Medical History

Name: _____ Date: _____

Date of Birth: _____ Referred by: ____LTN OR ____First State Lipedema

Address: _____

Cell Phone: _____ Home: _____ Work: _____

Email Address: _____

Primary Insurance: _____

Name of Insured: _____ Date of Birth: _____

Policy Number: _____ Phone #: _____

Secondary Insurance: _____

Name of Insured: _____ Date of Birth: _____

Policy Number: _____ Phone #: _____

Name, Address, and Phone # of Primary Care Physician:

_____

_____

Would you like your PCP to receive a copy of our examination findings? Yes/No

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What is your current occupation? _____

What percent of the time do you spend standing: _____% sitting: _____%

Weight: _____ lbs Height: _____

Please answer all questions truthfully and to the best of your knowledge so that we may provide proper care for you. Be assured, we are not judging you or your lifestyle.

Medications: (Current or recent prescription medications, vitamins, and supplements): _____

_____

_____

Allergies to Medications: Yes/No

-If yes, please explain: _____

_____

Allergy to Latex? Yes/No

Unusual reaction or poor response to local anesthetics? Yes/No

-If yes, please explain: _____

_____

Were you told you have unusual reactions to any drugs (e.g. CYP 450 drugs or MTHFR genes)? Yes/No

If yes, please explain: _____

_____

Past/other medical problems:

Yes	No			Yes	No	
		Diabetes				Rheumatic Fever
		Anemia				Shingles
		Bone/Joint Disease				Stroke
		Asthma				Neurological Disease
		Cancer				Chronic Viral Infections HIV/AIDS
		Goiter/Thyroid Disease				Connective Tissue Disease (Such as Ehlers Danlos or Hypermobility)
		Heart Issues				Breast Disease
		Hepatitis				Depression

		High Blood Pressure				Anxiety
		Kidney Disease				Clotting Disorders/Blood Disorders
		Lymphedema				

Please elaborate on any "yes" answers: _____

_____

Previous Surgeries (including cosmetic), hospitalizations and trauma:

- Procedure aimed to treat varicose veins?
- Leg thrombosis
- Inflammation of the skin
- Major Injuries, other illnesses

Please Elaborate: _____

_____

_____

Obstetrics:

Is there any chance you may be pregnant? Yes/No
Are you on birth control pills or hormonal replacement? Yes/No
Number of prior pregnancies: _____ Mother of _____, Ages _____

What brings you to us? (check all that apply)

_____ Leg Issues
_____ Arm Issues
_____ Other reasons (please list) _____

What body areas are affected by lipedema? (check all that apply)

_____ Buttocks
_____ Hips
_____ Outside and front of thighs
_____ Inside and back of thighs
_____ Knees
_____ Legs down to ankles
_____ Top of feet
_____ Toes
_____ Upper arms
_____ Lower arms
_____ Top of hands
_____ Abdomen
_____ Other body parts: _____

General:

_____ I pay attention to my carbohydrate and calorie intake and diet
_____ I am regularly participating in exercise; What kind? _____
_____ I used to participate in exercise until Lipedema prevented me from this _____ years ago.
_____ I took birth control pills or hormone replacement for ____ years
_____ I noticed a change in my legs during or after pregnancy
_____ I have or have had menstrual problems

In retrospect:

I have had "fat legs" since the age of _____.
I recall symptoms first appeared at the age of _____.
Has the condition progressed? Yes/No

-If yes, please explain: _____

The diagnosis of Lipedema was made by? _____ on _____ (date) *OR*

_____I have not been diagnosed.

My Symptoms:

	None	Slight	Moderate	Severe
Legs Feel Heavy				
Increase in Size of Arms				
Increase in Size of Legs				
Pain during walking				
Pain on sitting				
Feeling of tightness				
Pain under pressure (tenderness)				
Itching				
Cramping at night				
Bluish discoloration of the skin on the legs				
Leg irritation or pain at night				
Stinging or burning pains in the legs or arms				
Pain with mild touch (hypersensitivity to touch)				
Swelling				
Extremely dry or sensitive skin				
Cellulitis				
Bruising of the legs or arms				
Feeling cold at the involved areas				

Does your pain or discomfort become worse?:

- In hot weather? Y/N
- During menstruation? Y/N
- During everyday home activities? Y/N
- After standing for a long time? Y/N
- While walking? Y/N
- During pregnancy? Y/N
- Since menopause? Y/N
- During menopause or perimenopause? Y/N

