

Date of Birth: _____/____/_____ **Gender**: M F **Marital Status**: S M D W

Age: _____ **Height**: _____'_____" **Weight**: _____ lbs.

Emergency Contact: Name: _____Phone:_____

ALLERGIES: (please list any foods, drugs, or medications you are hypersensitive or allergic to. Please include reaction.) _____

MEDICATIONS: _____

_____

MEDICAL AILMENTS *THAT YOU HAVE SEEN A PHYSICIAN FOR:* _____

_____

_____

SYMPTOMS OR COMPLAINTS *YOU CURRENTLY HAVE:*_____

_____

WHY ARE YOU HERE?_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Please complete all information and indicate areas of confusion with a question mark. Thank You.

1. **Menstrual/Birthing History** Last Menstrual Cycle:_____

   Age of first Menses: _____ # of Pregnancies: _____
   # Of Days of Menses:_____ # of Miscarriages: _____
   Length of Cycle:_____ # of Abortions: _____
   Birth Control Type: _____ # of Live Births: _____

2. When and where did you last receive health care?

   _____
   _____
   For what reason?
   _____
   _____

3. If it possible you may be pregnant? Yes____ No____

   If "Yes" How far along are you or may you be? _____

4. Do you have any infectious diseases? Yes____ No____

   If "Yes" Please Identify: _____

5. **Family History** (check those that apply)

	Father	Mother	Brothers	Sisters	Children
Age (if living)					
Health (G=Good. P=Poor)					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Mental Illness					
Asthma/Hay Fever/Hives					
Kidney Disease					
Age (At Death)					
Cause Of Death					

6. **(10 year)** Past Max Weight: _____ Past Min Weight: _____

7. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____Taken: ___/___/___

HAVE YOU BEEN DIAGNOSED WITH OR HAD ANY OF THE FOLLOWING CONDITIONS:
Please Circle ALL that apply: ***Past or Present.***

➢Hepatitis	➢Spasms/Cramps	➢Constipation / Diarrhea
➢Headaches	➢Hot Flashes	➢Shortness of Breath
➢Scoliosis	➢Tendonitis	➢Thyroid Dysfunction
➢Brain Fog	➢Rash /skin problems	➢Asthma/Allergies /Hay Fever
➢Neck Pain	➢Numbness/Tingling	➢Diabetes
➢Fatigue	➢Arthritis/Stiff/Painful Joints	➢Dizziness
➢Back	➢Sciatica/Shooting pain	➢Pregnancy
➢Pain	➢Osteoporosis	➢Infection
➢Fever	➢Heart Disease	➢PMS /Menstrual Problems
➢Shoulder Pain	➢Bladder/Kidney Disease	➢High Cholesterol
➢Night Sweats	➢Stroke	➢TMJ or Jaw Pain
➢Leg Pain	➢Cancer	➢Gout
➢Insomnia	➢Blood Clots	➢Anorexia
➢Heart Murmur	➢Gas / Bloating	➢Bulimia
➢Depression	➢High Blood Pressure	
➢Epilepsy / seizures	➢Abdominal Pain	
	➢Chest Pain	
	➢ Anxiety	

If yes

*Explain:*_____

_____

_____

8. Digestion Issues:

(Circle if yes)

Nausea | Vomiting | Diarrhea | Blood in stool | Pain | Bloating | Gas | ABD Distention | Constipation | Incomplete Evacuation | Small Round Stool | Hard Stool | Significant Residual When Wiping | ABD cramping | other digestive concerns if any_____

BM FREQUENCY: Number of times Per Day: 1 2 3 4

If don't typically have a daily BM how often do you evacuate? 1-2 per week | 3-4 per week | 5-6 per week | less than once a week

Does it feel like there is more feces stuck in you after having bowel movement? yes / no

Do you have a diet low in fiber: yes / no

Does your diet include a lot of meat/cheese or processed foods: yes / no

Incontinence: yes / no | Pain upon defecation: yes / no | Blood in Stool: yes / no | Hemorrhoids: yes / no |

Last Bowel Movement_____Previous Interventions: None / Laxatives / Enemas / Other_____

Frequency of Bowel Movements_____ Color_____ Consistency: (circle all that apply): thin, thick, hard, soft, watery, small round, clay like

