NORTH TEXAS CLINICAL WEIGHT LOSS

3730 N. Josey Lane, Suite 101, Carrollton, Texas 75007 ~ 214-731-THIN (8446)

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

By signing below, you acknowledge that you have received the HIPAA Notice of Privacy Practice from North Texas Clinical Weight Loss Center regarding your health information for treatment, payment, and health care operation purposes. “Protected Health Information” means any information, whether oral or recorded, in any medium or form by the health care provider that relates to the past, present or future mental health or physical condition of an individual.

North Texas Clinical Weight Loss Center reserves the right to have absolute authority on any modification or amendment to this Notice from time to time. Any alterations will be made clear and posted at the patient service location. In addition, a date will be made clear when upcoming changes will come into effect and an up to date copy of any current Notice will be available upon request.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE RECEIVED NOTICE

PRINTED NAME OF PATIENT ____

PATIENT SIGNATURE _________________________ DATE _____________

INITIALS OF PARENT OR GUARDIAN, IF PATIENT IS UNDER 18 YEARS OF AGE _______

STAFF INITIAL ______________

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We may utilize the appetite suppressant medication, Phentermine, together with nutritional counseling and diet recommendations, as part of our medically supervised weight loss program and because of possible complications related thereto,

YOU CANNOT TAKE THE PHENTERMINE *IF* ANY OF THE FOLLOWING APPLIES:

You currently have any of the following conditions:

- Uncontrolled high blood pressure
- Hyperthyroidism
- Heart disease (including irregular beats)
- Pregnancy (or are presently breastfeeding)
- Seizure disorder
- Glaucoma

You plan to have major surgery within the next two weeks.

You have a BMI (body mass index) of less than 27.

You are less than 16 years old. Between 16-18 years old, you must have a BMI of at least 30.

You are currently taking any of these medications:

- Nardil
- Pamate
- Marplane
- Coumadin
- Certain cardiac drugs – ask if unsure
- MAOI's within the past two weeks
- Glaucoma medications (for increased pressure in your eyes)
- Adderall, Concerta, or any other stimulant for Attention Deficit Disorder (ADD/ADHD) or for any other condition

You have any other prohibitive condition as determined by the medical provider.

By signing below, I affirm that I have read and understood the above information, that I am not taking any of the medications listed, nor do I have any of the disqualifying conditions stated above.

Patient signature ____

Staff initials ___________

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Patient Medical History

Please fill this form out as accurately as possible as this information will assist us in assessing your problem areas and establishing your medical weight loss and management needs.
Thank you for your time and patience in completing this form.

First Name _________________ Last Name __________________ Date of Birth __________ Sex: M / F

Address ____________________________________ City ________________ State _____ Zip _____

Phones: Home ___________________ Work __________________ Mobile _____________________

Email: _____________________________________ Occupation: ______________________________

Marital Status: Married / Divorced / Separated / Single (never married) / Widowed

Number & Ages of Children (if any): _____________________________

YOUR HEALTH HISTORY

To the best of your knowledge are you in good health? Yes / No

Are you under a Doctor's care at the present time? Yes / No

If yes, for what are you being treated? ____

Doctor's Name and Phone Number ____

DON'T HAVE A FAMILY DOCTOR? WE RECOMMEND YOU ESTABLISH A RELATIONSHIP WITH ONE.

Previous diets you have followed? ____

Do you have any allergies to any medications? Yes / No
If Yes, to which medications? ____

Do you have any food allergies? Yes / No
If yes, to which foods? ____

Do you suffer from Frequent Headaches? Yes / No
(If you take medication for headaches, what do you take?) ________________________________

Have you ever taken Phentermine? Yes / No If yes, when & for how long? _______________________

Are you taking any prescription and/or over the counter medications, at the present time? Yes / No
If yes, please specify:

Name of Medication	Taken for

Medical History Form, cont.

