**PATIENT INFORMATION**

Name_____ Birth date_____

❒ Male ❒ Female SSN_____ Driver's License State & Number:_____

Mailing Address_____
(Street) (City) (State) (Zip)

Street Address (if different)_____
(Street) (City) (State) (Zip)

Home Phone: _____ **Email Address:** _____

Mobile Phone: _____

Work Phone: _____

All information will be kept confidential and only used to contact you. Phone support is important. We would also like to email reminders and our monthly newsletter.

Place of Employment_____ Occupation_____

How did you hear about Physician's Plan? If friend, who?_____

***HEALTH HISTORY***

How would you rate your overall health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Are you currently taking any medications (including birth control)? List name and dose _____

Are you allergic to any medications? _____

Have you been seriously ill in the past 10 years? _____

Do you have any chronic health conditions? _____

Are you under a physician's care? ❒ Yes ❒ No If yes, physician? _____

Date of last routine physical? _____ Have you been advised by your physician to lose weight? ❒ Yes ❒ No

Does your physician know you are a patient here? ❒ Yes ❒ No May we contact and update your physician? ❒ Yes ❒ No

Do you have any health concerns/complications that are affected by your weight?

❒ Diabetes ❒ Arthritis ❒ High Cholesterol
❒ Heart Disease ❒ Thyroid Problems ❒ Injury _____
❒ High Blood Pressure ❒ Sleep Apnea ❒ Other _____

Do you smoke? If yes, for how long and packs per day _____

Do you drink alcohol? If yes, what kind and drinks per week _____

Have you ever taken any "prescription diet medication" before? If yes, list _____

Have you ever taken any over the counter diet medications before? If yes, list _____

Do you have any family members that are overweight or obese?

❒ Spouse ❒ Children (ages _____) ❒ Mother ❒ Father ❒ Siblings (#_____ ) ❒ Other

**For Women Only:**

Do you have a gynecologist? ❒ Yes ❒ No If yes, name? _____

Date of last routine exam? _____ Have you been advised by your gynecologist to lose weight? ❒ Yes ❒ No

Does your gynecologist know you are a patient here? ❒ Yes ❒ No May we contact and update your gynecologist? ❒ Yes ❒ No

Are you pregnant or breast feeding? ❒ Yes ❒ No Date of last menstrual period? _____

**I understand I am responsible for payment when services are rendered. I have provided all information to the best of my knowledge.**

Patient's Signature _____ Today's Date _____

Physician's Plan
one to one weight loss & wellness

# CONSENT FOR MEDICAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

**This consent serves as confirmation that Physician's Plan one to one weight loss & wellness has discussed the nature and purpose of your medical treatment, the risks which may be associated, and that Physician's Plan has answered all of your questions in a satisfactory manner.**

**Please read carefully and complete this form. If you do not understand any portion of this form, please inquire and we will be glad to explain any information and/or questions.**

1. I hereby authorize and direct Physician's Plan, with assistants of their choice, to perform

   upon _____ the following medical treatment.
   (NAME OF PATIENT)

2. Physician's Plan combines nutritional counseling and education with the use of prescription medications to aid in appetite suppression.

3. Some of the reported risks known to be associated with the use of these medications include , but are not limited to:
   A) Insomnia
   B) Nausea, other GI Symptoms
   C) Headaches
   D) Dry Mouth
   E) Primary Pulmonary Hypertension (Very Rare Side Effect)

I have been informed of the probability of occurrence of each of the foregoing risks as the result of taking these medications.

I hereby state that I have read and understand this consent. All questions about the treatment program have been answered in a satisfactory manner, and all blanks were filled in prior to my signature.

This consent is valid until revoked by me in writing.

Patient's Signature: _____ Date: _____

I understand that photographs will be taken in order to document the program's effectiveness and results. I agree to allow any images taken to be used for testimonial purposes with the knowledge that my identity will be kept private.

Patient signature: _____ Date: _____

Physician's Plan
one to one **weight loss** & wellness

## *Cancellation/No Show Appointment Policy*

Physician's Plan requires at least a 24-hour notice to cancel a scheduled appointment. We understand that occasionally instances may arise that do not allow for a full 24-hour notice to cancel an appointment, however, we do continue to require a notification prior to scheduled appointment time to avoid being charged a fee.

In the event that an appointment is missed without prior notification, (either canceled or rescheduled) you will be charged $25.00 upon next visit.

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I (print name) _____, have read the above stated Physician's Plan Cancellation/No Show Appointment Policy. I fully understand that I will be charged $25.00 upon return visit for any previous no show, no call, appointments. I also understand that this policy will be strictly enforced.

_____ _____

Patient Signature Date

*Initial Assessment for:* _____ *Date:*_____

## Part 1: The Goal & Support

1. What is your goal weight? _____
2. When do you want to reach this weight? (date or event?)_____
3. Why now? _____
4. Are your family and friends aware of your decision?
   _____
5. If yes, do they support your decision? _____
   Are you going to tell them about joining Physician's Plan? _____

## Part 2 Nutritional History

1. Do you eat **breakfast**? _____ Time: _____
   If yes, # of weekdays you eat at home?_____
   What do you eat? _____
   _____
   How many weekdays do you eat out? _____
   Where/What do you eat?_____
   _____
2. Do you eat **lunch**? _____ Time: _____
   If yes, # of weekdays you bring your lunch? _____
   What do you bring? _____
   _____
   How many weekdays do you eat out? _____
   Where/What do you eat? _____
   _____
   Do you eat **dinner**? _____ Time: _____
   If yes, # of weekdays you cook? _____
   What do you have? _____
   _____
   How many weekdays do you eat out? _____
   Where/What do you eat? _____
   _____
3. Do you have snacks between meals? _____
   If yes, what do you eat and what time?
   Mid-morning? _____
   Mid-afternoon? _____
   After dinner? _____
   Middle of the night? _____
4. Do you consume any of the following drinks? If yes, provide quantity per day or week.
   Soda – regular or diet _____
   Coffee – cream and/or sugar _____
   Alcohol – type? Mixers? _____
   Tea – sweet or unsweetened _____
   Fruit Juice, Kool-Aide, Sports Drinks _____
5. How much water do you drink per day? _____
   _____
6. On average, how many servings of fruits and vegetables do you get each day? (Remember, a serving is ½ cup fruit, ½ banana, 1 cup raw vegetables or ½ cup cooked.) _____
   _____
7. When you eat at a "Fast Food" restaurant, what do you typically order? _____
   _____
   How many times per week do you eat fast food? ___
   _____
8. What are your three favorite foods?
   1. _____
   2. _____
   3. _____

## Part 3 Weight History

1. How long have you been overweight?
   a. 1 year or less
   b. 2 to 5 years
   c. 6 to 10 years
   d. Over 10 years
   e. Since childhood
2. When did you begin to gain weight?
   a. After childbirth
   b. After marriage
   c. After a stressful event
   d. Change of job/or home
   e. Other _____
3. Have you tried to lose weight before? Yes No
   If yes, number of serious attempts? _____
4. Weight at 20 yrs. Old?_____Weight 1 yr. ago?_____

| Diet Type or Diet Center? | How Long on Diet? | Why did you drop out? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Part 4: Activity History

1. Do you work outside the home? Yes: f/t p/t No
   If yes, Occupation? _____
2. Is your lifestyle sedentary or active? _____
3. Do you have a consistent exercise/activity routine?
   _____
   If yes, what do you do? _____
   _____
   How often and for how long? _____
   _____