FOUNTAIN OF YOUTH MEDICAL SPA

MD WEIGHT LOSS

NAME:____ D.O.B:______/______/______ AGE:________

ADDRESS:____ SEX: M / F

CITY:______________________________________ STATE:_____________________ ZIP CODE:__________

HOME:_____________________________CELL:_________________________ WORK:__________________

EMAIL ADDRESS:____

WOULD YOU LIKE TO BE CONTACTED REGARDING CURRENT SPECIALS? YES: (CELL EMAIL BOTH) NO

EMPLOYER:____ OCCUPATION:___________________

EMERGENCY CONTACT:____ RELATION:________________

HOME:_____________________________CELL:_________________________ WORK:__________________

HOW DID YOU HEAR ABOUT US?

☐ GOOGLE ☐ WEBSITE ☐ FACEBOOK ☐ RADIO AD ☐ TV AD

☐ PHONE BOOK ☐ WORD OF MOUTH ☐ FLYER ☐ GIFT CARD ☐ NEWSPAPER

☐ PHYSICIAN REFERRAL:______________________________ ☐ STAFF

☐ CURRENT CUSTOMER:_______________________________

HEALTH INFORMATION: YOUR HEALTH IS IMPORTANT TO US! PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

Are you currently under a physician's care? _____ If so, what for?_______________________________________

List all medications and/or herbal supplements that you are currently taking or have taken in the past year:____

____

Drug and food allergies:____

Past hospitalizations and/or surgeries:____

____

HAVE YOU EVER BEEN DIAGNOSED WITH, DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Severe allergic reaction (to shellfish or medications)	Yes	No	Are you pregnant or breastfeeding	Yes	No
Fainting or dizzy spells	Yes	No	Have you given birth within the last 6 weeks	Yes	No
Stroke	Yes	No	Depression or other mental disorder	Yes	No
High blood pressure	Yes	No	Uncontrolled Epilepsy (within the last 6 months)	Yes	No
Blood disorders (Hemophilia, sickle cell anemia, etc.)	Yes	No	Liver Disease/disorder (Active Hepatitis A/B/C, Cirrhosis)	Yes	No
Heart disease (attacks, angina, bypass, stent, Pacemaker)	Yes	No	Thyroid Disorder	Yes	No
Congestive Heart Failure	Yes	No	Smoker	Yes	No
Kidney disease/disorder (Nephrosis, Gout, High uric acid, kidney stones within the past year, less than one functioning kidney)	Yes	No	Cancer (History or current, if current, are you actively receiving chemo or radiation?)	Yes	No
Diabetes	Yes	No	Eating disorder (Anorexia, Bulimia)	Yes	No
Gastric (Active Diverticulitis, Chron's, Colitis, IBS, Active Ulsers)	Yes	No	Organ transplant	Yes	No

TELL US ABOUT YOUR PAST:

Which methods have you tried in your endeavors to lose weight?

___ Adkins
___ LA Weight Loss
___ Internet Weight Loss Clinic
___ Jenny Craig
___ NutriSystem
___ South Beach
___ Weight Watchers
___ Exercise Videos
___ Physician Supervised – who?________________________________
___ Nutritionist Supervised – who? ______________________________
___ Fad Diet/Diet Book - _____________________________________
___ Diet Pills – which ones - ___________________________________
Other:____

How long did you use these diet methods? Why did you discontinue? ____

____

How much weight have you lost in the past? ______lbs How long did you keep it off?______________________________

How do you feel that you have gained the weight back? ____

What have you learned from your past experiences? (Check all that apply)

___ It is hard for me to make losing weight a priority.
___ I get distracted and give up too easily.
___ I need exciting/interesting motivation ideas.
___ I am discouraged when I do not see rapid results.
___ I do not have a good support system or receive adequate knowledge for small progress.
___ Life is too busy for meal planning. I need preset meal plan ideas.
___ I do not have time for the suggested physical fitness.
___ I lack the ability to follow structure.
___ I eat the wrong kinds of foods. Fast food for a busy lifestyle.
___ I simply like to eat.
___ I eat when I am bored.
___ I eat for comfort/when I feel depressed.
___ I get off track when I try to reward myself for positive weight loss.
___ It is hard to eat on a plan and feed a family a totally separate meal.
___ I have often set unrealistic goals for myself which cause me to fail.
___ I gain weight when I try to quit smoking.
___ Losing weight is easy. Keeping it off is hard for me.
___ Other:____

What habits or circumstances make losing weight challenging for you now?