Do you have a history of?:

- Varicose veins; or venous insufficiency? Y/N
- Circulatory problems? Y/N
- Clotting abnormalities, blood clots, thrombosis or lung embolism? Y/N
  If yes, please explain: _____
- Bleeding abnormalities? Y/N
- Tendency to form hypertrophic scars (keloid)? Y/N
- Wound inflammation associated with chills or cellulitis? Y/N
- Abnormal post-operative bleeding? Y/N
- Connective tissue weakness? (pelvic organ prolapse, torn tendons, etc.) Y/N
  If yes, please explain: _____
- Orthopedic or joint problems related to Lipedema (due to gait problems, walking difficulty, etc.) Y/N
  If yes, please explain: _____

What therapies for lipedema have you undergone in the past or are currently performing? If yes, please indicate if effective or not.

- Physical Therapy: Y/N Effective? Y/N
- Manual Lymphatic Drainage (without bandaging): Y/N Effective? Y/N
- Bandaging/Wrapping: Y/N Effective? Y/N
- Compression stockings: Y/N Effective? Y/N
- Exercise program: Y/N Effectice? Y/N
- Dietary changes (low carb, RAD, Keto, paleo, etc.): Y/N Effective? Y/N
- Liposuction: Y/N Effective? Y/N
- Supplements: Y/N Effective? Y/N
- Whole body vibration: Y/N Effective? Y/N
- Pneumatic pump such as Flexitouch or Lymphapress: Y/N Effectice? Y/N
- Other _____

Prior bariatric surgery, liposuction, and/or skin resection:

- Arms; method, successful? _____
- Legs; method, successful? _____
- Buttocks; method, successful? _____
- Other; method, successful? _____
- Bariatric or other surgery for weight loss, method, successful? _____

I have had joint problems (check all that apply):

- Since my youth
- It runs in my family
- My knees are affected
- In my hips
- In my ankles

My joint problems appeared:

- Before my legs got large
- Shortly after my legs became large
- Much later than the lipedema fat appeared on my body

Are there Lipedema or heavy leg or arm problems in the family that you know about? (check all that apply)

- On my mother's side
- On my father's side
- Mother
- Sister
- Aunt
- Niece
- Daughter
- Grandmother
- Granddaughter
- Cousin

Weight Changes:

How many years ago did you begin to notice a physical change in your body without any changes to your lifestyle? (e.g. unexplained weight increase)? _____years ago

- Any significant weight gain? _____pounds; mostly at _____
- Any significant weight loss? _____pounds; mostly from _____
- Any areas remained unchanged? _____

Quality of Life:
What activities of daily living have changed for you since you developed lipedema symptoms?

- Exercise
- Walking
- Running
- Driving
- Concentration levels
- General level of activity, hours of functioning before fatigue sets in
- Traveling
- Shopping
- Cooking, cleaning, dressing working, sitting
- Leisure activities (swimming, going out to eat, museums, concerts, etc)
- Sleeping
- Other _____

Social:

Profession: _____

Occupation: _____

Marital Status: _____

Smoking? Yes/No _____

Alcohol? Yes/No _____

Is there any additional information which you would like your surgeon to know? (severe illnesses which do not seem to be related to lipedema, etc.)

_____

_____

_____

_____

Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty with the activities listed below because of your lower limb problem for which you are currently seeking treatment. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activity	Extreme Difficulty	Quite a bit of Difficulty	Moderate Difficulty	Little bit of Difficulty	No Difficulty
1	Your usual work, housework or school activities	1	2	3	4	5
2	Your usual hobbies, recreational or sporting activities	1	2	3	4	5
3	Getting into or out of the bath	1	2	3	4	5
4	Walking between rooms	1	2	3	4	5
5	Putting on your shoes or socks	1	2	3	4	5
6	Squatting	1	2	3	4	5
7	Lifting an object like a bag of groceries from the floor	1	2	3	4	5
8	Performing light activities around your home	1	2	3	4	5
9	Performing heavy activities around your home	1	2	3	4	5
10	Getting in and out of the car	1	2	3	4	5
11	Walking two blocks	1	2	3	4	5
12	Walking one mile	1	2	3	4	5
13	Going up or down 10 stairs (about 1 flight)	1	2	3	4	5
14	Standing for an hour	1	2	3	4	5
15	Sitting for an hour	1	2	3	4	5
16	Running on even ground	1	2	3	4	5
17	Running on uneven ground	1	2	3	4	5
18	Making sharp turns while running fast	1	2	3	4	5
19	Hooping	1	2	3	4	5
20	Rolling over in bed	1	2	3	4	5
	Column Totals					

