ADVANCED HEALTH
& WELLNESS

900 Biddle Road
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? _____

iet & ifestyle

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? _____

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

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.
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 Health & Wellness 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 ____ (initials)
7. I acknowledge that Advanced Health & Wellness 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 Health & Wellness. _____ (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)

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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 Health & Wellness 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 Health & Wellness 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 Health & Wellness 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 Health & Wellness 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): _____

Name of disclosing party _____

Address _____

City, State Zip _____

Phone _____ Fax _____

To disclose to: _____

Name of Recipient _____

Address _____

City, State Zip _____

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 Health & Wellness 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 _____

Patient Signature

_____ Date Signed _____

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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 Health & Wellness 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 Health & Wellness 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_____