New Patient Weight Loss Intake Form

Name:	Date:	
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email Address:		
Sex: M☐ F☐ Birth Gender: M☐ F☐ Birth date:	Height:	Weight:
Race (ie. White, Asian, African American):	Hispanic or Latino: ☐ **Yes** ☐ **No**	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced		
Occupation:		
How did you hear about us?		
Primary Care Physician:	Phone:	
Emergency Contact:	Phone:	Relationship:

Health and Wellness History

Has your doctor advised you to lose weight?		
Do you have any dietary restrictions? Please explain:	☐ **Yes**	☐ **No**
How often do you exercise?	What type of exercise?	
Do you feel stressed? Please explain:	☐ **Yes**	☐ **No**
Check ALL that apply to you: ☐ Pregnant ☐ Might Be Pregnant ☐ Breast Feeding ☐ Currently Undergoing Chemotherapy		

Please answer the following questions honestly so we can do our best to help you reach your goals.

What changed that caused the weight gain (if anything)? _____

What's the main reason you are seeking treatment at this time? _____

What are your goals about weight control and management? _____

What do you consider to be your ideal weight? _____

When was the last time you were at your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is the hardest part about managing your weight? _____

What have you tried in the past that has failed? _____

Please check all previous programs that you have tried in order to lose weight. Indicate dates and length of and any current medications:

Program	Date	Medication	Dose/Freq.
Weight Watchers			
Liquid Diets			
Keto Diet			
Diet Pills (Phen-Fen)			
Nutrisystem/Jenny Craig			
Surgery			

Have you maintained weight loss for up to a year with any of these programs?_____

What did NOT work for you about these programs?_____

What has been your lowest _____ and highest _____ weight as an adult?

What's more important, fast or permanent? _____

How fast do you want to be slim, trim and fit? _____

What would stop you from a weight loss program? _____

Do you binge eat?	□ **Yes**	□ **No**
Do you suffer from uncontrollable cravings?	□ **Yes**	□ **No**
Do you feel that food controls you?	□ **Yes**	□ **No**
Do you eat because of your emotions?	□ **Yes**	□ **No**
Do you eat between meals?	□ **Yes**	□ **No**
What do you choose to eat between meals?		
Do you feel that your eating behaviors are normal?	□ **Yes**	□ **No**
Briefly describe your daily eating behaviors:		
Does your family support your weight loss efforts?	□ **Yes**	□ **No**
Can you remember being at your ideal weight?	□ **Yes**	□ **No**
What do you remember most about it?		
Commitment to weight loss: (please rate): (low) 1 2 3 4 5 6 7 8 9 10 (high)		

List of current medications/Supplements:

Name of Medication	Dosage	How Often

Please list all known **Drug** and **Food** Allergies/Sensitivities

Drug Name/Food Name:	Reaction:

enlightened Medical CARE

Check <u>ALL</u> medical conditions that you may have had or currently have now:

- ☐ ADD/ADHD
- ☐ Alcholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gall Bladder
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Chlosterol
- ☐ HIV/AIDS
- ☐ IBS
- ☐ Kidney Stones
- ☐ Lyme Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Thyroid
- ☐ Vertigo

Other: _____

_____

Alcohol Use? ☐/☐ Amount: _____ ☐/ W☐ly/S☐ly

Tobacco Use? ☐s/N☐r/Form☐moker PPD _____ How many years?

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

May we leave a detailed message for you on your answering device? **Yes**_____ **No**_____

May we send text messges to you on your anwering device? **Yes** _____ **No** _____

I fully understand that my signature is consent and authorization to be examined by Enlightened Medical Care.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature _____ Date _____

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment you provide a 24 hour notice. Appointments which are cancelled within less than 24 hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees can be directed to the front desk at (937)859-5864.

Please sign that you have read, understand and agree to this cancellation and no-show policy.

_____

Patient Name (Please Print) Date

_____

Signature of Patient Date