Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

Medical Weight Loss Program Intake Form

Patient Name: _____ Marital Status: S M D W
Last First MI

Address: _____Apt#_____

City: _____ State: _____ Zip: _____

Phone: Home (____)_____
Cellphone (____)_____
Work (____)_____

Email Address: _____

Race: O White Gender: O Male Ethnicity: O Hispanic or Latino
O Black O Asian O Female O Not Hispanic or Latino
O American Indian or Alaska Native
O Native Hawaiian or other Pacific Islander
O Other or mixed

Birthdate: _____Age: _____ Sex: M F

Occupation: _____

In Case of Emergency:

Name:_____ Relationship: _____

Phone: _____

How did you hear about us?_____

Are you under the care of a qualified healthcare professional? Please list whom. *

_____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change. *

I acknowledge the above statement above. Sign:_____

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Informed Consent for Medically Management Weight Loss Therapy

I acknowledge that I am voluntarily entering into a medically managed weight loss program with Centerpoint Family Practice. I fully realize that entering any program involving weight reduction, which includes moderate calorie restriction, exercise, and medications, involves potential risks and side effects. The risks include, but may not be limited to the following:

1. **Sudden Death:** Patients with morbid obesity, particularly those with hypertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient. (Please initial) _____

2. **Reduced Potassium Levels:** The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids, nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in electrolytes, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential. (Please initial) _____

3. **Gall Bladder Disease:** Any program resulting in rapid weight loss may precipitate the formation of gallstones, which could lead to cholecystitis (inflammation of your gallbladder), which is a medical urgency or emergency and could require surgery. This is typically because of the rapid weight loss, not the medications you are taking. Symptoms include right upper abdominal pain, abdominal just below your ribs, nausea, and vomiting. (Please initial) _____

4. **Pancreatitis:** Pancreatitis, or an infection in the bile ducts, may be caused by gallstones or the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis is long-term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death. (Please initial) _____

5. Men over 40 and post-menopausal women in general, and patients with risk factors for cardiovascular disease should have a cardiovascular evaluation before entering a

medically managed weight loss program. This may include an ECG, a stress test, or other testing procedures, as per the discretion of a cardiologist. If you are over the age of 40, post-menopausal (female), smoke, have a history of high blood pressure, high cholesterol or you are diabetic, you acknowledge that you have had a cardiac evaluation and that you have been cleared medically prior to starting this weight loss program. (Please initial) _____

6. Drug interactions may occur if other medications are taken. Therefore, I will check with my prescribing medical provider before starting the program if I am taking other medications. (Please initial) _____

7. Certain medical conditions may be worsened if on this program, including glaucoma, hypertension, and heart disease. (Please initial) _____

8. Pregnancy (Females Only). If you become pregnant, inform your physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss. (Please initial) _____

9. The use of medications for weight management is indicated for those patients who have a BMI of 30 or higher or a BMI of 27 or higher with other medical conditions such as high blood pressure, diabetes, or high cholesterol. Prescribing medications for patients not fitting these criteria, is considered "off label" and not "FDA approved." Therefore, the potential risks vs. benefits may be great. For patients not fitting the BMI criteria for use of appetite suppression medication, you are acknowledging that:

    a. You have put forth a true effort to lose weight through diet and exercise over the past 6 months and have still not achieved your weight loss goals.
    b. That your inability to lose weight is causing significant emotional distress
    c. You are choosing to enter this medically managed weight loss program voluntary and hold harmless Centerpoint Family Practice and Diana L. Corley, DNP for use of such medications.
    d. (Please initial) _____

10. I understand that the physician and I will determine what my daily caloric intake will be at my initial visit. (Please initial) _____

11. I acknowledge that I understand that the amount of weight loss varies from patient to patient, and is, to a large extent dependent on each patient's personal motivation and commitment to their diet and exercise plan. No claims as to efficacy or specific amount of weight loss is either expressed or implied. I understand the importance of routinely following up with Centerpoint Family Practice to monitor my progress during treatment. I understand this is vital to the safety of the treatment program and certify that I will be returning monthly as prescribed. (Please initial) _____

12. I hereby authorize Centerpoint Family Practice, Diana L. Corley, DNP and additional staff of

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Centerpoint Family Practice to evaluate me for admission into Centerpoint Family Practice weight management program and treat me accordingly. I consent to obtaining blood work before treatment if deemed necessary. I certify that I am signing this under my free will and am competent to make my own medical decisions. (Please initial) _____

13. I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with medically managed weight loss therapy with Centerpoint Family Practice**.** I release any claim in court or any type of complaint that could result from treatment with Centerpoint Family Practice**.**, Diana L. Corley, DNP and any other staff associated with Centerpoint Family Practice**.** and will not hold liable any provider or staff of Centerpoint Family Practice. (Please initial) _____

By signing below, I acknowledge that I have had an opportunity any concerns and the above information with Centerpoint Family Practice, either in person or by telephone conversation. I consent to the treatment being offered to me by Centerpoint Family Practice/Diana L. Corley, DNP and I am satisfied with the explanation. I acknowledge that I have read or have had read to me the above consent and understand the information presented.

_____

Signature of patient Date

_____

Printed Name of patient

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CONSENT FOR WEIGHT LOSS THERAPY AND TREATMENT WITH CENTERPOINT FAMILY PRACTICE.

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $25 administrative fee.

_____Services must be paid for at the time of service.

_____I understand that health insurance typically does not cover weight loss management services provided at Centerpoint Family Practice. Insurance claims WILL NOT be filed by clinic for weight loss management.

_____I understand that treatments used at Centerpoint Family Practice might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through nutritional and supplemental counseling, and weight loss treatment.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that Centerpoint Family Practice and Diana L. Corley, DNP are not my primary care provider unless I elect them so. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at Centerpoint Family Practice.

