NY LONGEVITY

INITIAL INTAKE

Section 1: Personal Information

Today's Date:

- Full Name: _____
- Date of Birth: ____ / ____ / _____
- Age: ____
- Gender: ☐ Male ☐ Female
- Height: ____
- Weight: ____
- Home Address: _____
- Occupation: _____

Section 2: Medical & Hormonal History

1. **Diagnosed Conditions** *(Check all that apply)*
   ☐ Thyroid disorder
   ☐ Diabetes / Prediabetes
   ☐ PCOS (women)
   ☐ Endometriosis (women)
   ☐ Low testosterone (men)
   ☐ High cholesterol
   ☐ High blood pressure
   ☐ Cardiovascular disease
   ☐ Osteopenia / Osteoporosis
   ☐ Depression / Anxiety
   ☐ Other: _____

2. Current Hormone Replacement Therapy: ☐ Yes ☐ No
    - If yes, list: _____
    - Date of Starting HRT
      _____

3. Allergies & Reactions:_____

4. List all medications and dosages you are currently on:

_____

_____

_____

_____

Section 3: Women's Hormonal & Menopause History

Menopause Rating Scale (MRS)

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark 'none'.

Symptoms:	none	mild	moderate	severe	very severe
Score =	0	1	2	3	4
1. Hot flushes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early)	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Menstrual & Reproductive History

- Age at first period: ____
- Are your periods: ☐ Regular ☐ Irregular ☐ Stopped
- Date of last period (if applicable): ____ / ____ / ____
- Early menopause (before age 45)? ☐ Yes ☐ No

- Hysterectomy or oophorectomy? ☐ Yes ☐ No
    - If yes, date: ____ / ____ / ____
- History of hormonal contraceptives or hormone therapy? ☐ Yes ☐ No
    - If yes, type/duration: _____

Menopause & Perimenopause Symptoms

- Current status: ☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal ☐ Unsure

●

Bone & Heart Health

- Bone density scan? ☐ Yes ☐ No
    - If yes, date & result: _____
- History of cardiovascular disease, high blood pressure, or high cholesterol? ☐ Yes ☐ No

Lifestyle & Symptom Triggers

- Symptoms worsen with: ☐ Stress ☐ Lack of sleep ☐ Certain foods ☐ Exercise ☐ Other: _____
- Supplements for menopause symptoms? ☐ Yes ☐ No
    - If yes, which ones? _____

Goals & Priorities During Menopause

- Top 3 priorities:
  ☐ Weight management / Fat loss ☐ Energy & vitality ☐ Mood stabilization ☐ Hormonal balance
  ☐ Bone health ☐ Heart health ☐ Sleep quality ☐ Libido / Sexual health ☐ Other: _____

Section 4: Men's Hormonal History

- Changes in libido/erectile function? ☐ Yes ☐ No
- Diagnosed with low testosterone? ☐ Yes ☐ No
- History of prostate issues? ☐ Yes ☐ No
- History of testicular cancer? ☐ Yes ☐ No

ADAM Questionnaire about symptoms of low testosterone

(Androgen deficiency in the aging male)

This basic questionnaire can be very useful for men to describe the kind and severity of their low testosterone symptoms.

Check the box next to the question with the appropriate answer.

Question	Yes	No
1. Do you have a decrease in libido (sex drive)?		
2. Do you have a lack of energy?		
3. Do you have a decrease in strength and/or endurance?		
4. Have you lost height?		
5. Have you noticed a decreased "enjoyment of life?"		
6. Are you sad and/or grumpy?		
7. Are your erections less strong?		
8. Have you noticed a recent deterioration in your ability to play sports?		
9. Are you falling asleep after dinner?		
10. Has there been a recent deterioration in your work performance?		

You may have low testosterone if:
– You answer YES to number 1 or 7 or
– You answer YES to more than 3 questions.
Consult with your physician to find out if testosterone replacement therapy is right for you.

Section 5: Lifestyle Factors

- Activity Level: ☐ Sedentary ☐ Light ☐ Moderate ☐ Very Active
- How many steps do you average per day?

☐ 2,000 – 4,000

☐ 5,000 – 7,000

☐ 8,000 – 10,000

☐ 10,000 +

- How many workouts do you do per week?

☐ 0 – 1

☐ 2 – 3

☐ 4 – 5

☐ 6 +

- Nutrition Approach: ☐ None ☐ Low-carb/Keto ☐ Mediterranean ☐ High-protein ☐ Vegetarian/Vegan ☐ Other: _____
- Sleep: ☐ <5 hrs ☐ 5–6 hrs ☐ 7–8 hrs ☐ 9+ hrs
- Stress: ☐ Low ☐ Moderate ☐ High
- Alcohol: ☐ None ☐ Occasional ☐ Weekly ☐ Daily
- Tobacco/Nicotine: ☐ Yes ☐ No

Section 6: Symptoms & Concerns

- ☐ Fatigue / Low energy ☐ Weight gain ☐ Difficulty losing weight ☐ Brain fog ☐ Mood swings / Irritability
- ☐ Low libido ☐ Hair loss ☐ Muscle loss / Weakness ☐ Sleep issues ☐ Joint or bone pain
- ☐ Digestive issues ☐ Other: _____

Section 7: Goals & Expectations

- Top 3 Health Goals:

1. _____
2. _____
3. _____

- Main reason for visiting: ☐ Weight loss ☐ Longevity / Healthy Aging ☐ Hormonal balance ☐ Improved energy
  ☐ Disease prevention ☐ Other: _____

- Motivation to change (1–10): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Section 8: Additional Information

Preventative Test	Date	Normal	Abnormal	
PAP				
Mammogram				
Bone Density				
Colonoscopy				
Rectal Exam				
PSA				
Chest X-Ray				
EKG				
Stress Test				
Other testing				

REVIEW OF SYSTEMS (ROS)
(Check "Yes" if present, "No" if not)

General: ☐ Yes ☐ No — Fever, chills, fatigue, weight change

Skin: ☐ Yes ☐ No — Rash, itching, dryness, color changes

HEENT: ☐ Yes ☐ No — Headache, vision changes, hearing loss, nasal congestion, sore throat

Cardiovascular: ☐ Yes ☐ No — Chest pain, palpitations, leg swelling

Respiratory: ☐ Yes ☐ No — Shortness of breath, cough, wheezing

Gastrointestinal: ☐ Yes ☐ No — Nausea, vomiting, diarrhea, constipation, abdominal pain

Genitourinary: ☐ Yes ☐ No — Dysuria, frequency, urgency, hematuria

Musculoskeletal: ☐ Yes ☐ No — Joint pain, stiffness, muscle weakness

Neurological: ☐ Yes ☐ No — Dizziness, numbness, weakness, tremors, seizures

Psychiatric: ☐ Yes ☐ No — Anxiety, depression, mood changes, sleep disturbance

Endocrine: ☐ Yes ☐ No — Heat/cold intolerance, excessive thirst or urination

Hematologic/Lymphatic: ☐ Yes ☐ No — Easy bruising, bleeding, swollen glands

Allergic/Immunologic: ☐ Yes ☐ No — Allergies, frequent infections