

**TRUE WEIGHT LOSS CLINIC
13450 RESEARCH, SUITE 115
AUSTIN, TX 78750**

Patient Information Form

Personal Information:

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Birthdate: _____ Age: _____ Sex: M F SS# _____ - _____ - _____

Country of Birth: _____ Country of Parents' Birth: _____

How did you hear about us? _____ Referred by: _____

E-mail address: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone No: _____ Ext. _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Financial Policy:

Thank you for selecting True Weight Loss Clinic for your weight loss needs for your weight loss 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 time services rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and Discovery.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient signature: _____ Date: _____

Patient Name: _____

DOB : _____ Date: _____

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**PATIENTS PLEASE FILL THIS OUT TO LET US KNOW IF YOU HAVE ANY PROBLEMS
WITH ANY OF THESE SYSTEMS.**

General- NONE

- Weight loss or gain
- Weakness
- Fatigue Trouble sleeping

Head- NONE

- Headache Head injury

Ears- NONE

- Decreased hearing
- Ringing in ears (tinnitus)
- Earache Drainage

Eyes- NONE

- Vision Glasses or contacts
- Pain Redness
- Blurry or double vision
- Flashing lights Specks
- Glaucoma Cataracts
- Last eye exam

Neck- NONE

- Lumps Swollen glands
- Pain Stiffness

Respiratory- NONE

- Cough (dry or wet, productive)
- Shortness of breath (dyspnea)
- Wheezing Painful breathing

Cardiovascular- NONE

- Chest pain or discomfort
- Tightness Palpitations
- Shortness of breath with activity (dyspnea)
- Difficulty breathing lying down (orthopnea)
- Swelling in feet or hands (edema)
- Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal- NONE

- Swallowing difficulties Heartburn
- Change in appetite Nausea
- Change in bowel habits
- Rectal bleeding Constipation
- Diarrhea Yellow eyes or skin (jaundice)

Vascular- NONE

- Calf pain with walking (Claudication)
- Leg cramping

Musculoskeletal- NONE

- Muscle or joint pain Stiffness
- Back pain Redness of joints
- Swelling of joints Trauma

Neurologic- NONE

- Dizziness Fainting
- Seizures Weakness
- Numbness Tingling Tremor

Endocrine- NONE

- Head or cold intolerance Sweating
- Frequent urination (polyuria)
- Thirst (polydypsia)
- Change in appetite (polyphagia)

Psychiatric- NONE

- Nervousness Depression
- Memory loss Stress Anxiety

Date of latest EKG _____

Date Of Latest Echocardiogram _____

Patient signature: _____ Date: _____

Patient Name: _____

DOB : _____

Date: _____

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Medical History

Present Health Status:

1. Are you in good health at the present time to the best of your knowledge? ____ Yes ____ No

Do you see a medical provider regularly? _____ When was your last visit? _____

Explain a "no" answer: _____

3. Are you taking any medications at the present time? ____ Yes ____ No

Please list all medications: Prescription and over the Counter Drugs:

Drug:

Dosage:

4. do you have any allergies to any medications? ____ Yes ____ No Please list: _____

5. Gynecological History: Pregnancies : Number: _____ Dates: _____

Natural Delivery or Cesarean Section ? _____

Menstrual History : Are your periods regular? ____ Yes ____ Pain Associated ? ____ Yes ____ No

Birth control method : _____ LNMP; _____

6. Serious Injuries: ____ Yes ____ No Specify (list all) _____

7. Any Surgery: ____ Yes ____ No Specify: (List all) _____

8. Family History: (check all that apply)

_____ Alcohol Abuse _____ Diabetes _____ Eating Disorder _____ Heart Valve Disorder

_____ Heart Disease _____ Hypertension _____ Kidneys disease _____ Liver Disease

_____ Psychiatric Illness _____ Thyroid Disorder Other: _____

9. Personal Past Medical History: (check all that apply)

____ Alcohol Abuse _____ Anemia _____ Arthritis _____ Cancer ____ Diabetes ____ Type 1

Diagnosed at what age ? ____ Type 2 Diagnosed at what age ? _____ _____ Recreational Drug Use/Abuse