_____I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

_____I understand that having an appointment with Centerpoint Family Practice does not necessarily entitle me to being issued a prescription for weight loss medication or additional medications. Every individual is different, and it is at the medical providers discretion to issue a prescription.

_____I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes.

_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with Centerpoint Family Practice and Diana L. Corley regarding weight loss therapy as determined by a mutual decision between myself and the medical provider even if my levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

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_____I do not hold any medical practitioner of Centerpoint Family Practice responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Centerpoint Family Practice and Diana L. Corley harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to Centerpoint Family Practice as this could change the treatment prescribed to me.

I have read, understand and agree to all of the above statements.

Print Name:_____

Signature:_____Date_____

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Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by Diana L Corley, FNP, LLC; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by Diana L Corley, FNP, LLC; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by Diana L Corley, FNP, LLC; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by Diana L Corley, FNP, LLC;. I am aware of the potential side effects associated with weight loss therapy, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____Date:_____

Witness:_____Date:_____

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Medical History

Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis, etc…): *

_____
_____
_____
_____

What medications, supplements and over the counter items do you take regularly or are currently prescribed: *

_____
_____
_____
_____

Any past surgeries and hospitalizations? *

_____
_____
_____

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

_____
_____
_____
_____

Personal History

What are your main interests and hobbies?

_____

What is your line of work or study?

_____

Do you exercise regularly? Please detail.

_____

What kind of other movement or activities do you enjoy?

_____

You have problems falling or staying asleep?

_____

How many hours do you sleep?

_____

Do you wake up refreshed?

_____

How is your energy?

_____

Does your energy level affect your daily activities?

_____

How would describe your mood, generally:

_____

Does your mood affect your life or daily activities?

_____

How would you describe your stress level?

_____

What are your sources of stress?

_____

How do you manage stress?

_____

Do you have people close to you who support you?

_____

Diet and lifestyle

Do you regularly drink alcoholic beverages? Y N

If yes, how many per week? _____

Do you smoke tobacco? Y N

Do you use recreational drugs? Y N

How is your appetite?

Snack Habits:

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What: _____

How much: _____

When: _____

Typical Breakfast:

What: _____

How much: _____

When: _____

Typical Lunch:

What: _____

How much: _____

When: _____

Typical Dinner:

What: _____

How much: _____

When: _____

How often do you eat out?_____

What restaurants do you frequent?

_____

How often do you eat "fast foods"?_____

Food allergies? _____

Food dislikes? _____

Food cravings? _____

Do you eat because of emotions (explain)?

_____

Do you drink coffee or tea? Y N If Yes, how much daily?

_____

Do you drink pop / soft drinks? Y N If yes, how much? _____

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Do you use sugar substitutes? _____

What are your worst food habits? _____

How much fluids do you normally drink? Please approximate in ounces.

_____

Please list all types of beverages you regularly drink.

_____

_____

Please list any food allergies, intolerances, or foods you avoid and the reason.

_____

_____

_____

What past struggles and difficulties have you experienced in terms of food and dieting?

_____

_____

_____

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

_____

_____

_____

_____

What types of diet and exercise approaches have worked for you in the past?

_____

_____

_____

_____

And what hasn't worked for you at all?

_____

_____

_____

_____

When did you first become overweight? _____

How did your weight gain start? Describe any circumstances:

_____

_____

_____

What do you think is the cause of your weight problem?

_____

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_____
_____

What was your highest weight? (excluding pregnancy) _____

What was your lowest weight?_____

Have you ever stayed the same weight for 10 years or more?_____

How MOTIVATED are you to lose weight?

_____
_____
_____

Is there anything else you would like to tell us?

_____
_____
_____
_____

Please list the factors you feel have contributed to your current weight (check all that apply):

Slow metabolism	☐
Family history of obesity	☐
Comfort food dependency	☐
Lack of exercise	☐
Binge eating	☐
Late night snacking	☐
History of trauma	☐
History of grief and loss	☐
Medication related weight gain	☐
Significant restrictive eating behaviors like anorexia	☐

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Please answer the following questions to the best of your knowledge:

Health History *

	No, never	Yes, currently	Not currently, but within the last year	Not currently and longer than 1 year ago
Fatigue	○	○	○	○
Unexplained weight loss or gain	○	○	○	○
Change in appetite	○	○	○	○
Depressive symptoms	○	○	○	○
Anxiety	○	○	○	○
Mood swings	○	○	○	○
Nervousness	○	○	○	○
Addictive dependency	○	○	○	○
Disordered Eating Pattern/Tendency	○	○	○	○
Tension	○	○	○	○
Lack of mental focus	○	○	○	○
Thyroid problems	○	○	○	○
Diabetes	○	○	○	○
Blood sugar irregularities	○	○	○	○
Excessive thirst or hunger	○	○	○	○
Sugar cravings	○	○	○	○
Abnormal hair growth	○	○	○	○

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Excessive perspiration	○	○	○	○
Feeling excessively hot or cold	○	○	○	○
Headache	○	○	○	○
Lightheadednes	○	○	○	○
Joint pain or stiffness	○	○	○	○
Muscle weakness or soreness	○	○	○	○
High blood pressure	○	○	○	○
Heart murmur/palpitations	○	○	○	○
Cold or pale extremities	○	○	○	○
Asthma	○	○	○	○
Short of breath	○	○	○	○
Heartburn	○	○	○	○
Abdominal discomfort after eating	○	○	○	○
Nausea	○	○	○	○
Abdominal bloating	○	○	○	○
Belching/gas	○	○	○	○
Constipation	○	○	○	○
Diarrhea	○	○	○	○
Daily bowel movements	○	○	○	○

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