New Patient Weight Loss Packet

Today's Date: ______________

First Name: ______________ **Last Name:** ______________ **Email:** ______________

Address: ______________ **City:** ______________ **State:** ______________ **Zip Code:** ______________

Home Phone: ______________ **Work Phone:** ______________ **Cell Phone:** ______________ **Date of Birth:** ______________

Age: ______________ **Height:** ______________ **Weight:** ______________ **Gender:** ☐ Male ☐ Female

How did you hear about us?: ______________ **If referred by someone, who?:** ______________

Please answer the following questions honestly so we can do our best to help you reach your goals

Who encouraged you to lose weight?: ______________

How important to you is it to lose weight?: ______________

What important reason, special occasion, or goal date do you have to lose weight?: ______________

____

How many pounds would you like to lose?: __________ How fast do you want lose the weight?: __________

Would you commit to one visit a week?: ☐ Yes ☐ No

Have you ever attended any other weight reduction centers, if so, which ones?: ______________

What kinds of diets have you tried on your own?: ______________

What is the longest you have been able to stick with a diet?: ______________

Does your family support your weight loss efforts?: ☐ Yes ☐ No

Have you been advised by your family physician to lose weight?: ☐ Yes ☐ No

If you answered Yes, what is your doctor's name?: ______________

Do you eat because of emotions?: ☐ Yes ☐ No

If you answered yes, please explain: ______________

____

____

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On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals (How many per day? ______)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Hormonal Cancer
- ☐ Thyroid Imbalance
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfur, food or medication
- ☐ Vegetarian

If you checked any of the above, please explain: ______________________________

____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?: ☐ Yes ☐ No

If you answered yes, please explain: ______________________________

____

Please list all medications you are currently taking, including doses and reasons for taking

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

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Symptom Survey

Please complete the following survey using the key below

☑ ☐ ☐ ☐ = No symptoms (0 points)
☐ ☑ ☐ ☐ = Mild symptoms (1 point)
☐ ☐ ☑ ☐ = Moderate symptoms (2 points)
☐ ☐ ☐ ☑ = Severe symptoms (3 points)

Weight:

☐ ☐ ☐ ☐ Inability to lose weight
☐ ☐ ☐ ☐ Food cravings
☐ ☐ ☐ ☐ Binge eating
☐ ☐ ☐ ☐ Nausea or vomiting
☐ ☐ ☐ ☐ Water retention

Hormone:

☐ ☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ ☐ Weight gain
☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Depression/ anxiety
☐ ☐ ☐ ☐ Mental fuzziness
☐ ☐ ☐ ☐ Memory problems
☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Decreased libido
☐ ☐ ☐ ☐ Aggression
☐ ☐ ☐ ☐ Hot flashes and/or night sweats

Head and Ears:

☐ ☐ ☐ ☐ Migraines
☐ ☐ ☐ ☐ Headaches

Emotional and Mental:

☐ ☐ ☐ ☐ Depression
☐ ☐ ☐ ☐ Anxiety
☐ ☐ ☐ ☐ Mood swings
☐ ☐ ☐ ☐ Irritability
☐ ☐ ☐ ☐ Poor concentration

Skin Conditions:

☐ ☐ ☐ ☐ Acne /acne scars
☐ ☐ ☐ ☐ Sagging skin
☐ ☐ ☐ ☐ Fine lines and wrinkles
☐ ☐ ☐ ☐ Loss of volume
☐ ☐ ☐ ☐ Enlarged pores
☐ ☐ ☐ ☐ Lip lines

Allergies:

☐ ☐ ☐ ☐ **Sulfa**
☐ ☐ ☐ ☐ Pollen
☐ ☐ ☐ ☐ Food
Other: ____________________

Hair Conditions:

☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Thinning hair
☐ ☐ ☐ ☐ Receding hair

Muscle & Joint:

☐ ☐ ☐ ☐ Arthritis
☐ ☐ ☐ ☐ Foot trouble
☐ ☐ ☐ ☐ Low back pain
☐ ☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ ☐ Pain between shoulders
☐ ☐ ☐ ☐ Headaches

Pain or numbness in:

☐ ☐ ☐ ☐ Shoulders
☐ ☐ ☐ ☐ Arms
☐ ☐ ☐ ☐ Elbows
☐ ☐ ☐ ☐ Hips
☐ ☐ ☐ ☐ Legs
☐ ☐ ☐ ☐ Knees
☐ ☐ ☐ ☐ Sciatica

Energy:

☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Lethargy
☐ ☐ ☐ ☐ Restlessness
☐ ☐ ☐ ☐ Insomnia
☐ ☐ ☐ ☐ Hyperactivity

Other Symptoms:

☐ ☐ ☐ ☐ Irregular heartbeat
☐ ☐ ☐ ☐ Chest pains
☐ ☐ ☐ ☐ Muscle aches

Please list any symptoms you experience that were not previously mentioned: ________________________________

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HIPAA FORM

Introduction

At Advanced Medical Weight Loss, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31th, 2003 and applies to all protected health information as defined by federal regulation.

Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company.
3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which Advanced Medical Weight Loss is permitted or required to disclose confidential information without the individual's written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures Advanced Medical Weight Loss may contact patients with appointment reminders, requests for the patient to contact Advanced Medical Weight Loss for appointments, notices and letters concerning medical findings. Advanced Medical Weight Loss may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; Updated April 10, 2008.

Individual Rights

Although your health record is the physical property of Advanced Medical Weight Loss, the information belongs to you. You have the right to:

1 The right to request restrictions on certain uses and disclosures of your information;
2 The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
3 The right to receive confidential communications;
4 The right to obtain a copy or inspect your health information;
5 The right to amend protected health information;
6 The right to receive an accounting of disclosures of protected health information.

Advanced Medical Weight Loss Center's Rights

1. Advanced Medical Weight Loss has 30 days with which to comply with a patient's request to review or copy their health information. Advanced Medical Weight Loss is allowed an additional 30 days if the record is off site. Advanced Medical Weight Loss may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;
3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. Advanced Medical Weight Loss will charge staff time for this service.

Advanced Medical Weight Loss Medical Center's Duties

1. Advanced Medical Weight Loss is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. Advanced Medical Weight Loss is required to abide by the terms of this Notice; and
3. Advanced Medical Weight Loss reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

Complaints

Individuals may complain to the Office Manager in writing to address above. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W.,Rm. 509F, HHH Building, Washington DC 20201.
Further Information-Please contact the SMC administrator at 747-5861 for further information.
I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:______________________________ Date of Birth:________________

Signature:______________________________ Date:________________

Witness Signature (Check In)____________________ Date:________________

PATIENT'S RELEASE OF THE PROVIDER OF SERVICE AND THE CLINIC

The undersigned hereby represents that I have disclosed all my pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that I have disclosed all medications that I am currently consuming to this provider of service during my examination and from whom, if any, I am obtaining my medications.

I understand that this provider of services makes a determination based on full disclosure from the patient.

I acknowledge that this provider of services reserves the right to limit any patient's medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggest false representation were made to this provider of service by the patient, I without reservation waive any and all rights to any claim, of any type or nature whatsoever including but not limited to monetary damages, which I have now or in the future may accrue against the provider of service and this clinic.

I understand that if I lose my medications, which are handed out on a bi-weekly or monthly basis, I will not be able to obtain a new supply until the following office visit whether it be bi-weekly or monthly. As a patient I also understand that if I go to another provider of service during the time frame of treatment at this clinic, I am to notify this clinic and its representatives immediately of any other medications I might be receiving and that said notification must be made in writing by and between this clinic and or its representative and myself. As the patient, I will also receive a copy of this notification after it is awarded.

