**NEW PATIENT FORM SD Weight Loss C.**

Name:

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Please check if you do not wish to be contacted via phone or be left a voice mail

**Health History**

Do you or did you previously have a history of any of the following? If yes, please describe your condition in the space provided. List any medications in the margins for the following:

YES NO Explain

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1.** | Heart Problems/Chest Pains: |  |  |  |
| **2.** | High or Low Blood Pressure: |  |  |  |
| **3.** | Respiratory Problems: |  |  |  |
| **4.** | Labored Breathing: |  |  |  |
| **5.** | Diabetes: |  |  |  |
| **6.** | High Cholesterol: |  |  |  |
| **7.** | Cancer: |  |  |  |
| **8.** | Epilepsy or Seizures: |  |  |  |
| **9.** | Anxiety/Depression: |  |  |  |
| **10.** | Dizziness: |  |  |  |
| **11.** | Sleeping Problems: |  |  |  |
| **12.** | Easy Fatigue: |  |  |  |
| **13.** | Arthritis: |  |  |  |
| **14.** | Headaches: |  |  |  |
| **15.** | Leg Cramps: |  |  |  |
| **16.** | Swelling of Hands or Feet: |  |  |  |
| **17.** | Abdominal/Bowel Disorders: |  |  |  |
| **18.** | Indigestion: |  |  |  |
| **19.** | Irregular Menstruation: |  |  |  |
| **20.** | Do you Smoke? |  |  |  |
| **21.** | Have you ever had any history of substance abuse? |  |  |  |
| **22.** | Major illness or hospitalization in last 3 years including surgery? |  |  |  |
| **23.** | Any other health problems not listed or? |  |  |  |
| **24.** | Are you pregnant or breast feeding? |  |  |  |
| **25.** | Do you have any drug allergies? |  |  |  |
| **26.** | Are you allergic to bees? |  |  |  |
| **27.** | Have you ever had or been diagnosed with Glaucoma? |  |  |  |
| **28.** | Do you have any thyroid problems? |  |  |  |

List all your medications and Surgery:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY MEDICAL HISTORY** *(circle one)*

Female Organ Problems Y/N Cancer Y/N High Blood Pressure Y/N

Kidney Trouble Y/N Diabetes Y/N Low Blood Pressure Y/N

If Yes, Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you answered yes to any of the above questions, a physician approval may be needed before participating in this weight loss program.**

28. How would you rate your overall health? *(Circle one)*

Excellent Good Fair Poor

29. Have you ever been on a supervised weight loss program before? Y / N

If Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What is your weight loss goal? *(please list any or all of the below)*

\_\_\_\_\_\_\_\_\_Lbs\_\_\_\_\_\_\_\_\_Size\_\_\_\_\_\_\_\_\_\_Inches

What have you done in the past to achieve these goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30. How much time can you devote to exercising each week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

31. How frequently do you eat? (How many meals per day?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

32. Do you eat out? Y/N If so, how many times per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

33. What is your fluid intake PER DAY? List number of glasses/cups in each category.

WATER \_\_\_\_\_\_COFFEE \_\_\_\_\_\_ SODA \_\_\_\_\_\_\_ TEA \_\_\_\_\_\_ ENERGY DRINKS \_\_\_\_\_\_ ALCOHOL \_\_\_\_\_\_ OTHER \_\_\_\_\_\_\_\_

34. Do you take supplements? If so, what kind and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

35. Please finish this statement. (Use the back of the page if necessary.)

**The best way to describe my nutritional habits is** …\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Information:

Do you have any of the following? *Check any that apply*

Sweet Cravings □ Alcohol Cravings □ Cheese Cravings □ Night Hunger □

Bread Cravings □ Salt Cravings □ Pasta Cravings □ Soda Cravings □

Do you have specific weaknesses when trying to lose weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale from 1-10 how motivated are you to losing weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about SD Weight Loss Center?

Internet □

Craigslist □

The Clipper/Savvy Shopper □

Money Mailer □

Friend/Family □

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT**:

Patient Consent: The above information is a true representation of my current health status. I have read and understand the above and do hereby agree to treatment administered to me, including medications for weight control. I, the undersigned, having been informed by SD Weight Loss Center of the hazards and possible consequences involved in treatment by medications, supplements, injections for the purpose of weight loss, nevertheless consent to such treatment and agree to hold. SD Weight Loss Center free and harmless for any claims, demands, or suits for damages from any injury or complications whatever, save negligence, that may result from such treatment.

**Notice**: All patients may receive medications dispensed by SD WEIGHT LOSS CENTER *(or receive written prescription to take to a pharmacy of their choice for a fee).*

**If you suspect you are pregnant, discontinue medication. Pregnant or nursing mothers should not be taking this medication.**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*IF PATIENT IS UNDER THE AGE OF 18, A PARENT OR LEGAL GUARDIAN MUST SIGN ABOVE*