9. **Other :**

   Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

10. **Childhood Illness:** (circle any that you have had):

    Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Immunizations:** (circle any that you have had):

    Polio Tetanus Rubella/Mumps Pertussis Diphtheria HiB Hepatitis-B Chicken Pox

    Pneumonia Flu Other_____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

13. **X-Rays / CAT Scans / MRIs / NMRs / Special Studies:**

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

For the following questions:
(circle any that you experience now and underline any you have experienced in the past)

14. **Emotional/Psychiatric :**

    Mood Swings Nervousness Mental Tension Irritability Depression Grief Obsessive Thinking

    other issues:_____

15. **Energy and Immunity:**

Fatigue Slow Wound Healing Chronic Infections Lyme Disease Chronic Fatigue

Candida / Yeast Infections

16. **Head, Eye, Ear, Nose, Throat:**

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing

Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds

Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

17. **Respiratory :**

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy

Asthma Tuberculosis Shortness of Breath Other Respiratory_____

18. **Cardiovascular :**

Heart Disease Chest Pain Swelling of Ankles High BP Palpitations/Fluttering Stroke Bruising

Heart Murmurs Rheumatic Fever Varicose Veins Abnormal Bleeding Pain in Calves

19. **Gastrointestinal :**

Ulcers Changes In Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn Belching

Gallbladder Disease Liver Disease Hepatitis A, B or C Hemorrhoids Abdominal Pain

Diverticulosis Diverticulitis IBS

20. **Genito-Urinary Tract :**

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

21. **Female Reproductive / Breasts :**

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge

Premenstrual Problems Clotting Bleeding Between Cycles Menopausal Symptoms

Difficulty Conceiving Painful Periods

22. **Male Reproductive :**

Erectile Dysfunction Prostrate Problems Testicular Pain/Swelling Penile Discharge

23. **Musculoskeletal :**

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Lower Back Pain Leg Pain Joint Pain

24. **Neurologic :**

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

25. **Endocrine :**

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

26. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, why not?_____

b. Exercise routine: _____

c. Spiritual Practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate
Other

f. Occupation: _____ Employer: _____

Hours/Week: _____ Do you enjoy work? Y N Why/Why Not?_____

_____

g. Nicotine Use (what form):_____ (past or present)

Amount:_____ Frequency:_____

h. Alcohol Use (what form):_____ (past or present)

Amount:_____ Frequency:_____

i. Recreational Drugs(what form):_____ (past or present)

Amount:_____ Frequency:_____

j. Have you experienced any major traumas? Y N Explain: _____

_____

k. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

l. Interests and Hobbies:_____

_____

Have You Been Able To Follow Prescribed Medications/Treatments? yes/no If "no" why not?_____

Family Physician_____

I _____(patient name) acknowledge and understand that Kenneth Lewandowski, D.O. and The Cleansing Clinic is NOT my primary Medical Doctor and ALL medical decisions regarding any current or future health conditions should be addressed by my primary care physician. I have spoken to my primary care physician regarding the HCG Diet and he/she has no objections to my starting the program. The Cleansing Clinic serves as only a resource for general wellbeing and preventive medicine and does NOT treat any existing illness. I agree that there are no guarantees relating to the effectiveness of the HCG Diet and that I have done my own research and have made a well informed decision to start the diet and agree that The Cleansing Clinic is not responsible for my individual performance or my ability to adhere to the diet.

X _____ _____

Signature Date

Patient Name_____ **Age**_____ **Date**_____

The Cleansing Clinic does NOT treat any diseases and any services performed by staff, are designed to improve overall nutritional wellbeing of our patients. **The HCG Diet requires daily injections to be administered to patient. No published studies have shown that the HCG Diet is effective. HCG has not been approved by FDA for weight loss.**

Since 1975 the FDA has required all marketing and advertising of HCG to state the following: **"HCG has not been demonstrated to be effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or 'normal' distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets."**

"HCG is a hormone extracted from urine of pregnant women. It is approved by FDA for treatment of certain problems of the male reproductive system and in stimulating ovulation in women who have had difficulty becoming pregnant. No evidence has been presented, however, to substantiate claims for HCG as a weight-loss aid."

