1150 Anderson Street
Clermont FL, 34711
(352-227-3000

INTAKE FORM: OBESITY & WEIGHTLOSS PROGRAM

LAST NAME: ______________________ FIRST NAME: ________________________ M.I.: ____________

DATE OF BIRTH: ______________ SSN: _______________ MARITAL STATUS: _____________ SEX: ______

HOME PHONE: ________________ CELL PHONE: _________________ EMAIL: __________________________

ADDRESS: ________________________________ ______________________ _________ ______________
STREET ADDRESS CITY STATE ZIP CODE

OCCUPATION: ____________________ EMPLOYER: _______________ PHONE NUMBER: __________________

EMERGENCY CONTACT

NAME: ____________________________ RELATIONSHIP: __________________ PHONE: __________________

MEDICAL HISTORY: AGE: ________ HEIGHT: __________ WEIGHT __________

ALLERGIES:

____

____

MEDICATIONS:

____

____

____

SOCIAL HISTORY:

TOBACCO USE_________________ ALCOHOL_____________________DRUG USE______________________

FAMILY HISOTRY:

____

____

MEDICAL HISTORY/SURGERIES:

- ☐ FOOD DISORDERS
- ☐ DEPRESSION/PSCYH DISORDER
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ CHRONIC PAIN

- ☐ DIABETES
- ☐ THYROID DISORDERS
- ☐ ELEVATED CHOLESTEROL
- ☐ HORMONAL IMBALANCE
- ☐ VITAMIN DEFICIENCIES

OTHER:

____

____

____

____

GYN: Pregnant or trying___________ **Last Menstrual Cycle**______________ **Birth Control**_________________

LIFESTYLE OVERVIEW

GOALS: ____

OBSTACLES: ____

How motivated are you on a scale of 1-10? ______________________________

What methods of weight loss have you used previously? Have you had any previous success?

____

____

DIET:

Diet restrictions:____

Food Recall-24hr:

____

____

____

Favorite Foods: ____

Foods I do not eat: ____

Water Intake: ____

PHYSICAL ACTIVITY:

Physical Limitations: ____

How many times have you exercise in the past month? ______________________________

SLEEP:

Bedtime:__________________ Hours of sleep nightly: __________________ Sleep Aides: ______________________

NOTES: (Any other pertinent information you would like to share)

____

____

____

COMMITMENT STATEMENT: (Write a commitment statement or motivational note to yourself)

____

____

____

____

____

Patient Signature: ____ Date: ____________________

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OBESITY & WEIGHT LOSS MANAGEMENT CONSENT FORM

I, ___________________________________, (patient/guardian) do hereby authorize Kemeisha Morgan, APRN and staff, to assist me with obesity management and weight loss reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise, and behavioral lifestyle changes and my treatment may include the use of appetite suppressants. I further understand that in order to continue to receive appetite suppressants, I must have regular follow up and show continued weight loss. Regarding the use of appetite suppressants, as with any prescription medication, I understand that there are potential risks involved. Side effects may include nervousness, constipation, insomnia, headaches, dry mouth, weakness, fatigue, medication allergy, increased blood pressure and increased or irregular heart rate. I understand that these and other risks could be serious or in rare cases life threatening.

Initial: _______ I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify your provider immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants.

Initial: _______ I agree not to take any other weight loss medications, other than those prescribed by Kemeisha Morgan, APRN and further agree to inform the staff of ANY changes in my medication or medical history.

Initial: _______ I understand that I can be successful without the use of appetite suppressants as long as I am following a reduced calorie nutrition plan and increasing my activity level, however the use of such medications may significantly help with my weight loss progress. I understand the risks associated with being overweight or obese include the possibility of high blood pressure, diabetes, heart disease, stroke, cancer, arthritis and pain of the joints, gallbladder disease and even sudden death.

Initial: _______ I understand that there is no guarantee that this program will work for me. I understand that I must follow the program as directed in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. I understand that these charges may or may not be covered by my insurance and Mini Health Clinic does not provide or fill out claim forms for insurance purposes. I also understand that payments are nonrefundable.

Initial: _______ By signing below I certify that I have read and fully understand this consent form and understand the risks and benefits associated with my treatment for weight loss.

DISCLOSURE OF HEALTH INFORMATION

Based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we request consent to share and retrieve your health information if necessary to provide you care.

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I hereby acknowledge that a copy of the Notice of Privacy Practices is available upon request to me by Mini Health Clinic.

It is in our office policy to require your reading and signing this consent form prior to treatment or medical services in our office. If you have any questions, please ask a staff member for clarification. I understand that I have the right to revoke this consent in writing, at any time, and that any revocation will become effective on the date it has been received by this office and will apply to the specific uses and disclosures as addressed above.

Patient Name: ____ Date: ____________________

Patient Signature (or guardian) ____