Please be advised that Advanced Medical Weight Loss requires that all patients have a yearly diet panel drawn to give us a thorough perspective of our patient's general health. We also require all new patients and returning patients have a diet panel drawn within the first two weeks of their initial visit, and will not disperse any further medications until this is done. However, extenuating circumstances will be taken into consideration. This is to protect our patients and allow us to provide safe, effective assistance for weight loss and lifestyle change.

As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document.

Patient signature: ________________________________ Date: ______________________

Patient Printed name: ____

Medication Release Form

By signing this form, I certify that I received patient education and verbal counseling information on one or more of the following drugs:

- ☐ Phentermine Hydrochloride
- ☐ Phendimetrazine
- ☐ Phendimetrazine Tartrate
- ☐ Diethylpropion Hydrochloride
- ☐ Hydrochlorothiazide
- ☐ Human Chorionic Gonadotropin (HCG)

I understand that it is in my best interest to read and understand the material I have received. I furthermore do not hold Advanced Medical Weight Loss or any of its practitioners responsible if I do not read or follow the instructions for taking any of these drugs.

Date:____________________ Patient Signature:____

Printed Name: ____

I understand and acknowledge:

- Advanced Medical Weight Loss has provided me with information concerning self-injections. ______ Initials
- The injections do expire on the expiration date printed on label and **I do not get a refund for any unused injections.** ______ Initials
- By taking the injections home I **cannot** bring back any of the injections for any reason unless in a Bio-Hazard Container. ______ Initials
- **To throw away injections in a regular garbage can is illegal.** I either have access to a Bio-Hazard Container or I will purchase one from (your clinic name) at the price of $5.00 plus tax. I can bring the full container back to (your clinic name) for safe disposal. ______ Initials
- Injections need to be kept away from children and I have been offered a Bio-Hazard Container for safe storage of my used injections. ______ Initials
- I have received the "Giving Self Injections" sheet and the staff at (your clinic name) has answered all of my questions regarding self-injections. ______ Initials
- By taking my injections home, **Advanced Medical Weight Loss is not liable for any consequences that may come from giving myself an injection at home.** ______ Initials

______________________ ______________________

Patient's Signature Date

PATIENT INFORMED CONSENT FORM

Protocol Title: HCG Diet Informed Consent to Treat

Purpose

This Informed Consent Form is intended to give fair notice of the requirements of patients seeking to participate in the HCG Diet Program at Advanced Medical Weight Loss, to fully disclose any risks associated with participation in the HCG Diet program, and to obtain written "Informed Consent" from the patient to undergo treatment by health care professionals associated with the above stated clinics.

Clinical Applications

HCG was used in the treatment of obesity disorders by a British Doctor and PHD, A.T.W. Simeons of the renown Salvator Mundi International Hospital in Rome Italy over a 16 year period commencing in the mid 1950's. Dr. Simeons concluded that HCG ("Human Chorionic Gonadotrophic" Hormone) when used for weight reduction and concurrent with a regimented protein diet, not only resulted in significant weight loss from targeted areas where fat deposits were likely to collect, but also improved the lipolytic functions of the body when co-utilized with dietary protein sources. Dr. Simeons hypothesized that HCG, which is produced in the female body in large quantities at the time of pregnancy commencing from the 8th week forward and in quantities ranging anywhere from 5000 mIU/ml to 288,000 mIU/ml, had a significant role in not only producing a healthy placenta for the fetus to survive, but also had a role in metabolizing fats from the mother's subcutaneous fat stores as an additional food source for the fetus.
Dr. Simeons theorized that by giving daily injections of small amounts of HCG concurrent with a high protein diet, that the HCG would mobilize the fat into the blood stream where protein and various enzymes could exercise their lipolytic functions (lipolytic means to break down fats usually for the consumption of energy). Dr. Simeons' clinic had a 97% success ratio.

