1463 E McAndrews Rd.
Medford, OR 97504
Phone: (541) 414-0481
Fax: (541) 414-0482

Medical Weight Loss Program Intake Form

Patient Name: ______________________________

Patient Address: ______________________________

City: ____________________ State: ____________________ Zip: ______________

Phone Number: ____________________ Email: ____________________

Occupation: ____________________ Date of Birth: ____________ Age: ________ Sex: ☐ M ☐ F

In Case of Emergency

Name: ____________________ Relationship: ____________________

Phone Number: ____________________

How did you hear about us? ______________________________

Are you under the care of a qualified healthcare professional? Please list whom.*

____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues - that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change.*

I acknowledge the above statement above. Signature:______________________________

MEDICAL HISTORY

Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis, etc.):*

____

____

____

____

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What medications, supplements and over the counter items do you take regularly or are currently prescribed:*

____

____

____

Any past surgeries and hospitalizations?*

____

____

____

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

____

____

____

PERSONAL HISTORY

What are your main interests and hobbies? ______________________________

What is your line of work or study? ______________________________

Do you exercise regularly? (Please detail) ______________________________

What kind of other movement or activities do you enjoy? ______________________________

You have problems falling or staying asleep? ______________________________

How many hours do you sleep? ______________________________

Do you wake up refreshed? ______________________________

How is your energy? ______________________________

Does your energy level affect your daily activities? ______________________________

How would describe your mood, generally: ______________________________

Does your mood affect your life or daily activities? ______________________________

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How would you describe your stress level? ______________________________

What are your sources of stress? ______________________________

How do you manage stress? ______________________________

Do you have people close to you who support you? ______________________________

DIET & LIFESTYLE

Do you regularly drink alcoholic beverages? ☐ Yes ☐ No If yes, how many per week? ______________

Do you smoke tobacco? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

How is your appetite? ______________________________

	What:	How much:	When:
Snack Habit	______________	______________	______________
Typical Breakfast	______________	______________	______________
Typical Lunch	______________	______________	______________
Typical Dinner	______________	______________	______________

Do you regularly drink alcoholic beverages? ☐ Yes ☐ No If yes, how many per week? ______________

How often do you eat out? ______________________________

What restaurants do you frequent? ______________________________

How often do you eat "fast foods"? ______________________________

Food allergies? ☐ Yes ☐ No If Yes, Please list allergies? ______________

Food dislikes? ______________________________

Food cravings? ______________________________

Do you eat because of emotions (explain)? ______________________________

Do you drink coffee or tea? ☐ Yes ☐ No If Yes, how much daily? ______________

Do you drink pop / soft drinks? ☐ Yes ☐ No If Yes, how much daily? ______________

Do you use sugar substitutes? ☐ Yes ☐ No

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What are your worst food habits? ______________________________

How much fluids do you normally drink? (Please approximate in ounces) ______________________________

Please list all types of beverages you regularly drink: ______________________________

____

Please list any food allergies, intolerances, or foods you avoid and the reason

____

____

What past struggles and difficulties have you experienced in terms of food and dieting?

____

____

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

____

____

What types of diet and exercise approaches have worked for you in the past?

____

____

And what hasn't worked for you at all?

____

____

How MOTIVATED are you to lose weight?

____

____

Is there anything else you would like to tell us?

____

____

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Please list the factors you feel have contributed to your current weight (check all that apply):

☐ Slow metabolism ☐ Family history of obesity ☐ Comfort food dependency

☐ Lack of exercise ☐ Binge eating ☐ Late night snacking

☐ History of trauma ☐ History of grief and loss ☐ Medication related weight gain

☐ Significant restrictive eating behaviors like anorexia

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

	No, never	**Yes, currently**	**Not currently** *(within the last year)*	**Not currently** *(longer than 1 year ago)*
Fatigue	☐	☐	☐	☐
Unexplained Weight Loss or Gain	☐	☐	☐	☐
Change in Appetite	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐
Addictive Dependency	☐	☐	☐	☐
Disordered Eating Pattern/Tendency	☐	☐	☐	☐
Tension	☐	☐	☐	☐
Lack of Mental Focus	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Blood Sugar Irregularities	☐	☐	☐	☐
Excessive Thirst or Hunger	☐	☐	☐	☐