___ Skipping meals
___ Busy lifestyle/schedule
___ Lack of exercise
___ Lack of motivation
___ Dining out/fast food
___ Snacking
___ Emotional/stress eating
___ Portion size
___ Resisting bad food choices
___ Not losing weight fast enough

What time if say is most difficult for you to resist snacking or eating desired foods?

___ Mid-morning
___ Mid-afternoon
___ After school/work
___ During the night
___ Before bed/late dinner
___ While watching TV/surfing the internet

What about exercise?

___ I exercise regularly – about ___ times a week for about ___ minutes
___ I exercise sometimes - _______________ (how often) for _________________ (how long)
___ I seldom exercise - __________________ (how often)
___ I never exercise

If you do not exercise regularly, tell us why - ____

____

If you exercise, tell us what type of exercise you do most often and why you choose that form of exercise - _________

____

Let us know how being overweight makes you feel?

___ Depressed ___ Stressed ___ Angry ___ Out of Control ___ Tired
___ Frustrated ___ Unattractive ___ Sad ___ Hopeless ___ Other:_______________

Who is more likely to support you when you are losing weight?

___ Spouse ___ Significant other ___ Parents ___ Friends
___ Children ___ Co-Workers ___ Other:____

Who do you share frustrations concerning your weight with?____

____

The most I have ever weighed is __________. My weight loss goal is _____________.

I have wanted to lose weight for __________________. I would be happy wearing a size:_____________.

My current weight is __________. My current height is ___________.

My target weight is __________. My target date to achieve this weight is _________.

I WANT TO LOSE WEIGHT BECAUSE: (CHECK ALL THAT APPLY)

___ I feel unattractive
___ My loved ones comment on my weight
___ I want to see improved relationships with family and friends
___ I want to be a good example to my children
___ I am not able to fit in the size clothes that I want
___ I have an important event coming up
___ Other:____

WHY DID YOU COME IN TODAY?

___ I wanted to know more about the program.
___ I am exploring my options.
___ I am seriously considering a weight loss program.
___ I desire to know more about what it takes to lose weight and keep it off.
___ Other:____

LOSING THE WEIGHT I WANT TO LOSE WILL MAKE ME FEEL

___ Happy/satisfied ___ Healthier ___ More successful ___ Attractive
___ Confident ___ More energetic ___ Other:____

ON A SCALE OF 1 TO 10 (10 BEING THE HIGHEST), HOW COMMITTED ARE YOU TO LOSING WEIGHT?

1 2 3 4 5 6 7 8 9 10

WE WOULD LIKE TO INVITE YOU ALLOW US TO HELP YOU ACHIEVE YOUR WEIGHT LOSS GOALS. WE OFFER A FULL HEALTH EVALUATION, INITIAL BLOOD WORK, BODY MASS INDEX EVALUATION, ONE-ON-ONE COUNSELING, REGULAR WEEKLY CHECK-UP EVALUATIONS, EXERCISE/FITNESS RECOMMENDATIONS, MEAL PLANNING, PROTEIN SHAKES, SUPPLEMENTS, VITAMIN B12 INJECTIONS, FAT BURNERS, AND APPETITE SUPPRESSANTS AS NEEDED.

PLEASE READ CAREFULLY AND INITIAL AND SIGN AFTER READING

PAYMENT POLICY:

ALL APPOINTMENTS MUST BE PAID IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND CARE CREDIT. THERE WILL BE A CHARGE OF $50 FOR ANY RETURNED CHECKS. THE FOUNTAIN OF YOUTH DOES NOT EXTEND CREDIT OR OFFER PAYMENT PLANS IN HOUSE.

