**New Patient Intake Form- Weight Management**

**Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Please Print Legibly**

Patient Name: (Last) (First) (MI)

Patient Address:

City: State: Zip:

Home Phone: Cellular:

Birthdate: Age: Sex: M F

**Employment Information:**

Occupation:

**In Case of Emergency:**

Name: Relationship: Phone:

Primary Care Physician: Phone:

**Referred by: (**circle one or more**)**

 Patient Referral  My physician (please identify)  Internet

 Printed Ad (please identify)  Passing by our office  Other (please describe)

**EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We are primarily paperless. Please indicate if it is acceptable for us to use the above email for information &/Or special offers? YES\_\_\_\_\_ NO\_\_\_\_\_

**Past History: (**Please circle if you have had any of the following):

 High Blood Pressure  Stroke Arthritis  Sleep Apnea

 Diabetes  GERD (Reflux)  Kidney Disease  Anemia

 High Cholesterol  Depression/Anxiety  Hepatitis  Abnormal Bleeding

 Heart Disease \_\_\_\_\_\_\_\_\_\_\_  Mental Illness  Migraines  Seizure Disorder

 Lung Disease \_\_\_\_\_\_\_\_\_\_\_\_  Thyroid Disease\_\_\_\_\_\_\_\_\_\_  Allergies (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cancer, Type:  Other Diseases

**SURGERIES (dates)**

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

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

**Current Medications** (including vitamins, birth control pills):

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

**Allergies to medicines, foods, etc**

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

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

**Family History:**

Father: Health \_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Deceased \_\_\_\_\_ at age \_\_\_\_\_ Cause

Mother: Health \_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Deceased \_\_\_\_\_ at age \_\_\_\_\_ Cause

# of siblings:\_\_\_\_\_\_\_ # living\_\_\_\_\_\_ #deceased: \_\_\_\_\_\_\_\_ Cause

**Examinations**:

Date of last physical examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:

Hospitalizations \_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_\_\_ Reason:

Other \_\_\_\_ Date of last laboratory tests:

**Review of Systems** (circle all that apply)

Skin: itching, easy bruising, bleeding, hair loss, rashes.

Head: headaches.

Eyes: blurred vision, double vision, loss of vision, inflammation, pain.

Neck: swelling, palpable masses or lymph nodes, neck pain.

Respiratory: Chest wall pains, cough, shortness of breath, wheezing, sputum production.

Cardiovascular: palpitations, dizzy spells, orthopnea, leg edema.

Gastrointestinal: weight change, heartburn, change in bowel habits, nausea, emesis, melana, abdominal pains, h/o hepatitis, gallstones, rectal bleeding, hemorrhoids.

GU: urinary frequency, hesitancy, incontinence, dysuria. No gross hematuria.

Musculoskeletal: recurring joint pain, swelling.

Neurological: weakness, numbness, tingling, loss of balance, dizziness, vertigo, seizures.

Hematologic: unusual bruising or bleeding, clotting problems.

Endocrine: heat or cold intolerance, unusual weight gain or loss.

Psychiatric: h/o depressive symptoms, suicidal ideation, anxiety, lack of concentration, memory problems

**Weight History:**

When did you first become overweight? (your age then or year)

How did your weight gain start? Describe any circumstances:

What do you think is the cause of your weight problem:

Your present weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ your weight goal: height:

What was your highest weight? (excluding pregnancy) \_\_\_\_\_\_\_your age then # of years ago:

What was your lowest weight? your age then # of years ago:

Have you ever stayed the same weight for 10 years or more? Yes/ No

Have you attempted to lose weight before? \_\_\_\_\_\_ most lbs lost: how long it took:

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:

Where and when do you do most of your overeating?

How many meals do you eat a day? \_\_\_\_\_\_ How many times do you snack a day? \_\_\_\_\_\_\_\_How many times a week do you eat out? \_\_\_\_\_\_What foods do you eat when snacking?

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

HOW MOTIVATED ARE YOU TO LOSE WEIGHT NOW? (1- NONE, 10 – VERY MOTIVATED)

Do you currently have any medical concerns? Please List:

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

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

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

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

Patient’s Signature Date

**Financial and Refund Policy:**

Thank you for selecting Prime MediSpa for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be

advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney’s fees and court costs. Due to our financial obligations immediately following any of your purchases, our policy is that all sales are final. No refunds are allowed, and no exchanges are allowed.

I have read and understand all of the above and have agreed to these statements.

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

Patient’s Signature Date

**LAB CONSENT**

*PLEASE INITIAL ONE OF THE FOLLOWING:*

\_\_\_\_\_\_\_\_I have received lab within one year and will bring a copy before my next visit to have filed in my records at Prime MediSpa.

\_\_\_\_\_\_\_\_I have not had lab drawn within one year but will schedule an appointment with my primary care physician

to have these lab tests performed. I will bring a copy of this lab as soon as possible to be filed in my records.

\_\_\_\_\_\_\_\_ I am interested in obtaining labs ordered via Prime Medi Spa and will be responsible

for any unpaid labs that are completed with my approval.

\_\_\_\_\_\_\_\_ I have no history of any medical illnesses. I do not have medical insurance

so I decline to have lab tests taken at this time. I understand the risks and accept responsibility for any medical problems, including fatal illnesses that may arise from taking Adipex, HCG, or any other weight loss supplements.

I have been provided and have read the EWW Privacy Policy: YES NO \_\_\_\_\_\_\_\_\_(initials)

I have read the Release of Liability statement and agree to provide my release: YES NO \_\_\_\_\_\_\_\_\_(initials)

I have read the Confidentiality Agreement and agree with its terms: YES NO \_\_\_\_\_\_\_\_(initials)

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

Patient’s Signature