New Patient Questionnaire (Health Care Analysis)

Today's Date: ________________________

First Name:	**Last Name:**	**Email:**		
________________________	____________________	____		
Address:		**City:**	**State:**	**Zip Code:**
____		_______________	___________	___________
Home Phone:	**Work Phone:**	**Cell Phone:**	**Date of Birth:**	
________________________	____________________	_______________	_________________________	
Age:	**Height:**	**Weight:**	**Gender:**	
________________________	____________________	_______________	☐ **Male** ☐ **Female**	
How did you hear about us?	**If referred by someone, who?**	**I "opt in" to receive electronic communication:**		
________________________	__________________________	_________ **Initial**		

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

Who encouraged you to lose weight?: ____

How important to you is it to lose weight?: ____

What important reason, special occasion, or goal date do you have to lose weight?: ________________________________

____

How many pounds would you like to lose?: ___________ How fast do you want lose the weight?: _____________

Would you commit to one visit a week?: ☐ Yes ☐ No

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 have been able to stick with a diet?: ____

Does your family support your weight loss efforts?: ☐ Yes ☐ No

Have you been advised by your family physician to lose weight?: ☐ Yes ☐ No

If you answered Yes, what is your doctor's name?: ____

Have you ever considered Gastric Bypass surgery, or Liposuction? ☐ Yes ☐ No

Do you eat because of emotions? ☐ Yes ☐ No

If you answered yes, please explain: ____

____

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

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals (How many per day? ______)

Current level of exercise (Please check one that applies):

- ☐ 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.)

Have you ever been interested in looking 5 to 10 years younger? ☐ Yes ☐ No

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Thyroid Imbalance
- ☐ Hormone Cancer, Breast, Cervical, Testicular, Uterine, Ovarian, etc.
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfa, other medications or foods.
- ☐ Deep Vein Thrombosis (Blood Clot), Pulmonary Embolism or clotting disorders.

If you checked any of the above, please explain: ____

____

Have you ever been hospitalized, under medical care, or admitted into rehab for alcohol or drug treatment?: Yes / No

If you answered yes, please explain: ____
____

Please list all medications (including over the counter, and vitamins/supplements) you are currently taking, including dose, frequency and reason.

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

Food and Chemical Sensitivity

Please complete the following survey using the key below

☑ ☐ ☐ ☐ = No symptoms (0 points)
☐ ☑ ☐ ☐ = Mild symptoms (1 point)
☐ ☐ ☑ ☐ = Moderate symptoms (2 points)
☐ ☐ ☐ ☑ = Severe symptoms (3 points)

Weight:

☐ ☐ ☐ ☐ Inability to lose weight
☐ ☐ ☐ ☐ Food cravings
☐ ☐ ☐ ☐ Binge eating
☐ ☐ ☐ ☐ Nausea or vomiting
☐ ☐ ☐ ☐ Water retention

Digestive Symptoms:

☐ ☐ ☐ ☐ Stomach pains or cramping
☐ ☐ ☐ ☐ Constipation
☐ ☐ ☐ ☐ Diarrhea
☐ ☐ ☐ ☐ Reflux or heartburn
☐ ☐ ☐ ☐ Bloating
☐ ☐ ☐ ☐ Gas

Head and Ears:

☐ ☐ ☐ ☐ Migraines
☐ ☐ ☐ ☐ Headaches
☐ ☐ ☐ ☐ Earaches
☐ ☐ ☐ ☐ Wheezing
☐ ☐ ☐ ☐ Ear infection
☐ ☐ ☐ ☐ Ringing in ear

Eyes and Throat:

☐ ☐ ☐ ☐ Itchy eyes
☐ ☐ ☐ ☐ Watery eyes
☐ ☐ ☐ ☐ Sore throat
☐ ☐ ☐ ☐ Persistent canker sores

Sinus and Respiratory:

- ☐ ☐ ☐ ☐ Stuffy or runny nose
- ☐ ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ ☐ Chest congestion
- ☐ ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ ☐ Frequent sneezing

Skin Disorders:

- ☐ ☐ ☐ ☐ Dermatitis
- ☐ ☐ ☐ ☐ Excessive sweating
- ☐ ☐ ☐ ☐ Rashes
- ☐ ☐ ☐ ☐ Hives
- ☐ ☐ ☐ ☐ Eczema

Emotional and Mental:

- ☐ ☐ ☐ ☐ Depression
- ☐ ☐ ☐ ☐ Anxiety
- ☐ ☐ ☐ ☐ Mood swings
- ☐ ☐ ☐ ☐ Irritability
- ☐ ☐ ☐ ☐ Poor concentration

Energy:

- ☐ ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ ☐ Lethargy
- ☐ ☐ ☐ ☐ Restlessness
- ☐ ☐ ☐ ☐ Insomnia
- ☐ ☐ ☐ ☐ Hyperactivity

Other Symptoms:

- ☐ ☐ ☐ ☐ Joint pain
- ☐ ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ ☐ Irregular heartbeat
- ☐ ☐ ☐ ☐ Chest pains
- ☐ ☐ ☐ ☐ Muscle aches

OFFICE USE ONLY

Total Points:

____
_

Please list any symptoms you experience that were not previously mentioned: ______________________________________

____

____

What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness “My results are my top priority.”
- ☐ Time “I want results quickly.”
- ☐ Service “I need extra support along the way.”
- ☐ Ease “I have a difficult time losing weight.”

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_______________________________________ _________________________

Signature: **Date:**

Notes:____

____

____

Patient HIPAA Acknowledgment and Consent Form

Patient Name: ____ Date of Birth: ________________

______ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received or reviewed Healthy Weight Loss Solution's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

☐ I wish to receive a copy of Notice of Privacy Practices

☐ I do not wish to receive a copy of Notice of Privacy Practices

With this consent, Healthy Weight Loss Solutions may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Healthy Weight Loss Solutions may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Healthy Weight Loss Solutions may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payments and health care operations, such as appointment reminder cards and patient statements. I have the right to request that Healthy Weight Loss Solutions restrict how it uses or discloses my PHI to carry out TPO (treatment, payment and health care operations). The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Healthy Weight Loss Solutions to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Healthy Weight Loss solutions may decline to provide treatment to me.

____ ________________

Signature of Patient or Legal Guardian Date

____

Print Patient's Name