Elpis Healthcare

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NEW PATIENT WEIGHT LOSS INTAKE FORM

BASIC PATIENT INFORMATION

Name: _____ Date: _____

Street Address: _____

Phone: _____Home Phone: _____

Type of Business: _____

Email**:** _____Birth Date: _____

Sex: ☐ M ☐ F Birth Gender: ☐ M ☐ F Height:_____Weight: _____

Race (i.e. White, Asian, African American): Hispanic or Latino: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____

How did you hear about us? _____

Primary Care Physician: _____Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

HEALTH AND WELLNESS HISTORY

Has your doctor advised you to lose weight?

Do you have any dietary restrictions? ☐ Yes ☐ No

Please explain: _____

How often do you exercise? _____ What type of exercise? _____

Do you feel stressed? ☐ Yes ☐ No Please explain: _____

Check ALL that apply to you: ☐ Pregnant ☐ Might Be Pregnant ☐ Breast-Feeding ☐ Currently undergoing Chemotherapy

Please answer the following questions honestly so we can do our best to help you reach your goals:

What changed that caused the weight gain (if anything)?_____

What's the main reason you are seeking treatment at this time? _____

What are your goals about weight control and management?_____

What do you consider to be your ideal weight?_____

When was the last time you were at your ideal weight?_____

How much weight do you want to lose?_____

How many times a year do you diet?_____

What is the hardest part about managing your weight? _____

What have you tried in the past that has failed? _____

Please check all previous proorams that Y'ou have tried in order to lose weight. Indicate dates and length of any current medications:

Program	Medication	Dose/Freq.
Weight Watchers		
Liquid Diets		
Keto		
Diet Pills (Phen-Fen)		
Nutrisystem/Jennv Craig		
Surgery		

Have you maintained weight loss för up to a year with any of these programs?_____

What did NOT work for you about these proaranms? _____

What has been your lowest_____ and highest _____ weight as an adult? _____

What's more important inches lost or pounds: _____

What's Inore important, last or permanent? _____

How fast do you want to be slim, trim and fit? _____

What would stop you from a weight loss prograln? _____

Do you binge eat?	☐ Yes	☐ No
Do you suffer from uncontrollable cravings?	☐ Yes	☐ No
Do you think that food controls you?	☐ Yes	☐ No
Do you eat because of your emotions?	☐ Yes	☐ No
Do you eat between meals?	☐ Yes	☐ No
What do you choose to eat between meals?	☐ Yes	☐ No
Do you think your eating behaviors are normal?	☐ Yes	☐ No
Briefly describe our daily eating behaviors:	☐ Yes	☐ No
Does your family support your weight loss efforts?	☐ Yes	☐ No
Can you remember being at your ideal weight?	☐ Yes	☐ No
What do you remember most about it? _____		
Commitment to weight loss: (please rate): (low) 1 2 3 4 5 6 7 8 9 (high)		

What is the most important element in deciding to use our services?
(Circle only one of the four answers)

EFFECTIVENESS:	"My results are my top priority."
TIME:	"l want results quickly."
SERVICE:	"1 need extra support along the way."
AFFORDABILITY:	"l need this to be affordable.'

Check the following conditions you would like help with or more information on:

O Weight Loss	O Thyroid	O Knee Arthritis	O Memory & Mood
O Hormone Balancing	O Immune Boosting	O Immune	O Pain Relief
O Neuropathy	O Joint Pain	O Quitting Smoking	O Stress Relief
O Fatigue	O General Wellness	O Diabetic Education	O Fitness

List ALL medications & supplements you take (prescription & over che counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?

Alcohol use? ___Yes / ___ No Amount _____ Daily _____ weekly _____ Socially _____

Tobacco use?____ Yes / ____ No _____Never Former Smoker PPD _____ How many years? _____

Please list all known DRUG and FOOD allergies:

Drug Name Food: Reaction:

Check ALL medical conditions that you may have had or currently have now.

O ADD/ADHD	O Depression	O Hepatitis	O Miscarriage
O Alcoholism	O Diabetes	O High Blood Pressure	O Multiple Sclerosis
O Allergy	O Eczema	O High Cholesterol	O Parkinson's
O Alzheimer's	O Emphysema	O High Blood sugar	O Pneumonia
O Anemia	O Epilepsy/seizures	O HIV AIDS	O Raynaud's
O Appendicitis	O Fibromyalgia	O Irritable Bowel	O Rheumatoid Arthritis
O Asthma	O Gall Bladder	O Kidney Infect. /stones	O Ringing in ears
O Arthritis	O Goiter	O Low Blood Pressure	O Sinus Infection
O Cancer	O Gout	O Low Blood Sugar	O Stroke
O Celiac Disease	O Heart Attack	O Lyme Disease	O Thyroid Problems
O Chronic Fatigue	O Heart Disease	O Lupus	O Ulcers
O Migraine	O Vertigo/Dizziness		

Other: _____

Please list all previous surgeries & dates: _____

Authorization and Notices of Privacy Practices

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

May we leave a message for you on your answering device? ☐ Yes ☐ No

I fully understand that my signature is consent and authorization to be examined by Elpis Healthcare medical team.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Name: (Please Print) _____

Patient Signature: _____ Date: _____

Cancellation and No-Show Policy

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that you cancel your appointment if you provide 24-hour notice. Appointments which are cancelled within less than 24-hour notice may be subject to pay che full balance owed at the time of cancellation. Cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel with less than 24 hours' notice. Fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no-show fees can be directed to the front desk at 817.354.7070.

Please sign that you have read, understand and agree to this cancellation and no-show policy.

Patient Name: (Please Print) _____

Patient Signature: _____ Date: _____