INITIAL VISIT INTAKE RECORD

NAME_____ | DATE OF BIRTH_____ AGE _____

ADDRESS_____ | HEIGHT _____' _____" SEX: M / F

CITY/STATE_____ ZIP_____ | STATUS: MARRIED / SINGLE / DIVORCED / OTHER

EMAIL _____ | HOME PHONE (____) _____

WORK PHONE (____) _____

EMPLOYER_____ OCCUPATION_____

PRIMARY CARE PHYSICIAN_____

PLEASE LIST PAST OR CURRENT MEDICAL CONDITIONS, DISEASES, SURGERIES, INJURIES AND DATES

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS & SUPPLEMENTS YOU ARE TAKING, ALONG WITH DOSAGES

_____ _____

_____ _____

PLEASE LIST ANY DRUG ALLERGIES _____

DO YOU DRINK ALCOHOL? ☐ NEVER ☐ RARELY ☐ MODERATELY ☐ DAILY

HAVE YOU BEEN TREATED FOR ALCOHOL OR SUBSTANCE ABUSE ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MANY PACKS PER DAY _____

HAVE YOU TAKEN PRESCRIPTION DIET PILLS BEFORE? ☐ YES ☐ NO

HAVE YOU TAKEN "OVER THE COUNTER" DIET PILLS? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL or PHYSICAL CONDITIONS (CHECK IF YES):

____ANOREXIA/BULIMIA _____BINGE EATING _____CHEST PAIN/ANGINA _____ANXIETY/PANIC ATTACKS

____DEPRESSION _____DIABETES _____CONSTIPATION _____SHORTNESS OF BREATH

____GALLSTONES _____INSOMNIA _____SEVERE HEADACHES _____SWELLING OF ANKLES/HANDS

____FEEL COLD usually _____HOT FLUSHES or SWEATING _____ANEMIA _____LOW ENERGY/ TIRED/ FATIGUE

FAMILY HISTORY:

PLEASE LIST ANY MAJOR MEDICAL CONDITIONS OR CAUSE OF DEATH, IF DECEASED, FOR YOUR

FATHER _____

MOTHER_____

BROTHERS_____

SISTERS_____

CHILDREN _____

HOW DID YOU LEARN OF DOCTOR'S WELLNESS STUDIO?_____

_____

DIETARY/NUTRITIONAL HISTORY:

DO YOU EAT THREE OR MORE MEALS A DAY? ☐ ALWAYS ☐ OFTEN ☐ OCCASIONALLY ☐ NEVER

WHAT TIME WOULD YOU TYPICALLY EAT BREAKFAST? _____

WHAT ARE YOUR HUNGIEST TIMES OF THE DAY? _____

WHAT TIME DO YOU NORMALLY GET UP IN THE MORNING? _____ GO TO BED? _____

DO YOU GET UP DURING THE NIGHT TO EAT/SNACK? ☐ YES ☐ NO ☐ OCCASIONALLY

AVERAGE NUMBER OF SOFT DRINKS YOU CONSUME DAILY: REGULAR _____ DIET _____

BESIDES WATER, WHAT OTHER BEVERAGES DO YOU COMMONLY DRINK? _____

_____

PLEASE CHECK WHICH ITEMS APPLY TO YOU:

_____ SNACK ON SWEETS OFTEN _____SNACK ON SALTY ITEMS OFTEN _____ EAT FAST FOOD OFTEN

_____EAT RESTURANT MEALS OFTEN _____TRAVEL AWAY FROM HOME FOR WORK OVERNIGHT REGULARLY

DO YOU EXERCISE? ☐ FREQUENTLY ☐ OCCASIONALLY ☐ RARELY ☐ NEVER

DOCTOR'S WELLNESS STUDIO, LLC

PATIENT INFORMED CONSENT
FOR ADMINISTRATION OF APPETITE SUPPRESSANTS

I,_____ authorize DOCTOR'S WELLNESS STUDIO physicians (hereinafter referred to as "physician") to use dietary and nutritional counseling, behavior modification, exercise counseling, the administration of appetite suppressants and other supplements, to assist me in achieving my weight loss goals.

I agree to follow the instructions of the physicians and their assistants in this program carefully and to report promptly any change in my condition possibly related to the administration of the appetite suppressants.

I understand that the purpose of this program is my long-term weight control, and that other unrelated conditions are my responsibility and the responsibility of my personal physician.

Furthermore, I understand that the physician may recommend, on the basis of his experience and that of his colleagues, published papers in the Bariatric (weight management) and nutritional literature, and ongoing clinical trials, that I use appetite suppressants for significantly longer periods of time and at higher doses than indicated on the labeling of the medication. I understand that the labeling represents the opinion of the drug manufacturer and the Food & Drug Administration. I understand that although the appetite suppressants used in this program have low addiction potential and that I may elect to discontinue their usage at anytime, that I may or may not regain the weight lost while taking the medications. I also understand that the physician considers the risks of long-term administration of these appetite suppressants to be minimal, and appropriate to achieve long-term weight reduction; however, as with the long-term administration of any medication, serious or life-threatening side effects, though highly unlikely, cannot be absolutely excluded.

I understand that there are other means and programs available to me to lose weight utilizing various methods of caloric restriction and/or exercise without appetite suppressants, but that these methods necessitate greater "will-power" because of unrelieved hunger.

RISKS OF THE WEIGHT LOSS PROGRAM:
I understand that giving my consent for entering the weight loss program may involve the use of appetite suppressants for more than 12 weeks and in higher doses than recommended in the labeling and may expose me to side effects including, but not limited to: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergies, and increased blood pressure. These and other risks could conceivably be serious, and in rare cases fatal. I understand there is a risk of developing primary pulmonary hypertension, with the use of appetite suppressants, which is extremely rare and can possibly be fatal if symptoms are ignored and the medications are not discontinued. The most noticeable side effects are unusual fatigue and shortness of breath upon exertion. If I experience these side effects, I understand I should discontinue the medications and call my physician. When the medications are discontinued, the condition is generally 100% reversible. This condition usually takes a period of months to develop, however, cases have been reported where the condition developed in less time. I understand that the medications may have adverse reactions when taken with alcohol or other drugs.

RISKS ASSOCIATED WITH BEING OVERWEIGHT OR OBESE:
I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, diabetes, heart attack, heart disease, stroke, certain cancers, gallstones, sleep apnea and pulmonary damage, arthritis and damaged joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks go up significantly the more overweight I am.

PATIENT'S CONSENT:
I have read and understand this consent form and acknowledge that all of my questions have been answered to my complete satisfaction.
PATIENT SIGNATURE_____DATE_____