DAY	Date	Time
DOC:		Acct#
Conf: Yes No		Staff:

ALLEGHENY MEDICAL
COMPLETE CARE. ONE PLACE.

WEIGHT LOSS INTAKE FORM

NAME: _____ Date of Birth: _____ SOC. SEC #: _____
First MI Last

ADDRESS: _____ Email:_____
Street City State Zip

Marital Status: ____ H#_____ C#_____ W#_____ Best # to reach you? H☐C☐W☐

How did you hear about us?_____ How much weight are you wanting to lose?_____

LIGHTEN UP: ☐ **6 Week**___ ☐ **10 Week**___ ☐ **14 Week**___ ☐ **20 Week**___ ☐ **Injections Only**

Please allow us to help you with **all** your health care needs and our advisor will discuss them with you. Please mark all that interest you and/or for someone else.

☐ Back Pain	☐ Migraines	☐ Primary Care	☐ General Health Consult
☐ Neck Pain	☐ Fibromyalgia	☐ Physical Therapy	☐ Stress Testing
☐ Knee Pain	☐ Head Injury	☐ Chiropractic	☐ Lab Work
☐ Shoulder Pain	☐ Spinal Injury	☐ Mental Health Care	☐ Hormone Testing
☐ Other Pain	☐ Arthritis	☐ Women's Health Care	☐ Allergy Testing

Referrals:_____

In Case of Emergency

Contact_____ (Relationship)_____

Phone Number_____

Insurance Information (only fill out if becoming a New Medical Patient_

Primary_____ Secondary_____

Plan_____ Group#_____ Policy Holder_____

Policy #_____Contact Person_____

Medical History: (please check all that apply)

☐Heart Disease	☐Kidney Disease	☐Arrhythmia	☐Liver Disease	☐Muscular Disease
☐Cancer	☐Arthritis	☐Anxiety	☐Nervous Disorder	☐Anemia
☐High Blood Pressure	☐Asthma	☐Dizziness	☐Cardiovascular Disease	☐Ulcers
☐Diabetes	☐Migraines	☐Head Injury	☐Spinal Injuries	☐Heartburn
☐High Cholesterol	☐Sleep Apnea	☐Seizures	☐Shortness of Breath	☐Frequent Headaches
☐Thyroid Disease	☐GI Disorder	☐Stroke	☐Irregular Heartbeat	☐Other

Please list all current medications/supplements:

Medications/Supplements	Doses	Frequency

Family Medical History:

Relative	Living Y/N	Age (or at death)	Overweight Y/N	Slight (5-15 lbs)	Moderate (16-49 lbs)	Very (50+ lbs)
Mother	NO		NO			
Father	NO		NO			
Sibling	NO		NO			
Sibling	NO		NO			
Sibling	NO		NO			
Maternal Grandmother	NO		NO			
Maternal Grandfather	NO		NO			
Paternal Grandmother	NO		NO			
Paternal Grandfather	NO		NO			

Weight History

Height_____ Weight_____ Weight 1 Year Ago_____ Lowest Adult Weight_____

At what age? (Lowest weight)_____ How Long?_____

Why do you wish to lose weight at this time?_____

What is your personal goal weight at this time?_____

Has your Primary Care Physician suggested a weight loss/exercise program? Yes No

If yes, what type of treatment was recommended? Exercise Diet Medication

Please list information below:

Diet Program	Year Started	Weight Loss	Reason-Stopped	Medication/Supplements

Have you ever had weight loss surgery? Yes ☐ No ☐

If yes, list approximate date_____

Have you ever had nutrition counseling? Yes ☐ No ☐

If yes, by whom_____

Are you currently receiving psychiatric/psychological service at this time? Yes ☐ No ☐

If yes, by whom_____

Are you currently being treated for depression? Yes ☐ No ☐

Have you ever been diagnosed with an eating disorder? Yes ☐ No ☐

Social and Personal History

Do you live alone? Yes No Do you have children? Yes ☐ No ☐ yes, what age(s)?_____

Do you currently exercise? Yes No If yes, frequency? _____

Any injuries preventing you from working out?_____ Does your weight affect work?_____

Does your weight affect your home life?_____ What are your hobbies?_____

What activities do you enjoy?_____

Please circle appropriate box that might contribute to your weight gain:

Emotional Eating	Portion Sizes	Stress Eating
Compulsive Eating	Late Night Eating	Lack of Exercise
Injury Prevents Exercise	Trouble knowing what foods to eat	Unmotivated

Do you smoke cigarettes? Yes ☐ No ☐ # Per day_____ # of Years_____

Do you drink alcohol? Yes ☐ No ☐ Type_____ # Per week_____

Do you use illegal drugs? Yes ☐ No ☐ Type _____ # Per week_____

List other reasons for weight gain:

_____

CONSENT FOR WEIGHT LOSS PROGRAM

Pt. Name_____

I came to Allegheny Medical for the purpose of participating in their medically supervised Weight Loss Program. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me in determining whether I am an appropriate candidate for the Weight Loss Program.

