



Phone: 636-978-6995 Fax: 636-272-6995

www.DoctorsWeightLossInfo.com

Person Requesting Evaluation: _____ Date: _____

How did you hear about the Doctors Weight Loss, LLC "A Thinner You" hCG Program?

Referred By? _____

Thank you for your interest in Doctors Weight Loss Center, LLC and our unique approach to helping you achieve your weight loss goals. The following is a case history form that will be evaluated by one of our physicians to determine if you qualify for this program. Please fill out the forms to the best of your ability and make sure all forms are signed.

Doctors Weight Loss Center, LLC 2315 Highway K

O'Fallon, MO 63366

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY.

Disclaimer

I have asked Doctors Weight Loss Center, LLC to evaluate my health condition and my ability to take part in a weight loss program involving homeopathic hCG, a very low calorie diet, and dietary supplementation.

I have read and understand the above statements.

Please Print Name _____ Signature _____

Date _____

Physician Signature _____



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New Patient Information

Personal Information

Last Name _____ First Name _____

M.I. _____ Birth Date _____

Mailing Address _____

E Mail Address _____

City _____ State _____ Zip _____

Home Phone _____ (May we leave a message at this number? Yes No)

Alt Phone _____ (May we leave a message at this number? Yes No)

Occupation/hours per week _____

Medical Providers

Who is your health care provider? _____

Name: _____

Emergency Contact

In case of an emergency, please contact the following:

Primary:

Name _____ Relationship to you _____

Phone _____

Secondary:

Name _____ Relationship to you _____

Phone _____

Health Information

Primary Health concerns _____

Past Hospitalizations _____

Past Surgeries _____

Current Medications _____

Current Supplements / vitamins: _____

Allergies (foods / drugs / environmental) _____

Current exercise (type / hours per week) _____

Please describe your exercise history in detail (types, what did you enjoy / dislike, any injuries while performing any exercise) :

Do you smoke? Yes / No Packs / day _____ How many years of smoking? _____

Do you drink alcohol? Yes No Amount? _____ drinks per week

Do you drink Caffeine? Yes No Amount / Drinks per day _____

Do you use recreational drugs of any sort? _____ Type / Name _____

What was the approximate date of your last medical exam or checkup? _____

What was your reason for seeing your medical doctor at that time? _____

Have you had a medical condition, illness, or injury for which you have attended an accident and emergency or other trauma center in the last 12 months? Yes No

If Yes, what was the reason? _____

For Women

Are you pregnant? _____ Nursing? _____

Will you be trying to become pregnant in the next 6 weeks? _____

What was the date of your last menstrual cycle? _____

Nutrition / Diet

Do you follow a particular diet? _____

Are you currently dieting or participating in any other dieting program? _____

Have you gained / lost weight recently? Yes No Describe:

What are the names of weight loss programs or diets that you have tried? (List most recent first)

Which type of diet was the most successful for you? _____

Please list foods you eat regularly for:

Breakfast

Lunch

Dinner

Goals

What is your motivation for losing weight? (listed below are some examples)

“I want to look better for an upcoming event.”

“I wish I looked better in my clothing / swimsuit”

“I am tired of ‘yo yo’ dieting. I want a permanent solution.”

“My medical doctor said that my weight could cause me serious health problems.”

(Please be detailed)

Amount of weight you would like to lose on the Doctors Weight Loss Center hCG program? _____

Are you aware that the loss of inches is one of the most important results of the Doctors Weight Loss Center hCG Program? Yes No

My "problem areas", where I have always had difficulty losing the weight are:

Once you have lost the weight and inches that you have set for your goal, are you willing to make easy to follow changes in your lifestyle to maintain your healthy weight? Answer Yes or No to each of the following:

Eating healthier foods _____

Exercising _____ I would be willing to join a gym to continue my healthier lifestyle _____

I would be willing to take part in personal training after my goals are met, if it was recommended _____

I have a friend or family member that would take part in my new healthy lifestyle _____

What would you identify is your largest obstacle(s) to maintaining your weight loss goals permanently?



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Please Check All Conditions, Past or Present:

Past / Present

Past / Present

<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Scoliosis
<input type="checkbox"/> <input type="checkbox"/> Pain	<input type="checkbox"/> <input type="checkbox"/> Neck Pain
<input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> Back Pain
<input type="checkbox"/> <input type="checkbox"/> Fever	<input type="checkbox"/> <input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> <input type="checkbox"/> Night Sweats	<input type="checkbox"/> <input type="checkbox"/> Leg pain
<input type="checkbox"/> <input type="checkbox"/> Insomnia	<input type="checkbox"/> <input type="checkbox"/> Spasms / Cramps
<input type="checkbox"/> <input type="checkbox"/> Hot Flashes	<input type="checkbox"/> <input type="checkbox"/> Tendonitis
<input type="checkbox"/> <input type="checkbox"/> Rash / skin problems	<input type="checkbox"/> <input type="checkbox"/> Numbness / Tingling
<input type="checkbox"/> <input type="checkbox"/> Arthritis /stiff / painful joints	<input type="checkbox"/> <input type="checkbox"/> Sciatica/Shooting pain
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease
<input type="checkbox"/> <input type="checkbox"/> Bladder/Kidney	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Blood Clots
<input type="checkbox"/> <input type="checkbox"/> Gas / Bloating	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction / Dependency
<input type="checkbox"/> <input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> <input type="checkbox"/> Constipation / Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> <input type="checkbox"/> Thyroid dysfunction	<input type="checkbox"/> <input type="checkbox"/> Asthma / Allergies / Hay fever
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Dizziness
<input type="checkbox"/> <input type="checkbox"/> Pregnancy	<input type="checkbox"/> <input type="checkbox"/> Infection
<input type="checkbox"/> <input type="checkbox"/> PMS / menstrual problems	<input type="checkbox"/> <input type="checkbox"/> Disc Problem
<input type="checkbox"/> <input type="checkbox"/> TMJ or Jaw pain	<input type="checkbox"/> <input type="checkbox"/> Heart murmur
<input type="checkbox"/> <input type="checkbox"/> Heart arrhythmia	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Epilepsy / seizures
<input type="checkbox"/> <input type="checkbox"/> Anxiety	<input type="checkbox"/> <input type="checkbox"/> Gout

Family History - major health problems (cancer, cardiovascular disease, obesity, diabetes, osteoporosis, depression.)

Father _____

Mother _____

Siblings _____

The confidentiality, security, and privacy of your personal health information is important to us.

Please see our privacy statement for details. (enclosed)

By signing below I state that I have fully read over and filled out the above health history questionnaire truthfully and accurately.

Signature _____

Date _____



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Additional Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. (Please circle)

ANY MEMBER OF THE IMMEDIATE FAMILY: Yes No

SPOUSE: Yes No

OTHER (please Specify) _____ Yes No

Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____

Statement of Privacy Practices - Doctors Weight Loss Center, LLC

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the **Health Insurance Probability and Accountability Act** and the state of Missouri. This personal health information will never be otherwise given to anyone- even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality weight loss and treatment programs, implement payment activities, conduct normal weight loss and treatment center operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, ECT. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail/answering machine messages, postcards, newsletters and special events.

I have received a copy of the Statement of Privacy Practices for Doctors Weight Loss Center, LLC (initial) _____