



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

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.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Migraines | <input type="checkbox"/> Primary Care | <input type="checkbox"/> General Health Consult |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Stress Testing |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Lab Work |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Mental Health Care | <input type="checkbox"/> Hormone Testing |
| <input type="checkbox"/> Other Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Women's Health Care | <input type="checkbox"/> 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)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Muscular Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Anemia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Spinal Injuries	<input type="checkbox"/> Heartburn
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Seizures	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> GI Disorder	<input type="checkbox"/> Stroke	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> 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						
Father						
Sibling						
Sibling						
Sibling						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

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 If 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
PAYMENT AUTHORIZATION 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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Missed Appointment and Cancellation Policy

Our goal is to provide quality individualized care in a timely manner to each of our patients. No-shows, late arrivals, and cancellations inconvenience those individuals who need access to our care. We would like to review with you our policy regarding missed appointments.

CANCELLATION OF AN APPOINTMENT/ MISSED APPOINTMENT

Appointments are in high demand. If you need to reschedule an appointment for any reason we require 24 hour notice. This policy enables us to better utilize available appointments for patients in need of medical care. A cancellation is considered late when the appointment is cancelled without 24 hour advanced notice. We will charge a \$75 missed appointment fee if we do not receive a 24 hour notice of cancellation. If a second appointment is missed we will charge the cost of services that would have been incurred at the time of the appointment.

LATE ARRIVALS

Patients arriving 10 minutes or later for an appointment will be asked to reschedule the appointment for another day. If possible, an attempt will be made to reschedule the same day in the next open appointment slot. This appointment may be brief in nature due to the need to work you in between other scheduled patients.

I have read and understand the Missed Appointment and Cancellation Policy of Allegheny Medical and I agree to its terms.

Patient Signature

Date