I understand that the Weight Loss Program is for individuals interested in safely losing weight with a high percentage of body fat and considered obese (based on Body Fat and Body Mass Index Standards) unless otherwise determined by the physician. I understand that I can participate in the complete program or individual components of the program

I understand that any medication given during the program is for the purpose of weight loss and will have time limitations determined by the physician.

The benefits and risks of treatment have been discussed with me and I understand the explanation. I have had the opportunity to ask questions and understand the information given to me.

I understand that Allegheny Medical cannot guarantee any specific results of any examination or treatment. I release Allegheny Medical, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Allegheny Medical or its employees.

In return for services to be provided by Allegheny Medical, I promise to pay and guarantee payment for services rendered to me. Such payments are due and payable at the time of the consultation.

By signing this document, I certify that I have read and understand its contents and that the information provided by me is accurate and complete.

A copy of the document may be utilized the same as the original.

Patient _____ Date_____

Witness_____ Date_____

CONSENT FOR MIC-B COMPLEX INTRAMUSCULAR INJECTION

I, _____ consent to have an Intramuscular injection of MIC-B Complex for the purpose of weight loss and weight management which can be given by_____ of Allegheny Medical, P.C.

The procedure has been explained to me, as well as the possible side effects/adverse reactions.

Reason for the injection: Weight Loss
Site: IM
Allergies:_____

Patient Signature: _____ Date:_____

Staff Signature: _____ Date:_____

PROVIDER EVALUATION

PATIENT NAME: _____ **MEDICAL RECORD#:**_____

MEDICATIONS:_____

_____

ALLERGIES: _____**Latex: ____YES ____NO**

PAST MEDICAL HISTORY: _____

PAST SURGICAL HISTORY: _____

VITALS:

BP: ____/____ P: ____ RR: ____ T: ____F HT: _____ WT: _____ BMI: ____% BF: ____

METABOLIC TESTING: _____

BLOOD WORK: ____N ____ABN **ECG: ____N ____ ABN**

PHYSICAL EXAMINATION:

____ **GENERAL:** Pt alert and in no acute distress. Appropriately dressed and maintaining eye contact throughout examination. Pt exhibits coherent thought process during physical exam.

____ **EYES:** PERRLA. Sclera white with pink conjunctiva. Full EOM.

____ **NECK:** Oropharynx and tonsils smooth without exudate, inflammation or drainage. No thyromegaly/ lymphadenopathy noted.

____ **CARDIAC:** Cardiac rhythm regular with clear S1 and S2, no MRG. No bruits noted over carotid arteries. No palpation of thrills, heaves, or lifts noted. Apical impulse located at 5th intercostal space about 2cm left of the midclavicular line. Pulses +2 and equal throughout. Extremities warm with no peripheral edema noted. No JVD noted.

____ **LUNGS:** Lungs CTA with no adventitious breath sounds. Good air movement bilaterally. Respiration rhythm and depth normal.

____ **ABD:** Nondistended, soft abdomen with no tenderness to palpation. Symmetrical abdomen, with midline umbilicus. No visible pulsations or hernia noted. BS normoactive x4 quadrants. No bruits noted or masses. On inspiration liver edge firm, smooth and nontender. No organomegaly or splenomegaly noted.

____ **MUSCULOSKELETAL:** Posture erect with bilaterally symmetry of extremities. No clubbing, cyanosis or edema noted in extremities. Extremities warm to touch with equal peripheral pulses +2 throughout.

COMMENTS:

_____

PLAN:

Cleared for weight loss program: ____ YES ____ NO

Medications:

LIPOTOCIN PLUS 2cc IM 1x/week	____ YES ____ NO
PHENTERMINE 37.5mg PO QD	____ YES ____ NO
HYDROCHLOROTHIAZIDE 25mg PO QD	____ YES ____ NO
NATUROPATHIC SUPPLEMENTS	____YES ____NO

Contraindications to Medications: _____

CONSULTS:

Nutritional: ____YES ____NO

Exercise: ____YES ____NO

The risks and benefits of treatments and medication side effects were reviewed with patient and patient expressed understanding of the weight loss program. Follow-up visit with medical provider in initial 2 weeks with medication.

_____ _____

Client Signature **Date**

_____ _____

Provider Signature **Date**

CREDIT/DEBIT CARD AUTOMATIC WITHDRAWAL
PAYMENTAUTHORIZATION FORM FOR LIGHTEN UP PROGRAM

A. APPLICANT INFORMATION
Last Name_____ First Name _____
Name as it Appears on Debit/Credit
Card_____
Billing address_____
City_____ State_____ Zip_____ Country
_____

B. CREDIT/DEBIT AUTHORIZATION
Select one: Visa Mastercard Discover Other _____
Credit/Debit Card Number_____ Card Expiration Date_____
CVS_____
1st Withdrawal Date_____
2nd Withdrawal Date _____
3rd Withdrawal Date _____
4th Withdrawal Date_____
5th Withdrawal Date_____
6th Withdrawal Date_____
Other:_____
Select One: 6 Week 10 Week 14 Week 20 Week Injections
Total Program Price_____
I authorize Allegheny Medical or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for payment of the medically supervised weight loss program which I am signing up for. I understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the program's terms, conditions, and provisions, including that program's premium payment and grace period provisions.

Signature_____Date_____

Staff
Signature_____Date_____

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