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Sugar Cravings	☐	☐	☐	☐
Abnormal Hair Growth	☐	☐	☐	☐
Excessive Perspiration	☐	☐	☐	☐
Feeling Excessively Hot or Cold	☐	☐	☐	☐
Headache	☐	☐	☐	☐
Lightheartedness	☐	☐	☐	☐
Joint Pain or Stiffness	☐	☐	☐	☐
Muscle Weakness or Soreness	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Heart Murmur/Palpitations	☐	☐	☐	☐
Cold or Pale Extremities	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Short of Breath	☐	☐	☐	☐
Heartburn	☐	☐	☐	☐
Abdominal Discomfort After Eating	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Abdominal Bloating	☐	☐	☐	☐
Belching/Gas	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Daily Bowel Movements	☐	☐	☐	☐

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Weight Loss Therapy and Treatment

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

1. If you are late or miss your appointment, you may be subject to a $50 fee. ____ (initials)
2. Services must be paid for at the time of service. ____ (initials)
3. Health insurance may not cover services provided at Advanced Care Health Systems If you want to seek insurance reimbursement, please let use know that at the time of scheduling ___ (initials)
4. Phentermine and Vyvanse are considered a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals. _____(initials)
5. I understand that treatments used at Advanced Care Health Systems might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.____ (initials)
6. I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department. ____ (initials)
7. I acknowledge that Advanced Care Health Systems is not my primary care provider unless I elect them so. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at Advanced Care Health Systems.____ (initials)
8. I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation. ____ (initials)
9. I understand that having an appointment with Advanced Care Health Systems does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical providers discretion to issue a prescription. ____ (initials)

I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that Advanced Care Health Systems manages my treatment and it is at their discretion to provide._____ (initials)

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10. I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment. ____ (initials)
11. I am voluntarily requesting treatment with Advanced Care Health Systems in regards to weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical recommendations and guidelines or if I am just considered overweight and not obese. ____ (initials)
12. I do not hold any medical practitioner of Advanced Care Health Systems responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Advanced Care Health Systems harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to Advanced Care Health Systems as this could change the treatment prescribed to me. (initials)_____

I have read, understand and agree to all of the above statements.

Patient Signature: ______________________________ Date: ______________

Patient Printed Name: ______________________________

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Authorization to Use and Disclose Health Information

______________________________	______________________________
I hereby authorize (previous healthcare provider):	To disclose to:
Name of disclosing party	Name of Recipient
Address	Address
City, State Zip	City, State Zip
Phone Fax	Phone Fax

Records and information pertaining to:

Patient name (list other names used) SS# Date of Birth

Address Phone number

For the purpose of:____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the above date of signature unless a different date is specified here________________________________ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box, initial to specify which type of information is to be disclosed, and then sign and date.

☐ Medical information __________ (initials) ☐ Psychiatric information __________ (initials)

☐ Drug/Alcohol Information __________ (initials) ☐ Results of HIV Test __________ (initials)

☐ Genetic Records __________ (initials)

Signature:____Date:______________________________

A copy of this authorization is as valid as the original.

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Consent to Release Protected Health Information

Patient Name____Date of Birth____________

Consent

I request Advanced Care Health Systems to release protected healthcare information to:

Name____

Relationship to Patient____Phone #______________________

Name____

Relationship to Patient____Phone #______________________

Name____

Relationship to Patient____Phone #______________________

This request and authorization applies to: (please check below)

☐ All healthcare information (Medical and Billing)

☐ Healthcare information relating to the following treatment, condition or dates:

____

____

☐ Other____

I understand that this designation applies only to

____ Date Signed____________

____

____ Date Signed____________

Patient Signature

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Acknowledgment of Receipt of Notice of Privacy Practices

I, (print patient name), acknowledge and agree that I have received a copy of Advanced Care Health Systems Notice of Privacy Practices.

Patient signature____Date_______________

Patient legal representative signature____Date_______________

Print name of legal representative____

Relationship to patient____

FOR CLINIC USE ONLY

Advanced Care Health Systems made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices.

____ Date_______________

____ Date_______________

____ Date_______________

____ Date_______________

____ Date_______________