# NEW PATIENT INTAKE FORM: Weight

HPC does not accept insurance for payment:

Name: (First)_____(Last) _____(MI)_____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
Phone: (Home/Cell)_____Gender: _____M_____F
ADDRESS:_____City:_____
State: _____Zip_____
Driver's License Number: _____ State_____
Cell phone: _____ Email: _____

Before you begin your weight loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

Please list five reasons you want to lose weight:

1._____

2._____

3._____

4._____

5._____

Describe the physical benefits you hope to get by losing weight:
_____
_____

Describe the functional benefits you hope to get by losing weight:
_____
_____

Describe the medical benefits you hope to get by losing weight:
_____
_____

Describe the psychological benefits you hope to get by losing weight:
_____
_____

Comments:
_____
_____

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Goal setting is the "how" of weight loss. Motivators are the "why." When setting goals, utilize the SMART technique:

| SMART | Technique | Example |
|---|---|---|
| Specific | Who, what, where, when, how… | "I want to lose 10 pounds in two months." |
| Measureable | How will you track? | 10 pounds in 8 weeks = 1.25 pounds/week |
| Attainable | Resources you have available, previous experience | "I have been able to do this before, and now I have new tools from my doctor!" |
| Relevant | Why this goal is important | Review your motivators |
| Timely | Set benchmarks and deadlines | "Focusing for two month intervals works for me." |

Please list three goals you would like to achieve during your treatment:

1._____

2._____

3._____

How does your weight is affect your life and health? _____

_____

_____

**Weight History**

When did you first notice that you were gaining weight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? ☐ Y / ☐ N If so, when? _____

How much did you weigh: one year ago? _____ Five years ago? _____ 10 years ago? _____

Life events associated with weight gain (check all that apply):

☐ Marriage ☐ Divorce ☐ Pregnancy ☐ Abuse ☐ Illness

☐ Travel ☐ Injury ☐ Nightshift work ☐ Job change ☐ Quitting smoking

☐ Alcohol ☐ Drugs

☐ Medication (please list: _____)

Previous weight-loss programs (check all that apply):

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins

☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet

☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____

# NEW PATIENT INTAKE FORM: Weight

What are your greatest challenges with dieting? _____

_____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen ☐ Wegovy/Ozempic
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion ☐ Mounjaro
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave

Other (including supplements): _____
What worked? _____
What didn't work? _____
Why or why not? _____

**Nutritional History**

How often do you eat breakfast? _____days per week at _____:_____ a.m.
Number of times you eat per day: _____What beverages do you drink? _____
Do you get up at night to eat? Y / N If so, how often? _____times
List any food intolerances/restrictions: _____

Food triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking reward
☐ Parties ☐ Eating out ☐ Other: _____

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ Fast food
☐ High fat ☐ Large portions

Favorite foods: _____

**Medical History**

Exercise type: _____
Duration: _____hours _____minutes Number of times per week: _____
Does anything limit you from exercising? _____
How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack ☐ Angina ☐ Gallbladder stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ GERD/Indigestion/reflux ☐ Thyroid Issues
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Arthritis ☐ Polycystic Ovarian Syndrome ☐ Seizures
☐ Bipolar ☐ Glaucoma ☐ Polycystic Kidney Disease
☐ Kidney Stones ☐ Cancer (type/s): _____
Have you ever been diagnosed with an eating disorder? ☐ N If yes, which one? _____

Past surgical history (check all that apply):

☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

# NEW PATIENT INTAKE FORM: Weight

**Social History**

Smoking: ☐ Never ☐ Current smoker (_____packs/day) ☐ Past smoker (quit _____years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____
Marijuana: ☐ Never ☐ Current user (_____times/day)

Allergies:
(Medications)_____
(Food)_____

Medications: Please be thorough:

Current Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

| Name | Dose | Frequency | |
|---|---|---|---|
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# NEW PATIENT INTAKE FORM: Weight

**Family History**

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____

Other: _____

**Gynecologic History**

Age periods started? _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ _____ Number of children:

Age of first pregnancy: _____ Age of last pregnancy: _____

**System Review**

(Check all that apply)

