Aligned Medical Group, P.C.
PROVEN CARE. HEALTHY LIVES.

Aligned Medical Weight Loss

Patient Information Form

Patient Full Name:		
Address:		
City:	State:	Zip Code:
Home Phone	Work/Cell Phone:	
Date of Birth:	Age:	Sex:
Email Address:		

Employment Information

Current Employer:		Occupation:
Employer Address:		
City:	State	Zip Code:
Work Phone:		Ext:

Emergency Contact Information

Name:	Relationship:	Phone:
Spouse:		Phone:
Primary Care Physician"		Phone:

Financial Policy

Payment is expected at the time of service; accepting cash, check and/or credit cards. At Aligned Medical Group, P.C. we understand the importance of serving our patients, therefore if full payment cannot be made, payment plans are available if you are accepted. We reserve the right to refuse treatment to patients with outstanding dues to Aligned Medical Group, P.C.. All accounts sent to collections will be billed an additional 40% of the outstanding total.

_____ _____

Patient Signature Date

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Present Status

1. Are you in good health at the present time to the best of your knowledge?	Yes	No
2. Are you under doctor's care at the present time?	Yes	No
3. Are you taking any medications at the present time, including beta blockers, heart, or pain medications?	Yes	No
If yes, please explain:		
4. History of Constipation (difficulty in bowel movements)?	Yes	No
5. History of frequent headaches?	Yes	No
6. History of migraines?	Yes	No
7. Do you smoke?	Yes	No
8. History of heart attacks or chest pain?	Yes	No
9. Any allergies to medications?	Yes	No
If yes, please explain:		
10. Do you suffer from allergies?	Yes	No
11. History of glaucoma?	Yes	No
12. History of high blood pressure?	Yes	No
13. History of swelling feet?	Yes	No
14. History of diabetes?	Yes	No
15. History of sleep apnea?	Yes	No
16. Serious injuries?	Yes	No
If yes, please explain:		
17. Any surgeries?	Yes	No
If yes, please explain:		

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Female History

Menopause?	Yes	No
Average Cycle Duration (in days)		
Are you regular?	Yes	No
Pain associated?	Yes	No
Last Menstrual Period	____/____/____	
Birth Control?	Yes	No
Last Annual Exam?	____/____/____	

Check all that apply

____ Low Libido	____ Lack of Energy	____ Decreased Strength
____ Decreased Muscle Mass	____ Poor Sleeping	____ Hair Loss
____ Poor Memory or Concentration	____ Sadness	____ Decreased Enjoyment of Life

Past Medical History (check all that apply)

____ HIV	____ Kidneys	____ Liver Disease
____ Lung Disease	____ Bleeding Disorder	____ Eating Disorder
____ Arthritis	____ Alcohol Abuse	____ Thyroid Disease
____ Anemia	____ Heart Valve Disorder	____ Heart Disease
_____ Cancer If yes, what type:	____ Gallbladder Disease	____ Psychiatric Illness
____ Drug Abuse	____ Other:	

Family Medical History (check all that apply)

____ High Blood Pressure	____ Nervous Breakdown	____ Heart Trouble
____ Cancer If yes, what type & who:	____ Strokes	____ Anemia
____ Obesity	____ Kidney Disease	____ Suicide

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____ Migraines	____ Allergy	____ Bleeding (abnormal)
____ Arthritis	____ Epilepsy	____ Syphilis or bad blood

Nutritional Evaluation

Present Weight:	Height:	Desired Weight:
In what time frame would you like to be at your desired weight?		
What is the main reason for your decision to lose weight?		
When did you begin gaining weight and why?		
What has been your maximum lifetime weight and when? (Not including pregnancy, if applicable)		
Previous Diets you have followed, when you followed them, and the results:		
Is your spouse, fiancée, or partner overweight?	Yes	No
Do you wake up hungry in the middle of the night?	Yes	No
How often do you eat out?		
How often do you eat "fast foods"?		
Do you wake up hungry in the morning?	Yes	No
What time of the day are you most hungry?		
What is your level of activity? ____ **Inactive** – No regular physical activity with a sit down job. ____ **Light Activity** – No organized physical activity during leisure time. ____ **Moderate Activity** – Occasionally involved in activities such as weekend golf, tennis, jogging, swimming, or cycling. ____ **Heavy Activity** – Consistent lifting, stair climbing, heavy construction, etc…. or regular participation in jogging, swimming, cycling, or active sports at least three times per week. ____ **Vigorous Activity** – Participation in extensive physical exercise for at least 60 minutes per session 4 times per week.		
On average, how many hours of sleep do you get per night?		

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Weight Loss Program Consent Form

I, _____, authorize Aligned Medical Weight Loss and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the mediation package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet, and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urges and have been given all the time I need to read and understand this form.
If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever are concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Please Note: Signing this form in no way obligates you to participate in the program.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____
(Or person with authority to consent for patient)