Patient Intake Form

How did you hear about us ____

Patient Name: (Last)______________________________(First)____________________________(MI)_________
Patient Address: ____
City: ____ State: ______________ Zip: _________________
Home Phone: ___________________________________Beeper/Cellular: _____________________________
Birthdate: _______________________________________Age: _________Sex: M F
Country of Birth: _________________________________
Email Address: _____________________________________
Pharmacy ______________________________________ **Phone #** ______________________________

In Case of Emergency:
Name: ___________________________________Relationship: _______________ Phone:_________________
Patient's Spouse: ____ Phone:_________________
Family Physician: ____ Phone:_________________
Referred by: ____

Weight History
When did you first become overweight? (your age then)____________________(year) _____________________
How did your weight gain start? Describe any circumstances: ____
____
What do you think is the cause of your weight problem____
____
Your present weight: ______________ your weight goal: __________________________height: ______________
What was your highest weight? (excluding pregnancy) _______your age then __________# of years ago:________
What was your lowest weight? ______________your age then _______________# of years ago:_______________
Have you ever stayed the same weight for 10 years or more? Yes:/ No
Have you attempted to lose weight before? ______ most lbs lost:______________how long it took:_____________
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:____
____

Where and when do you do most of your overeating?____
____

Please make any comments that you think might be helpful:
____

Do you currently have any medical concerns? Please List:____
____
____

Past History: (Please check if you have had any of the following):

☐ Allergies, Type: ___________________ ☐ Birth defects or abnormalities
☐Scarlet Fever ☐ Blood Clots ☐ High Blood Pressure
☐ History of Breast Cancer ☐ Influenza ☐ Rheumatic

☐ Fever German Measles (3 day) ☐ Polio ☐ Whooping Cough
☐ Frequent Colds ☐ Chickenpox ☐ Tonsillitis
☐ Pneumonia ☐ Diabetes: Type: ____
☐ Cancer, Type:__________________________________ ☐ Other Diseases ________________________________
☐ Operations: (dates) ____
Any mood altering or depression medication:____
Allergies to medicines, foods, etc…____

Current Medications

Name	Dosage	How often do you take the medication
__________________________	______________________	_________________________________
__________________________	______________________	_________________________________
__________________________	______________________	_________________________________
__________________________	______________________	_________________________________
__________________________	______________________	_________________________________
__________________________	______________________	_________________________________

Family History:

Father: Health ______________ Age ______ Deceased _____ at age _____ Cause ____________________________
Mother: Health ______________ Age ______ Deceased _____ at age _____ Cause ___________________________
Number of siblings:_______ # living______ #deceased: ________ Cause _______________________________

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure ☐ Allergy ☐ Heart trouble ☐ Anemia
☐ Migraine ☐ Bleeding (abnormal) ☐ Blood Clots ☐ Epilepsy
☐ Strokes ☐ Cancer ☐ Diabetes ☐ Nervous breakdown
☐ Kidney disease ☐ Syphilis or (bad blood) ☐ Suicide ☐ Obesity
☐ Arthritis ☐ Rheumatic ☐ Fever
☐ Other ____

Examinations:

Date of last physical examination _______________ Reason:____
Hospitalizations _________ Dates _____________ Reason:____
X-Rays: Chest ________Stomach _____________ Gallbladder ________ Kidney _____________Colon ________
Other ____________________________________Date of last laboratory tests:_____________________________
Electrocardiogram (heart tracing) ____________________ Date of last pap (cancer smear): ____________________

Do you now have or have had any of the following?

☐ Itching ☐ Eczema ☐ Hives ☐ Joint pains ☐ Muscle aches
☐ Arthritis ☐ Limitation of motion ☐ Backache ☐ Leg pains ☐ Heel Pains
☐ Pain or stiffness (neck) ☐ Goiter ☐ Swelling, enlarged glands
☐ Asthma ☐ Lung disease ☐ Raise sputum ☐ Emphysema Bronchitis
☐ Heart trouble ☐ High blood pressure ☐ Shortness of breath ☐ Palpitation or fluttering ☐ Chest pain ☐ Lips or nails turn blue ☐ Tire easily ☐ Swelling of ankles
☐ Indigestion ☐ Nausea or vomiting ☐ Abdominal pain ☐ Gas or bloating ☐ Diarrhea
☐ Hard bowel movements No. of bowel movements - daily _____ ☐ Colitis
☐ Jaundice ☐ Hemorrhoids (piles) ☐ Bleeding or black stools ☐ Hernia
☐ Urinary System ☐ Kidney disease ☐ Bladder disease ☐ Kidney stones
☐ Painful urination ☐ Pus or blood in urine ☐ Albumen or sugar in urine
☐ Dribbling of urine ☐ Varicose veins ☐ Nervousness or anxiety
☐ Trouble sleeping ☐ Headaches ☐ Bored or depressed ☐ Nervous breakdown
☐ Fainting ☐ Convulsions ☐ Numbness ☐ Loss of consciousness ☐ Neuritis or Neuralgia ☐ Paralysis

Are you on birth control? (method): ____

Financial Policy:
Thank you for selecting Carolina Pain and Weight Loss for your health care 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 the time services are rendered, unless only a deposit is required (Full hCG)

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's Signature Date

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Patient's Signature_______________________________________ Date_________________________