SCORE: _____/100 (fill in the blank with the sum of your responses)
Minimum level of Detectable Change (90% Confidence): 9 points

I have answered this patient intake form truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

Authorization to Release Medical Records

Name of Patient: _____ **Date of Birth:** _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical
Operative Reports
Consultation Report

The above information may be released (specify name to which records are to be released and the appropriate address):

Doctor: _____

Address: (city, state, zip) _____

Phone Number: _____

Fax Number: _____

Doctor: _____

Address: (city, state, zip) _____

Phone Number: _____

Fax Number: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

_____

Signature Date

_____

Printed Name

Telemedicine Appointment

Dr. Shapira is licensed to practice medicine only in Delaware, and therefore he can only formally consult with you when you are physically in Delaware. However, in order to save you the expenses and inconvenience associated with a special trip to Delaware, we can schedule you to meet Dr. Shapira via telemedicine. During this interview, you can ask and discuss your concerns. The discussion will be based on your Intake Form and the information you share during this meeting. The fee for this type of appointment is $250 if you are planning to self-pay, and is due no less than 2 business days prior to your appointment. This appointment can also be billed to your medical insurance as long as Dr. Shapira is in-network. It is your responsibility to obtain a referral if your insurance requires one, otherwise you will be charged the full fee of $250. Dr. Shapira may make suggestions or recommendations about your future treatment but these will be tentative and contingent upon what will be determined during a subsequent office consultation. If at the conclusion of your Telemedicine discussion you decide to plan treatment for WAL by Dr. Shapira, he will submit documentation and seek precertification approval for WAL(S) procedure(s) to your medical insurance company. This submission will only take place after you've completed the recommendations given to you by Dr. Shapira and have obtained all of the information he requests from you. This request will be based on the determinations, recommendations, and suggestions that were made during this telemedicine discussion and therefore will be tentative and contingent upon the determinations that will be made during your future in office consultation with Dr. Shapira at his Delaware office.

