Carolina Pain
& Weight Loss

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_____

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Patient Update Form

Patient Name_____ **Date of Birth**_____

Address_____

City_____ **State**_____ **Zipcode**_____

Primary Phone_____ **Secondary Phone**_____

Primary Care Doctor_____

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each box that can be given to person/entity listed on the left.
Voice Mail Use ☐ Home # ☐ Cell #	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Spouse (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Parent (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Other (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Email (provide email address)	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial ☐ Breach notification I elect to receive email and understand that email may not be sent in an encrypted manner and there is a risk it could be accessed inappropriately.

- I have the right to revoke this authorization at any time.
- I may inspect or copy the PHI to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I authorize the individual(s) listed above to have access to my medical information.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Patient Signature or Personal Representative **Date**