



PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ AGE: _____

Height: _____ Weight: _____ Gender: _____ Date: _____

How did you hear about us? _____ If referred by someone, who? _____

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

What made you decide to do something about your weight today? _____

Is there a specific program, or medication you are interested in? If yes which one? _____

Who encouraged you to lose weight? _____ Can you commit to one visit a week? _____

What important reason, special occasion, or goal date do you have for wanting to lose weight? _____

How important to you is it that you lose weight? _____

How many pounds would you like to lose? _____ How fast do you want to be slim, trim, & fit? _____

Have you ever attended any other weight reduction centers, if so, which ones? _____

What kinds of diets have you tried on your own? _____

What is the longest you've been able to stick with a diet? _____

Does your family support your weight loss efforts? _____

Have you been advised by your family physician to lose weight? _____

Do you eat because of emotions?
If yes, please explain:

On average, which of the following reflects your daily eating habits? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> 3 meals with healthy snacks | <input type="checkbox"/> Skip breakfast or other meals |
| <input type="checkbox"/> 3 meals | <input type="checkbox"/> Generally eat on the run |
| <input type="checkbox"/> 2 meals or less | <input type="checkbox"/> No regular eating pattern |
| <input type="checkbox"/> Graze; small frequent meals | <input type="checkbox"/> Often crave sweets/carbs |

Please check your current level of exercise:

- None
- Light exercise 1-3 times per week, easy pace, stretching, walking, etc.
- Moderate exercise 2-3 times per week, moderate pace, some weights, etc.
- Heavy exercise 3-4 times per week, vigorous pace, weights, fast running, etc.

Consult Notes:



NEW PATIENT INTAKE

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Phone # (H) _____ (W) _____ (Other) _____

Date of Birth: _____ Gender: _____ SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact: _____ Relation: _____

Phone # (H) _____ (W) _____ (Other) _____

Please list any additional health complaints: _____

Please list any surgeries (with dates) _____

Please list any medical conditions (past & present) _____

Family History: Please specify members of your family including extended family who have these illnesses.

Cancer: _____ Hypothyroidism: _____

Heart Disease: _____ High Blood Pressure: _____

Diabetes: _____ Obesity: _____

Current Medications/Prescriptions and Non-Prescriptions		
Prescriptions Medication/Dose/How often	Reason for taking	Prescribing M.D.

Please list any allergies (Medications & food) _____

Some of our programs use medications that are not deemed safe to take while pregnant or breastfeeding.

Are you Pregnant, or breastfeeding? Yes No

Females Only: What was the first day of your most recent menstrual cycle? Date: _____

Signature: _____ Date: _____



HIPPA ACKNOWLEDGMENT AND CONSENT

I, the undersigned, acknowledge that I have had access to a copy of the NOTICE OF PRIVACY PRACTICES. I consent to your disclosure, which you deem necessary in connection with myself or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Signature: _____ Date: _____

CONSENT TO TREAT

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL CARE

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at any facility that DBA Options Medical Weight Loss. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the medical treatments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date: _____

Parent/Legal guardian name: _____

Guardian Signature: _____ Date: _____