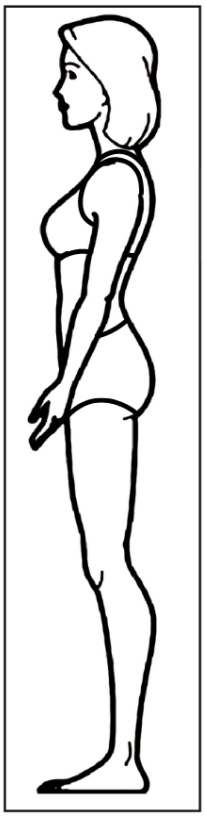
Signature: _____

Date: _____

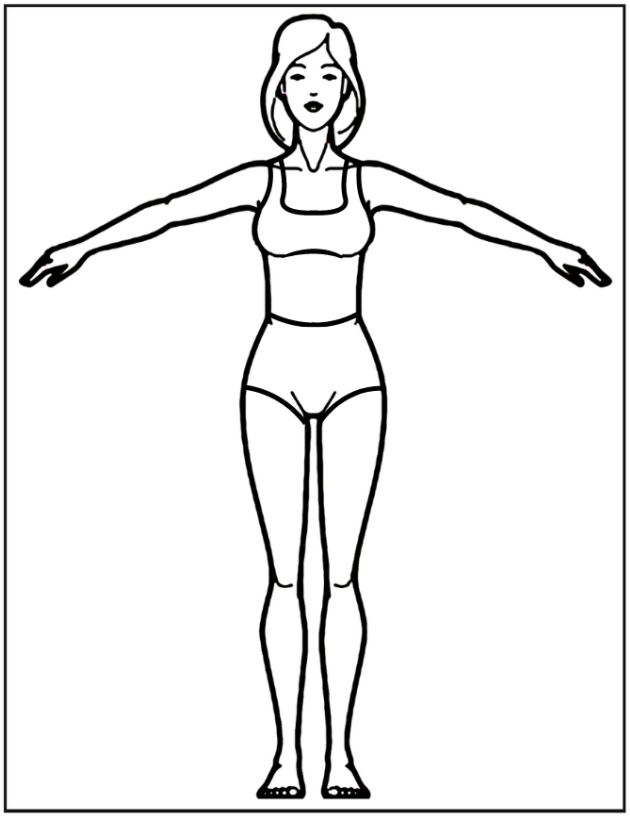
IMAGE SUBMISSION GUIDELINES

HEAD SHOT

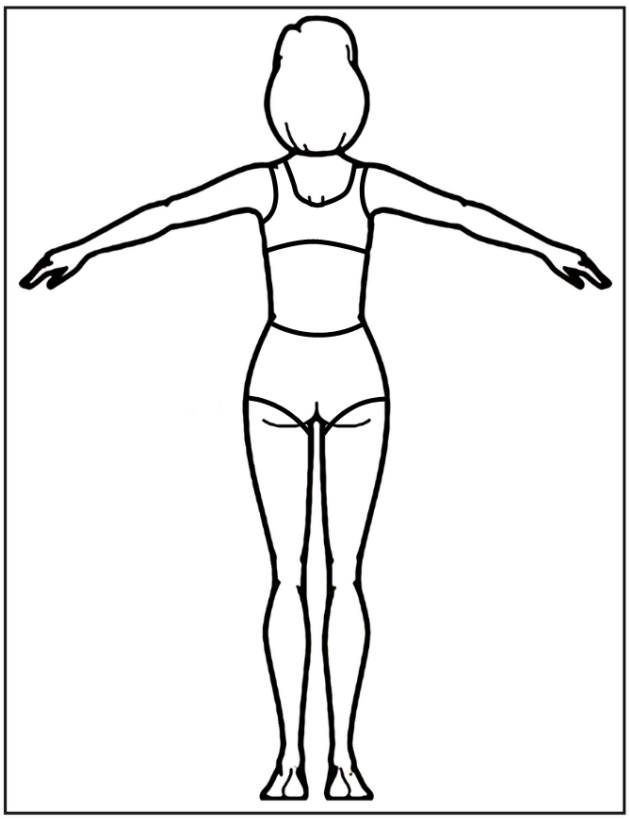
RIGHT SIDE



LEFT SIDE



FRONT



BACK

Photography Release and Consent Form

Clinical/Medical Consent:

_____I grant my permission for use of photographs, videos or case information for the following clinical purposes as indicated by my signature below:

_____I understand that these photographs, videos or case information are for clinical use and review by First State Med Spa

_____I understand that such consent is voluntary.

_____I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from First State Med Spa.

Marketing/Educational Consent:

_____I grant my permission for the use of photographs, videos or case information for the following clinical purposes as indicated by my initials below:

_____I understand that such photographs, videos or case histories may be published by and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, training manuals, presentations, and teaching courses, books, magazines, and internet websites, for the commercial, non-profit and/or educational purpose of informing others about non-surgical aesthetic treatment methods.

_____I release and discharge First State Med Spa and all parties acting under their license and authority from all rights that I may have in the photograph, and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

_____I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. Neither I, nor any member of my family, will be identified by name in any publication.

_____I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.

_____I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty years from the date written below.

In the Case of a Minor

I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

I have read the above Authorization and Release

Signature: _____ Date: _____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your patient health information

Under federal law, your health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. It also includes payment, billing, and insurance information. Under some circumstances, we may be required to use or disclose your health information without your permission. BY BECOMING A PATIENT OF THIS FACILITY, you are giving consent fo the use of your health information for certain activities including:

TREATMENT - We may use and disclose your past health information in order to provide you with medical needs and services. For example, members of our treatment team will record information in your chart and use t to determine the most appropriate course of care. We may provide information to other health care providers who are participating in your treatment, pharmacists who are filling your prescriptions, and to family members who are helping with your care.

PAYMENT - We may also use and disclose health information about you for payment purposes. Far example, we will submit information about you to your insurance company in order to receive payment for Services we have provided to you.

HEALTH CARE OPERATIONS - We may also use and disclose health information about you for this facility's health care operations, including administrative purposes and evaluation of the quality of care that you receive.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following uses of your health information may be made without any additional authorization from you.

APPOINTMENT REMINDERS - We may use and disclose your health information to contact you as a reminder of an upcoming appointment.

EMERGENCY SITUATIONS - We may use or disclose your health information in an emergency treatment situation

HEALTH-RELATED BENEFITS OR SERVICES - We may use and disclose health information to tell you about certain health-related benefits or services that may be of interest to you.

