# WEIGHT LOSS INTAKE FORM

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## BASIC PATIENT INFORMATION

Name: Date:

Street Address:

Phone: Home Phone:

Email: Birth Date:

Sex: ☐ M ☐ F Height: Weight:

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? ☐ Yes ☐ No Please explain:

How often do you exercise? What type of exercise?

Do you feel stressed? ☐ Yes ☐ No Please explain:

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 inches lost or pounds? _____

What's more important, fast or permanent? _____

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?<br>What do you remember most about it? _____ | ☐ Yes ☐ No |
| Commitment to weight loss: (please rate): (low) 1 2 3 4 5 6 7 8 9 10 (high) | |

**What is the most important element in deciding to use our services?**

*(Circle only ONE of the four answers):*

| | |
|---|---|
| EFFECTIVENESS: | "My results are my top priority." |
| TIME: | "I want results quickly." |
| SERVICE: | "I need extra support along the way." |
| AFFORDABILITY: | "I need this to be affordable." |

**Check the following conditions you would like help with or more information on:**

| | | | |
|---|---|---|---|
| ☐ Weight Loss | ☐ Thyroid | ☐ Knee Arthritis | ☐ Memory & Mood |
| ☐ Hormone Balancing | ☐ Immune Boosting | ☐ Immune | ☐ Pain Relief |
| ☐ Neuropathy | ☐ Joint Pain | ☐ Quitting Smoking | ☐ Stress Relief |
| ☐ Fatigue | ☐ General Wellness | ☐ Diabetic Educ. | ☐ Fitness |

List **ALL** medications & supplements you take (prescription & over the counter)

| Drug Name: | Dosage: | How long have you taken & for what conditions? |
|---|---|---|
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Please list all known **DRUG and FOOD** allergies:

| Drug Name Food: | Reaction: |
|---|---|
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| | |

Check **ALL medical conditions** that you may have had or currently have now:

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergy
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Fatigue
- ☐ Migraine
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ Gall Bladder
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Vertigo/Dizziness
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Blood Sugar
- ☐ HIV/AIDS
- ☐ Irritable Bowel
- ☐ Kidney Infect./stones
- ☐ Low Blood Pressure
- ☐ Low Blood Sugar
- ☐ Lyme Disease
- ☐ Lupus
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Raynaud's
- ☐ Rheumatoid Arthritis
- ☐ Ringing in ears
- ☐ Sinus Infection
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers

Other: _____

Circle any of the following: Pancreatitis, Decreased kidney function, Medullary thyroid cancer, Multiple endocrine neoplasia type 2, family history of medullary thyroid carcinoma, Kidney disease, Type 1 diabetes, Diabetic ketoacidosis.

Please list all previous surgeries & dates:

_____

_____

Alcohol use? ___Yes / ___ No Amount _____ Daily / Weekly / Socially

Tobacco use? ___ Yes / ___ Never / Former Smoker 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 message for you on your answering device? Yes_____ No_____

I fully understand that my signature is consent and authorization to be examined by Megan Bradley and Active Wellness Chiropractic & Rehabilitation

*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 _____

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# INFORMED CONSENT

I hereby give my consent to the performance of diagnostic tests and procedures associated with weight management with which I am seeking treatment for.

I understand that the treatment I receive at this clinic will be performed under the guidance of medical professionals not limited to advanced registered nurse practitioners. Diagnosis and treatment may at times involve discomforts and risk of injury. No guarantee has been made as to the result of examination and treatment at this facility. I have the right to consent to, or refuse, any proposed procedure or therapeutic course, subject to applicable provisions of law.

Weight management treatment with semaglutide and/or tirzepatide is the general recommendation given for those who qualify and are determined to be candidates for treatment. Like most health care procedures and products tirzepatide carries with it some risks. Unlike many such procedures and products the serious risks associated with the tirzepatide are extremely rare. **Following are the known risks:** Nausea, vomiting, diarrhea, and constipation.

Treatment with Tirzepatide may not be recommended those with the following:

Diabetic retinopathy

Low blood sugar

Gallbladder disease

Pancreatitis

Decreased Kidney function

Medullary thyroid cancer

Multiple endocrine neoplasia type 2

Family history of medually thyroid carcinoma.

Kidney disease

Type 1 Diabetes

Diabetic ketoacidosis

I understand that with weight management programs that no guarantee can be given as to the results or outcome of my care.

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• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

***I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.***

PATIENT'S NAME (Print)_____ DATE OF BIRTH_____

_____ _____ _____ _____

(PATIENT | GUARDIAN SIGNATURE) (DATE) (TRANSLATOR | INTERPRETER SIGNATURE) (if applicable) (DATE)

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CLINICIAN ONLY

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

☐ OF LEGAL AGE ☐ APPEARS UNIMPAIRED ☐ CONSENT GIVEN THROUGH GUARDIAN ☐ INTERN PRESENT - INITIALS_____

☐ ORIENTED X3 ☐ FLUENT IN ENGLISH ☐ ASSISTED BY A TRANSLATOR OR INTERPRETER ☐ INTERN NOT PRESENT

_____ _____

(ARNP SIGNATURE) (DATE)