_____ Eating Disorder _____ Gallbladder Disorder _____ Gout _____ Heart Valve Disorder

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_____ Heart Disease _____ Hypertension _____ Kidneys disease _____ Liver Disease _____
Psychiatric Illness _____ Thyroid Disorder _____ Headaches/Migraines _____ Glaucoma

Other Past Medical History: _____

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____ Weight one year ago: _____ lbs

2. What is the main reason for your decision to lose weight? _____

3. What has been your maximum lifetime weight (non-pregnant) and when? _____

4. Previous diets you have followed: Give dates and results of your weight loss: _____

5. Is your spouse, or partner overweight? Yes _____ No _____ By how much is he or she overweight? _____

6. Who plans meals at home? _____ Cooks? _____ Shops? _____

7.. Food(s) you crave: _____

8. Do you drink alcohol? _____ Yes _____ No What? _____ How much daily? _____
Weekly? _____

9. Do you awaken hungry during the night? Yes No What do you do? _____

10. What are your worst food habits? _____

11. Snack Habits: What? _____ How much? _____ When? _____

12. Typical Breakfast: _____

Time eaten: _____ Where: _____ With whom: _____

Typical Lunch: _____

Time eaten: _____ Where: _____ With whom: _____

Typical Dinner: _____

Time eaten: _____ Where: _____ With whom: _____

13. Activity Level: (answer only one)

_____ Inactive—no regular physical activity with a sit-down job.

_____ Light activity—no organized physical activity during leisure time.

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_____ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

_____ Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..

_____ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

14. Behavior style: (answer only one)

_____ You are always calm and easygoing.

_____ You are usually calm and easygoing.

_____ You are sometimes calm with frequent impatience.

_____ You are seldom calm and persistently driving for advancement.

_____ You are never calm and have overwhelming ambition.

_____ You are hard-driving and can never relax.

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

12 Reasons why I want to lose weight:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

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PATIENTS Please Initial Beside Each Statement That You Do Not Have These Conditions

_____ I do not currently have hyperthyroidism

_____ I do not currently have and never have been treated for glaucoma (a condition of increased pressure in the eyes)

_____ I do not currently have and have never been treated for heart/cardiovascular disease.

_____ I am not taking MAOI inhibitors (an old type of antidepressant) nor have I taken them in the past 14 days.

_____ I do not currently have not have I ever had arteriosclerosis (hardening of the arteries)

_____ I do not currently have and have never been treated for moderate or severe hypertension (high blood pressure)

_____ I do not currently have and have never been treated for anxiety disorder or agitation, bipolar disorder.

_____ I do not currently have, have never been in treatment for nor do I have a history of drug abuse.

_____ I am not currently pregnant nor do I plan to become pregnant while under medical treatment at True Weight Loss Clinic and am taking precautions to not get pregnant at this time.

_____ I am not currently breastfeeding.

_____ I am not currently taking any other prescription appetite suppressant or diet medication.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Patient Name: _____

Date: _____

Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I, _____ (patient or patient's guardian) authorize Cynthia Hodgins APRN, MSN, FNP-C to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my provider's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a bariatric provider, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

"As a bariatric provider, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the provider treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

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III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____ **TIME:** _____

PATIENT: _____ **WITNESS:** _____
(or person with authority to consent for patient)

VI. PROVIDER DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above. A medication handout has been provided to the patient with extensive information about prescription appetite suppressants and my recommendations for use of them.

Provider's Signature

Patient Name: _____

Date: _____

Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program.

I have read the above:

Patient's Signature _____ Date: _____

Patient Name: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES RECEIPT ACKNOWLEDGEMENT

All patients have the right to have confidential care provided. All information, Medical or Social, whether written, spoken, electronic or computer generated, is to be held in strict confidence.

By signing below you acknowledge receipt or availability of receipt of the True Weight Loss Clinic Notice of Privacy Practice. This notice explains how True Weight Loss Clinic may use and disclose your protected health information for treatment, payment and health care operation purposes. "Protected Health Information" means your personal health information found in your medical and billing records. True Weight Loss Clinic reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice is posted at patient service locations throughout True Weight Loss Clinic. The effective date of the notice appears on the first page of the notice or summary. In addition, True Weight Loss Clinic has available for you at your request, a copy of the current notice in effect.

Your signature below acknowledges that you are aware that there is a privacy notice located in the clinic available for you. That your have been offered a copy of the privacy notice and have received or declined said copy.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____