REQUIRED BY LAW - We may use or disclose health information about you when required to do so by federal, state or local law.

PUBLIC HEALTH ACTIVITIES - We may disclose health information to assist in investigations and audits eligibility for government programs and similar activities.

LAW ENFORCEMENT - We may use or disclose your health information if asked to do so by a law enforcement official, in response to
to a court order, subpoena, warrant, summons or similar process.

DEATH - We may use or disclose your health information about you to a coroner, medical examiner, funeral director or organ donor agencies.

RESEARCH - We may use or disclose your health information for approved medical research.

WORKERS' COMPENSATION - We may use or disclose your health information for workers' compensation o similar programs providing benefits for work-related injuries or illness.

INDIVIDUAL RIGHTS

You have the following rights with regard to your health information

INSPECT AND COPY - You have the right to inspect a copy your protected health information

REQUEST RESTRICTIONS - You have the right to request that we restrict the use and disclosure of your protected health information for treatment, payment and healthcare operations. We are not required to agree to your request.

CONFIDENTIAL COMMUNICATIONS - You have the right to request to receive private health information communications by alternative means or at alternative locations.

AMEND INFORMATION - If you feel that the protected health information we have about you is incorrect or incomplete, you have the right to request that your protected health information be amended.

ACCOUNTING OF DISCLOSURES - You have the right to an accounting of disclosures of your protected health information.

WE MAY CHANGE THIS NOTICE AT ANY TIME - Before we make a change in our policies we will change our notice and make the new notice available to all patients. You can request a copy of our notice at any time.

OUR LEGAL DUTY - We are required by law to protect and maintain the privacy of your health information and to abide by the notice currently in effect

COMPLAINTS - If you believe your privacy rights have been violated and/or we have to follow this policy, you may file a complaint with this facility or the U.S. Department of Health and Human Services.

I hereby acknowledge the receipt of the notice or privacy practices given to me.

Patient Name	Patient Signature	Date

COVID-19 WAIVER AND RELEASE

LIPEDEMA TREATMENT NETWORK (LTN) is taking every possible precaution with the sanitation of LTN's facility and health of our employees in response to the COVID-19 pandemic to ensure the safety of LTN's clients. LTN V 's facility shall follow the regulations set forth in the State of Delaware Declaration of a State of Emergency declared on or about March 12, 2020, as modified by the First through Nineteenth Modifications, and as modified from time to time, and as set forth in the Delaware's Reopening Guidance, as modified or updated from time to time. LTN's employees will be required to follow all necessary guidelines required by law to make LTN's facility as safe as possible.

Client understands that I may be exposed to COVID-19 or any other virus, illness, disease, sickness, infection, disorder or other ailment while being present at LTN's facility, having contact with LTN's employees, agents or other staff, or during the receipt of services offered at LTN. I hereby agree to indemnify, defend and hold harmless, LTN, its employees, agents or other staff from and against any and all liability associated with Client's exposure and potential contraction of COVID-19 or any other similar or related virus, illness, disease, sickness, infection, disorder or ailment I may contract, regardless if Client's contraction thereof is caused by any negligent act, negligent omission or willful misconduct of LTN, its employees, agents or other staff in the performance of services, during Client's utilization of LTN's facility, or contact with LTN's employees, agents or other staff. NSLLC shall not be liable to Client for consequential, incidental or punitive damages arising out of the performance of services, Client's presence in LTN's facility or Client's contact with LTN's employees, agents or other staff.

_____(Initial)

Client understands that the State of Delaware may require LTN to collect personal information for the purpose of Contract Tracing relating to COVID-19. I hereby agree to indemnify, defend and hold harmless, LTN, its employees, agents or other staff from and against any and all liability associated with collecting and providing collected information to the State of Delaware or any other government department, government division, or government agent as may be required by law.
LTN shall refuse service to any person who does not complete the below information completely and accurately. LTN shall not be liable for any penalties I may be subject to if I provide inaccurate information.

_____(Initial)

Client has read and understood all of the above information and hereby agree to all terms and conditions provided herein. I understand the risks in obtaining the above named services and I hereby forever release LTN from any and all liability hereunder.

_____

(Signature) Client Signature

Client Name (First, Middle, Last): _____

Date of Birth: _____ Driver's License Number: _____ State: _____

Address: _____

Street City State Zip Code

Email Address: _____@_____ . _____ Phone #: ____-_____-_____