SOLUTIONS WEIGHT LOSS PATIENT REGISTRATION

Date:

□ Mr. □ Miss □ Mrs. □Ms. □Dr. □ Single □ Married □ Divorced □ Separated □Widow(er) □ Partner

Last Name First Name Middle

Gender: □ Male □ Female Birth Date:___/___/_____ Age: _____

SSN: Email Address:

Address:

City: State: Zip Code:

Phone Number Mobile Number: Fax Number:

Employer: Occupation: Work Number:

How Did You Hear About Us?

□ Billboard □ Coupon □ Direct Mailing □ Employee □ Web □ MD/Doctor □ Phone App
□ Newspaper □ Friend/Patient □ TV □ Drive by □ Radio □ Magazine □ Auto

Do you know anyone else in our program? If so, who? Who, if anyone, referred you?

EMERGENCY CONTACT

Name: Relationship: Phone Number: Work Number:

Medical insurance policies typically do not cover weight management care and related expenses, including laboratory testing, electrocardiograms, prescription medication and related supplements. Your primary diagnosis is overweight or obesity. Payment is due at the time of service. An appropriate receipt of payment will be provided, including a list of charges and descriptions of the office visit for the levels of service provided. The codes used for this purpose may or may not correspond to the codes used by insurance companies. Changes to "codes" will not be made for the use of any insurance company. Insurance companies may reimburse patient for expenses related to weight management; for instance, if weight management is part of the treatment of a comorbid condition. Reimbursement will not be made from the insurance company to the physician. Please note that Solutions Weight Loss will not present a bill to any insurance company for weight management services or related charges. Also, Solutions Weight Loss will not be obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard. If you are covered by Medicare you must complete and sign an ABN form prior to participation in this Weight Management Program.

PATIENT STATEMENT OF UNDERSTANDING

I have read and fully understand the above information related to insurance and participation in Solutions Weight Loss Program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Patient/Guardian Signature: Date:

Printed Name: If guardian, list relationship to the patient:

PATIENT HISTORY

All questions contained in this history form are strictly confidential and will become part of you medical record on file.

Physician: Physician Phone Number:

Specialist Physician: Specialist Physician Phone Number:

Date of last physical:___/___/_____ Date of last EKG:___/___/_____ Date of last Lab Work:___/___/____
Normal/Abnormal:_____ Normal/Abnormal:_____ Normal/Abnormal:_____

HEALTH HISTORY

Are you under a doctor's care at the present time? □ Yes □ No If yes, for what? _____

Is your general state of health (circle one): Excellent / Good / Fair / Poor

Alcohol Abuse	□	Drug Abuse	□	Irregular Pulse	□
Anemia	□	Eating Disorder	□	Kidney Disease	□
Arthritis	□	Epilepsy	□	Liver Disease	□
Asthma	□	Fainting Spells	□	Lung Disease	□
Bleeding Dz.	□	Fatigue	□	Mental Illness	□
Bloody Stool	□	Food Allergies	□	Migraines	□
Bronchitis	□	UTI	□	Moodiness	□
Cancer	□	Gallbladder Dz.	□	Nervousness	□
Chest Pain	□	Glaucoma	□	Obesity	□
Convulsions	□	Headaches	□	Rashes	□
Depression	□	Heart Disease	□	Short of Breath	□
Diabetes	□	High Cholesterol	□	Sleep Apnea	□
Diarrhea	□	Hypertension	□	Stroke	□
Dizzy Spells	□	Insomnia	□	Thyroid Disease	□
Menses irreg.	□	Panic Attacks	□	Anxiety	□
Ovarian Cysts	□	Anorexia	□	Hypoglycemia	□

MEDICATION ALLERGIES

Medication Name	Reaction	□ I do not have any known allergies

HOSPITALIZATIONS AND SURGERIES

Year	Reason/Diagnosis	Hospital

Current Prescribed Medications, over-the-counter drugs, dietary supplements (inc. vitamins, inhalers, etc)

Medication Name	Strength	Frequency

Behavior Style: (Please mark only one answer)

□ Your are always calm and easygoing □ You are usually calm and easy □ You are never calm □ You never let yourself relax

Health habits & Personal Safety (This section will be kept strictly confidential)

Exercise	□ Sedentary (no exercise)
	□ Mild Exercise (i.e. climbing stairs, walking three blocks, golf)
	□ Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes)

	□ regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more)			
Diet	Are you dieting?	□ Yes	□ No	
	If yes, are you on a physician-prescribed medical diet?	□ Yes	□ No	
	How many meals do you eat in an average day?			
	Rank your salt intake:	□ High	□ Medium	□ Low
	Rank your fat intake:	□ High	□ Medium	□ Low
Caffeine	Rank your caffeine intake:	□ High	□ Medium	□ Low
	What types of caffeine do you drink?	□ Coffee	□ Tea	□ Soda
	How many cups/cans per day?			
Alcohol	Do you drink alcohol?	□ Yes	□ No	
	If yes, what kind?	□ Beer	□ Liquor	□ Wine
	How many drinks per week?			
Tobacco	Do you use tobacco?	□ Yes	□ No	
	□ Cigarettes – packs/day:	□ Chew – times/day	□ Pipe – times/day	□ Cigars – Times/day
	How many years?			
	If you previously used tobacco, what year did you quit?			
Drugs	Do you currently use recreational or street drugs?	□ Yes	□ No	
	Have you ever taken street drugs with a needle?	□ Yes	□ No	
Sex	Are you sexually active? □ Yes □No	If yes, what form of birth control are you using?		
	Are you trying for a pregnancy?			
	Do you suffer from PMS (e.g. mood swings prior to menstruation)? □ Yes □ No			

WOMEN ONLY		
Date of last menstruation? / /		
How often do you get your period (days)?		
Heavy periods, irregularity, spotting or pain?	□ Yes	□ No
Are you breastfeeding?	□ Yes	□ No

WEIGHT HISTORY		
Current Weight _____ lbs	Height ____ ft ____in	GOAL WEIGHT _____ LBS
Lowest adult weight _____ lbs at _____ years old		
Highest adult weight _____ lbs at _____ years old		

1. What is the main reason you decided to lose weight?

1. When did you begin gaining excess weight?

1. What do you think is the main cause of your weight problems?

1. Describe your previous attempts at weight loss or previous diets you have followed? Results if possible.
1. Is your spouse or significant other overweight? □ Yes □ No If yes, by how much?
1. List any food allergies:
1. What foods do you crave?
1. What areas of your body are you most dissatisfied with?
1. What do you feel will be your obstacle(s) to successful weight loss?
1. Who plans the meals, shops and cooks at home?
1. Any additional comments you think would be helpful to the doctor.

Accuracy Agreement	
I hereby agree that the information contained in this Medical history is accurate to the best of my knowledge.	
Signature:	Date:

SOLUTIONS
WEIGHT LOSS
REAL DOCTORS! REAL RESULTS!