☐ Recent weight loss more than 10 pounds

☐ Recent weight gain more than 10 pounds

| | | |
|---|---|---|
| ☐ Acne | ☐ Skin rash | ☐ Cough |
| ☐ Snoring | ☐ Shortness of breath | ☐ Chest pain |
| ☐ Difficulty breathing when flat | ☐ Fainting/Blacking out | ☐ Palpitations |
| ☐ Swelling ankles/extremities | ☐ Abdominal pain | ☐ Bloating |
| ☐ Constipation | ☐ Diarrhea | ☐ Food intolerance |
| ☐ Dysphagia/difficulty swallowing | ☐ Indigestion | ☐ Nausea/vomiting |
| ☐ Increased appetite | ☐ Decreased appetite | ☐ Heartburn |
| ☐ Gas and bloating | ☐ Urinary frequency/urgency | ☐ Slow urine flow |
| ☐ Nighttime urination | ☐ Blood in stools | ☐ Back pain (upper) |
| ☐ Back pain (lower) | ☐ Joint pain | ☐ Muscle aches/pain |
| ☐ Dizziness | ☐ Headaches | ☐ Seizures |
| ☐ Weakness/low energy | ☐ Anxiety | ☐ Depression |
| ☐ Insomnia | ☐ Memory loss | ☐ Inability to concentrate |
| ☐ Mood changes | ☐ Nervousness | ☐ Loss of interest |
| ☐ Cold intolerance | ☐ Excessive sweating | ☐ Hair changes |
| ☐ Heat intolerance | ☐ Blood clots | ☐ Fatigue/tiredness |

**(Women only)**

| | | |
|---|---|---|
| ☐ Absence of periods | ☐ Hot flashes | ☐ Change in bladder habits |
| ☐ Abnormal/excessive menstruation | ☐ Facial hair | |

Comments: _____

_____

_____

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# NEW PATIENT INTAKE FORM: Weight

## HPC Weight Loss Consent Form

I, _____, authorize Human Performance Clinic and associated healthcare providers, to help me in my weight-reduction efforts. I understand that my program may consist of a prescribed diet, increase in physical activity, instruction on behavior modification, and the use of anti-obesity medications.

I understand that any medical treatment may involve risks as well as benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks associated with obesity management programs are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and other heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with having obesity may include but are not limited to: high blood pressure; diabetes; heart attack; heart disease; cancer; arthritis of the joints, including hips, knees, feet, and back; sleep apnea; and sudden death. I understand that these risks may increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that my plan will be successful. I also understand that obesity is a chronic, lifelong condition that will require permanent changes in eating habits, activity level, and behavior to be effective.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (printed) Witness

_____ _____

Patient Signature Date

*(or signature of person with authority to consent for patient)*

Send this completed form in to Fax: 804-843-8556 or Email: DrWelch@myhumanperformance.com

# NEW PATIENT INTAKE FORM: Weight

## CONSENT FOR USE OF ANTI-OBESITY CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT Human Performance Clinic WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND [your name] DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Some anti-obesity medications are considered “controlled medications.” By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only Human Performance Clinic will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at Human Performance Clinic and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, or other medication use**. I agree that I will be honest in disclosing this information and will notify my provider(s) at [YOUR CLINIC NAME] of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by [YOUR NAME]. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered “off label” or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) at [YOUR CLINIC NAME] are experienced specialist(s) in obesity medicine who will, at times, elect or choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at [YOUR CLINIC NAME].

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: _____ Date: _____

Patient Name (printed): _____

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Financial Policy

Thank you for selecting Human Performance Clinic for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.
Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept all major credit cards.

I _____ authorize Human Performance Clinic to charge my credit card for
**PRINT FULL NAME** services rendered.

Lab Charge Amount: $ _____ USD

Monthly Charge Amount: $ _____ USD

CREDIT CARD

**CARD NUMBER** _____

**CARD CVC** _____

**EXPIRATION DATE** _____

**BILLING ADDRESS** _____

_____

**BILLING ZIP CODE** _____

**NAME ON CARD** _____
(As it appears on card)

_____
**SIGNATURE** **DATE**

**Your T Shirt Size** _____

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