New Patient Questionnaire (Health Care Analysis)

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?:**	
____			
Occupaton:			
________________________________		____	

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: ____

____

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
- ☐ Thyroid Imbalance
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfur, food or medication

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

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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.

Food and Chemical Sensitivity

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

Digestive Symptoms:

☐ ☐ ☐ ☐ Stomach pains or cramping
☐ ☐ ☐ ☐ Constipation
☐ ☐ ☐ ☐ Diarrhea
☐ ☐ ☐ ☐ Reflux or heartburn
☐ ☐ ☐ ☐ Bloating
☐ ☐ ☐ ☐ Gas

Head and Ears:

☐ ☐ ☐ ☐ Migraines
☐ ☐ ☐ ☐ Headaches
☐ ☐ ☐ ☐ Earaches
☐ ☐ ☐ ☐ Wheezing
☐ ☐ ☐ ☐ Ear infection
☐ ☐ ☐ ☐ Ringing in ears

Eyes and Throat:

☐ ☐ ☐ ☐ Itchy eyes
☐ ☐ ☐ ☐ Watery eyes
☐ ☐ ☐ ☐ Sore throat
☐ ☐ ☐ ☐ Persistent canker sores

Sinus and Respiratory:

☐ ☐ ☐ ☐ Stuffy or runny nose
☐ ☐ ☐ ☐ Asthma
☐ ☐ ☐ ☐ Chest congestion
☐ ☐ ☐ ☐ Chronic cough
☐ ☐ ☐ ☐ Frequent sneezing

Skin Disorders:

☐ ☐ ☐ ☐ Dermatitis
☐ ☐ ☐ ☐ Excessive sweating
☐ ☐ ☐ ☐ Rashes
☐ ☐ ☐ ☐ Hives
☐ ☐ ☐ ☐ Eczema

Emotional and Mental:

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

Energy:

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

Other Symptoms:

☐ ☐ ☐ ☐ Joint pain
☐ ☐ ☐ ☐ Arthritis
☐ ☐ ☐ ☐ Irregular heartbeat
☐ ☐ ☐ ☐ Chest pains
☐ ☐ ☐ ☐ Muscle aches

OFFICE USE ONLY
Total Points: ______________________________

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

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What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness “My results are my top priority.”
- ☐ Time “I want results quickly.”
- ☐ Service “I need extra support along the way.”
- ☐ Ease “I have a difficult time losing weight.”

Surgeries:

- ☐ Gastric Band
- ☐ Gastric Bypass
- ☐ Duodenal Switch
- ☐ Sleeve Gastrectomy
- ☐ Intragastric Stimulation
- ☐ Intragastric Balloon
- ☐ Biliopancreatic Diversion

Family History:

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hypothyroidism
- ☐ Obesity
- ☐ High Blood Presure
- ☐ Heart Disease
- ☐ Cancer

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

____ ________________________

Signature: **Date:**

Notes:

____

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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 Fast Medical Weight Loss Clinic 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 dispense 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: ____

HIPAA FORM

Introduction

At **Fast Medical Weight Loss Clinic** 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 **Fast Medical Weight Loss Clinic** 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 **Fast Medical Weight Loss Clinic** may contact patients with appointment reminders, requests for the patient to contact **Fast Medical Weight Loss Clinic** for appointments, notices and letters concerning medical findings. (**Fast Medical Weight Loss Clinic** 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 **Fast Medical Weight Loss Clinic** 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.

Fast Medical Weight Loss Clinic Center's Rights

1. **Fast Medical Weight Loss Clinic** has 30 days with which to comply with a patient's request to review or copy their health information. **Fast Medical Weight Loss Clinic** is allowed an additional 30 days if the record is off site. **Fast Medical Weight Loss Clinic** 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. **Fast Medical Weight Loss Clinic** will charge staff time for this service.

Fast Medical Weight Loss Clinic Medical Center's Duties

1. **Fast Medical Weight Loss Clinic** 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. **Fast Medical Weight Loss Clinic** is required to abide by the terms of this Notice; and
3. **Fast Medical Weight Loss Clinic** 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:__________________________