Please check all that apply:

______ High Blood Pressure	______ Typhoid Fever
______ Diabetes (What Age?_______)	______ Rheumatic Fever
______ Cancer	______ Gallbladder Disorder
______ Kidney Disease	______ Cholera
______ Thyroid Dysfunction	______ Arthritis
______ Heart Disease/Stroke	______ Measles
______ Chest Pain	______ Mumps
______ HIV / AIDS	______ Scarlet Fever
______ Hepatitis (type ______)	______ Whooping Cough
______ Tuberculosis	______ Bleeding Disorder
______ High Cholesterol	______ Gout
______ Swelling of the Feet or Hands	______ Malaria
______ Asthma	______ Osteoporosis
______ Pneumonia	______ Tonsillitis
______ Migraines / Headaches	______ Pleurisy
______ Epilepsy	______ Liver Disease
______ Constipation	______ Chicken Pox
______ Glaucoma	______ Infertility
______ Polio	______ Eating Disorder
______ Jaundice	______ Psychiatric Illness/Disorders
______ Lung Disease	______ ADD/ADHD
______ Ulcers	______ Nervous Breakdown
______ Anemia	______ Alcohol Abuse
______ Menopause	______ Drug abuse

Other Serious Illness/Disease (Please explain) ____
____

History of Past Surgeries/Hospitalizations:

Specify: ____ Date: _________________________

Specify: ____ Date: _________________________

Specify: ____ Date: _________________________

Daily Activity Level

Select one only:

____ **INACTIVE**. No regular exercise and a sit-down job.

____ **LIGHT TO MODERATE**. Occasionally involved in activities such as weekend golf, tennis, or cycling.

____ **HEAVY/VIGOROUS**. Participation in extensive physical exercise for at least 60 minutes.

Rate your energy level: ____ (1=Low, 10=High)

When you are under stress do you tend to overeat? Yes / No

Do you think you are currently undergoing a stressful situation? Yes / No

What is your "Comfort Food?" ____

Current Weight _________(lbs.) Height __________ Desired Weight _________(lbs.)

Weight at 20 years of age_________(lbs.) Weight one year ago_________(lbs.)

What time frame would you like to be at your desired weight? ________________________

Do you smoke? Yes / No If yes, how many cigarettes/packs a day: _____ For how many years? ____

If you smoked previously, when did you finally quit? ________________________

FAMILY MEDICAL HISTORY

Father: If living, current age ____ Is he in good health? Yes / No If deceased, age at death ____

Mother: If living, current age ____ Is she in good health? Yes / No If deceased, age at death ____

Has any **Blood Relative** (i.e. Father, Mother, Brother, Sister) had any of the following Diseases?

Heart Disease	Who? __________________________	At What Age? ___________
High Cholesterol	Who? __________________________	At What Age? ___________
Diabetes	Who? __________________________	At What Age? ___________
Cancer	Who? __________________________	At What Age? ___________
Obesity	Who? __________________________	At What Age? ___________
Glaucoma	Who? __________________________	At What Age? ___________
Asthma	Who? __________________________	At What Age? ___________
Epilepsy	Who? __________________________	At What Age? ___________
High Blood Pressure	Who? __________________________	At What Age? ___________
Kidney Disease	Who? __________________________	At What Age? ___________
Tuberculosis	Who? __________________________	At What Age? ___________
Psychiatric Disorder	Who? __________________________	At What Age? ___________
Heart Disease/Stroke	Who? __________________________	At What Age? ___________
HIV/Hepatitis	Who? __________________________	At What Age? ___________

The above information is correct to the best of my knowledge.

Signature ________________________________ **Date** __________________

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Please list 5 SIGNIFICANT reasons you personally want to lose weight.
(i.e. what really motivated your decision to get started now)

1.____

2.____

3.____

4.____

5.____

WHAT TO DO ABOUT THE MUNCHIES?

In order to triumph over cravings or overeating, you must have thought ahead and have made plans of action ready to implement when needed.

List AS MANY SPECIFIC things you can do instead of eating when you get the urge to munch or overeat (i.e. hobbies, exercise, chores, etc.).

Home:

1.____

2.____

3.____

4.____

Work or any other relevant situation/place:

1.____

2.____

3.____

4.____