INITIALS _____

APPOINTMENT AND CANCELLATION POLICY:

THE FOUNTAIN OF YOUTH MEDICAL SPA HAS A 24 HOUR CANCELLATION / RESCHEDULING POLICY. IF YOU MISS YOUR APPOINTMENT, CANCEL OR CHANGE YOUR APPOINTMENT WITH LESS THAN 24 HOURS NOTICE, YOU WILL BE CHARGED $50. THIS POLICY IS IN PLACE OUT OF RESPECT FOR OUR CLIENTS AND STAFF. CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE ARE DIFFICULT TO FILL. BY GIVING LAST MINUTE NOTICE OR NO NOTICE AT ALL, YOU PREVENT SOMEONE ELSE FROM BEING ABLE TO SCHEDULE INTO THAT TIME SLOT.

INITIALS_____

RECORDS:

WE KEEP CONFIDENTIAL RECORDS AT THE FOUNTAIN OF YOUTH MEDICAL SPA. INFORMATION IS NOT DISCLOSED UNLESS YOU DIRECT US TO DO SO OR UNLESS THE LAW AUTHROIZES SUCH. MEDICAL RECORDS ARE AVAILABLE UPON REQUEST FOR A FEE OF $20. PLEASE ALLOW 10 BUSINESS DAYS TO PROCESS YOUR MEDICAL RECORDS REQUEST.

INITALS _____

INSURANCE:

THE FOUNTATIN OF YOUTH MEDICAL SPA DOES NOT BILL INSURANCE COMPANIES. YOU MAY SUBMIT A COPY OF RECIEPT FOR REIMBURSEMENT AS PER YOUR INSURANCE POLICY.

INITIALS_____

BY SIGNING BELOW I UNDERSTAND EACH OF THE STATEMENTS THAT I HAVE INITIALED AND I HAVE HAD ANY QUESTIONS REGARDING THE STATEMENTS ANSWERED BY THE STAFF OF THE FOUNTAIN OF YOUTH.

____ _______________________

CLIENT SIGNATURE DATE

FOUNTAIN OF YOUTH MEDICAL SPA
NOTICE OF PRIVACY POLICY

UNDERSTANDING YOUR HEALTH INFORMATION:

A RECORD OF YOUR VISIT IS MADE EACH TIME YOU COME TO OUR FACILITY. THIS RECORD MAY CONTAIN PERSONAL, IDENTIFYING INFORMATION ABOUT YOU, YOUR HEALTH AND TREATMENTS HERE AT THE FOUNTAIN OF YOUTH MEDICAL SPA. THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES:

- TO PLAN YOUR CARE AND TREATMENT
- LEGAL DOCUMENTATION DESCRIBING THE CARE YOU RECEIVE
- TO HELP TECHNICIANS/PHYSICIANS MAKE DECISIONS ABOUT YOUR CARE

YOUR HEALTH INFORMATION RIGHTS:

YOUR RECORDS ARE CONFIDENTIAL AND YOU HAVE THE RIGHT TO:

- REQUEST THAT WE LIMIT CERTAIN USES AND RELEASES OF YOUR INFORMATION
- REQUEST THAT YOU GET A COPY AND ARE ALLOWED TO SEE YOUR RECORDS
- REQUEST THAT ANY AND ALL COMMUNICATIONS OF YOUR HEALTH INFORMATION BE MADE BY DIFFERENT MEANS OR TO A DIFFERENT LOCATION.

OUR RESPONSIBILITIES:

WE ARE REQUIRED TO:

PROTECT THE PRIVACY OF YOUR INFORMATION
RESPECT REASONABLE REQUESTS TO COMMUNICATE HEALTH INFORMATION BY DIFFERENT MEANS OR TO DIFFERENT LOCATIONS

ACKNOWLEDGMENT OF RECEIPT:

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE FOUNTAIN OF YOUTH MEDICAL SPA'S "NOTICY OF PRIVACY POLICY".

____ _____________________

CLIENT SIGNATURE DATE

I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION THE PERSON(S)

____
____
____
____

____ _____________________

CLIENT SIGNATURE DATE