Patient agrees to consult with primary care physicians as to the safety and efficacy of the treatments provided by staff at The Cleansing Clinic given their familiarity with patient's underlying medical history and response to medications received.

Patient has not been pressured to make any decision and I have had the opportunity to **discuss all treatments proposed with my primary care physician** and given the opportunity to ask questions.

Patient confirm they are making an informed decision based on all the information provided by The Cleansing Clinic and my primary healthcare practioner(s) and I have had the opportunity to review any peer reviewed scientific journals that may have reported on the therapies proposed. Such journals can be reviewed for free at UMDNJ Library 30 12th Ave. Newark NJ, 07101, Phone: 973-972-4580 or accessed by subscribing online at http://www.questia.com

Treatments may have risk factors listed or cause the side effects listed below. However, as **these treatments are experimental in nature**, as they may not have been funded for widespread scientific review under controlled conditions and have not been reported in peer reviewed scientific journals; there may be some side effects that we cannot predict.

WOMEN of Child Bearing Years: I certify that there is NO possible way that I could be pregnant Women in child bearing years must receive pregnancy test ($20 extra) if they have had sexual intercourse since last menstrual period unless they have had a hysterectomy. I agree that I will take precautionary measures with birth control during the time frame while on HCG Diet. X_____.

The patient's diagnosis, if known: **obesity | constipation** | **bloating** | **heart burn / acid reflux | gas | abdominal pain | sleep apnea | back pain | (other)**_____

- The nature and purpose of a proposed treatment or procedure: **Hcg Diet**
- The benefits of a proposed treatment or procedure: **Weight Loss**
- Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance): **change diet, exercise**
- The risks of not receiving or undergoing a treatment or procedure: **stay the same or get worse**
- The benefits of not receiving or undergoing a treatment or procedure: **save money or condition may resolve itself**

HCG Diet: Side effects / Potential risks or discomfort: *REMEMBER: ALL WOMEN WHO GET PREGNANT HAVE HAD HCG IN THEIR BODY AT FAR HIGHER LEVELS THAN THOSE TAKING HCG AS PART OF THE HCG DIET. ALL MEN WHO HAVE GONE THROUGH PUBERTY HAVE HAD HCG IN THEIR BODY AT FAR HIGHER LEVELS THAN THOSE TAKING HCG AS PART OF THE HCG DIET.*

The HCG medication manufacturer reports that on rare occasions some patients taking HCG at HIGH levels 10,000+ I.U.'s (50 times the HCG Diet Dosage) may experience headaches, mood swings, depression, blood clots, confusion, and dizziness. Some women also develop a condition called Ovarian Hyperstimulation Syndrome (OHSS); symptoms of this include pelvic pain, swelling of the hands and legs, stomach pain, weight gain, shortness of breath, diarrhea, vomiting/nausea, and/or urinating less than normal. In some women, being on the HCG diet protocol and taking HCG, may cause delayed menstrual cycle, early menstrual cycle, heavier flow, lighter flow and or heavy cramping. These conditions also are symptoms that women may experience during pregnancy.

X_____ _____ _____

Patient Signature | Cleansing Clinic Provider | Date

CONTRINDICATIONS or CONCERNS requiring more information prior to prescribing HCG Diet:

DO YOU HAVE or HAVE A HISTORY OF:

migraines YES / NO | ***congestive heart failure*** YES / NO | **asthma** YES / NO | **epilepsy** YES / NO | **kidney disease** YES / NO | **undiagnosed uterine bleeding** YES / NO | **heart disease** YES / NO | ***ulcerative colitis*** YES / NO | ***Crohn's disease*** YES / NO | ***are you nursing*** YES / NO | ***hormonal imbalances you are treated for*** YES / NO | **thyroid or adrenal gland disorder** YES / NO | ***bleeding disorders*** YES / NO | ***cancer*** **or a tumor of the breast, ovary, uterus, prostate, hypothalamus, or pituitary gland** YES / NO | ***diabetes*** YES / NO | ***brain surgery*** YES / NO | ***history of anorexia*** YES / NO | **ovarian cyst** YES / NO | ***do you have a history of bulimia*** YES / NO | ***is there any chance you are pregnant*** YES / NO | ***cirrhosis of the liver*** YES / NO | ***current pregnancy*** YES / NO | ***coronary occlusion*** (heart attack) YES / NO | ***cerebral vascular accident*** YES / NO | ***take diuretics*** YES / NO | ***swollen ankles*** YES / NO **|** ***Rheumatic pains*** YES / NO **|** ***menstrual disorders*** YES / NO **|** ***breathlessness on exertion*** YES / NO **|**

I acknowledge I do not have ANY of the above referenced contraindications for HCG Diet.