A number of medical authorities have since supported the theories advanced by Dr. Simeons. In "Medicine and Science in Sports and Exercise" (19:5, sec. 179-190, 1986), Dr Layman, M.D. affirmed that the intake of high dietary protein: (1) aided in the metabolism of the free floating fat; (2) enhanced increased muscle mass; (3) preserved protein composition in the organs; (4) stabilized the blood glucose levels, and (5) enhanced the production of human growth hormone from the pituitary gland. Accord in J Am. Coll. Nutr. 2004 Dec: 23 (6:Suppl): 631S-636S.

Nevertheless in spite of these findings by specialized experts in the field of Preventative Health Care, the American FDA requires the following disclaimer:

> "This weight reduction treatment includes the use of HCG, a drug which has not been approved by the Food and Drug Administration as safe and effective in the treatment of obesity or weight control. There is no substantial evidence that HCG increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie restricted diets."

Initials_______

Risks and Discomforts

Below is a list of risks and discomforts that may be experienced by a small part of the population, in particular, those patients that are already predisposed to allergies; the latter condition caused by a hyperstimulation of the hormone heparin within the body. The patient shall inform the primary health care provider if any of the following conditions occur:

Allergic responses

If you experience allergic reactions to other substrates, you may have a sensitivity to HCG. It is required that you stop using HCG and report your allergic response to your physician immediately (emphasis added). The following are signs of an allergic reaction:

- hives
- difficulty breathing
- swelling of your face, lips, tongue, or throat

Before receiving HCG tell your doctor if you are allergic to any drugs or if you have:

- a thyroid or adrenal gland disorder;
- an ovarian cyst;
- cancer or a tumor of the breast, ovary, uterus, prostate, hypothalamus, or pituitary gland;
- undiagnosed uterine bleeding;
- heart disease;
- kidney disease;
- epilepsy;
- migraines; or asthma

It is necessary for the doctor to know these predisposed pathologies in order to rule out any symptomatology that may not be related to the HCG.

Also in allergic responses, the body overproduces fibrin which induces blood clotting, a potentially lethal situation. Call your doctor at once if you have any of these **signs of a blood clot:**

- pain
- warmth
- redness
- numbness
- tingling in your arm or leg
- confusion
- extreme dizziness
- severe headache
- nausea or vomiting; or
- urinating less than normal.

Less Serious Side Effects May Include

Less serious side effects may occur from the change in dietary patterns, until the blood sugar levels stabilize over a period of time with high protein intake. These less serious side effects include:

- headache (diet related)
- feeling restless or irritable;
- mild swelling or water weight gain;
- depression;
- breast tenderness or swelling; or
- pain, swelling, or irritation where the injection is given.

Initials_______

Breast Feeding

It is not known whether HCG passes into breast milk. Do not use HCG without telling your doctor if you are breast-feeding a baby.

Other drugs may affect HCG

There may be other drugs that can interact with HCG. Tell your doctor about all the prescription and over-the-counter medications you use. This includes vitamins, minerals, herbal products, and drugs prescribed by other doctors. Do not start using a new medication without telling your doctor.

Mandatory Adherence to Diet Protocol

To experience success on the clinic's HCG diet program, it is mandatory that you follow the diet protocol explicitly. The Healthy Habits Clinic does not warrant the results of its diet program due largely to off-site administration and patient imposed application of the diet program.

Consent, Right to Receive a Copy

I, the undersigned patient of Advanced Medical Weight Loss, agree to undergo weight loss treatment that includes the use of Human Chorionic Gonadotrophin (HCG) along with diet and other therapies. I have disclosed my full medical history and have been physically examined by my health care practitioner. I am aware the significant or common risks, benefits, side effects and adverse reactions of HCG, and I have had full opportunity to ask any questions. I understand that HCG has not been approved by the United States Food and Drug Administration (FDA) for adjunctive therapy in the treatment of obesity and states that there is no substantial evidence that HCG increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets. Nevertheless, considering all the above, I hereby give my informed consent to this treatment.

Signature of Patient

________________________________ ______________

Signature of Patient Date

Clinic Witness to Signature:

________________________________ ______________

Clinic Witness Date

Initials______