New Patient Form

Patient Information:

Last Name		First Name	
Age	Birth Date	Sex	
Street Address			
City		State	ZIP
Home Phone	Cell Phone	Work Phone	
Email Address			

Emergency Contact:

Last Name	First Name
Phone	Relationship

Primary Care Physician:

Phyisican Name		
Mailing Address (Street)		
City	State	ZIP
Office Phone	Fax Number	

Referring Physician (if different):

Phyisican Name		
Mailing Address (Street)		
City	State	ZIP
Office Phone	Fax Number	

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Social History:

Marital Status (please circle one)		Single	Married	Divorced	Other:	
Do you have children?	Yes	No	If so, what ages?			
Do you or have you ever used Tobacco Products?		Yes	No	If so, how often:	Per Day	Per Week
Do you consume any alcoholic beverages?		Yes	No	If so, how often:	Per Day	Per Week
Do you or have you used any illegal drugs?		Yes	No			

Family History:

Please check any conditions that have affected a member of your family:

Heart disease		High blood pressure	
Stroke		Obesity	
Blood clot		Blood disorder	
Diabetes		Kidney disease	
Cancer*		Thyroid disease	
*Type of Cancer:			

Surgeries & Hospitalizations:

Please list any surgeries or hospitalizations and please include the date.

Date	Surgery or Hospitalization

New Patient Form

Thinnergy
MEDICAL WEIGHT LOSS

Medications:

Please list any medications you take on a regular basis. Include any over-the-counter herbal, vitamin or mineral supplements in addition to prescription medications.

Medication	Dosage (mg/IU/etc.)	How often (times/day)	Why do you take it?

Allergies:

Please list any drugs, foods or other substances you are allergic to (ex: latex).

Drug/Food/Substance	Reaction

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Medical History:

Please indicate which of the following conditions you have or have had. Circle **Y** for Yes and **N** for No.

Y	N	Diabetes (please circle) *Type 1 Type 2*	Y	N	Crohn's Disease/Colitis
Y	N	High Blood Pressure	Y	N	Irritable Bowel Syndrome
Y	N	High Cholesterol	Y	N	Stomach Ulcers (Peptic)
Y	N	Chest pain, Angina	Y	N	Heartburn, Indigestion, GERD
Y	N	Heart failure	Y	N	Lupus
Y	N	Heart Attack	Y	N	Thyroid Disease
Y	N	Emphysema	Y	N	Kidney Disease
Y	N	Asthma	Y	N	Urinary Incontinence
Y	N	Chronic lower back pain	Y	N	Hepatitis (please circle): *A B C*
Y	N	Fatty Liver Disease	Y	N	Poly-cystic Ovarian Syndrome (PCOS)
Y	N	HIV	Y	N	Blood Clots

Y	N	Heart Attack. If yes, when:
Y	N	Gallbladder Disease. Removed (circle one) *YES NO*
Y	N	Hernia. If yes, what kind:
		Repaired (circle one) *YES NO*
Y	N	Headaches. If yes, how often:
Y	N	Deep Vein Thrombosis. If yes, when:
Y	N	Pulmonary Embolism. If yes, when:
Y	N	Cancer. If yes, what type:
		When were you diagnosed:
		Treatment received (circle any that apply): *Surgery Radiation Chemotherapy*
Y	N	Sleep Apnea. If yes, do you use ___CPAP or ___BiPAP?
Y	N	Arthritis or joint pain. If yes, where:
Y	N	Psychological Diagnosis (Current or Past):
Y	N	If female, last monthly cycle:
Y	N	Currently participate in any form of physical activity on a regular basis. If yes, what activity:

Are there any other conditions or concerns you feel the doctor should know about (please list):

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Please read the following office policies. Initial that you have understood each and sign below. Your signature indicates that the information you have provided is complete and accurate, to the best of your knowledge.

______ If I fail to cancel any scheduled appointments without at least 24 hours' notice, I will be billed an $85.00 cancellation fee.

______ Payment in full is necessary at the time of treatment or service rendered. All payments are non-refundable and non-transferable. In the event that I am unable to complete a pre-paid treatment regimen, I could finish the treatment at a later date (up to one year from my last appointment).

______ All meal replacements are not returnable or exchangeable due to Department of Health Regulations.

Patient Name (please print) ____

Patient Signature ______________________________________ Date________________

HEALTH CARE PROVIDERS SECTION

This history has been reviewed with the patient and is complete to the best of my knowledge.

Physician Signature______________________________________ Date________________