HEALTHCARE **PROVIDER**

COMMENTS_____

_____

Patient Signature *X* _____

_____ _____

Cleansing Clinic Provider Date

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- ı I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- ı This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Patient ……..Date: ……

HIPAA Privacy Rule of Patient Authorization & Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

• a basis for planning my care and treatment;
• a means of communication among the health professionals who may contribute to my healthcare;
• a source of information for applying my diagnosis and surgical information to my bill;
• a means by which a third-party payer can verify that services billed were actually provided;
• a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

• I have the right to review this facility's Notice of Information practices prior to signing this consent;
• This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
• I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
• I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
• It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient …….. Date: ……

CLIENTS 64 & Older MUST SIGN THIS!!

This agreement is entered into by and between The Cleansing Clinic, Inc./ Kenneth Lewandowski, DO, (hereinafter called "Physician"), whose principal medical office is located at Suite 201, 90 Millburn Ave., Millburn NJ 07041 and

_____ (PRINT PATIENT NAME)

ADDRESS:

_____

A. Background

A change in the Social Security Act, effective January 1, 1998, permits Medicare beneficiaries and physicians to contract privately outside of the Medicare program. Under the law as it existed prior to January 1, 1998, a physician was not permitted to charge a beneficiary more than a certain percentage in excess of the Medicare fee schedule amount (limiting charge). The law now permits physicians and beneficiaries to enter into private arrangements through a written contract under which the Beneficiary may agree to pay the Physician more than that which would be paid under the Medicare program.

However, beneficiaries and physicians who take advantage of this provision are not permitted to submit claims or to expect payment for those services from Medicare. This agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

B. Obligations of Physician

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.

2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.

3. Physician acknowledges that (s)he will not execute this contract at a time when the Beneficiary is facing an emergency or urgent healthcare situation.

4. Physician agrees to provide the beneficiary or his/her legal representative with a copy of this document before items or services are furnished to the beneficiary under its terms.

5. Physician agrees to submit copies of this contract to the Clinics for Medicare and Medicaid Services (CMS), upon the request of the CMS.

C. Obligations of Beneficiary

1. Beneficiary or his/her legal representative agrees to be fully responsible for payment of all items or services furnished by Physician and understand that no reimbursement will be provided under the Medicare program for such items or services.

2. Beneficiary or his/her legal representative acknowledges and understands that no limits under the Medicare program (including the limits under section 1848 (g) of the Social Security Act) apply to amounts that may be charged by Physician for such items or services.

3. Beneficiary or his legal representative agrees not to submit a claim to Medicare unless the filing of such claim is required to obtain secondary coverage for Physician's charges. Beneficiary agrees not to ask Physician to submit a claim to Medicare

4. Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

5. Beneficiary or his/her legal representative enters into this contract with the knowledge and understanding that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out of Medicare.

6. Beneficiary or his/her legal representative understands that Medigap plans (under section 1882 of the Social Security Act) do NOT, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.

7. Beneficiary or his/her legal representative acknowledges that the Clinics for Medicare and Medicaid Services (CMS) has the right to obtain copies of this contract upon request.

D. Physician's Status

Beneficiary or his/her legal representative further acknowledges his/her understanding that Physician [has not] been excluded from participation under the Medicare program under section 1128, 1156, 1892 or any other section of the Social Security Act.

E. Term and Termination

This agreement shall become effective on _____(Today's Date) and shall continue in effect until _____(one year from Now). Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary or his/her legal representative agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract shall survive this contract.

F. Successors and Assigns

The parties agree that this agreement shall be fully binding on their heirs, successors, and assigns.

The parties hereto, intending to be legally bound by signing this agreement below, have caused this agreement to be executed on the date written below.

The Cleansing Clinic, Inc.

_____ _____
Signature of Staff Date

_____
Name of Patient (printed)

_____ _____
Signature Date