



680 Highway 51 Suite 51  
Ridgeland, MS 39157  
T: (769)251-1040  
F: (769)251-1047  
Performanceweightloss@hotmail.com

### Patient Registration

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M or F

### Employment Information

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

### Financial Policy

Please be advised that payment of all services is due at the time services are rendered. Performance Weight Loss also referred to as, "the clinic," will not bill your insurance, the clinic will not provide any information to insurance companies for any medical weight loss services rendered at Performance Weight Loss. For your convenience, we accept Visa, Mastercard, Discover and cash. I have read and understand all of the above and have agreed to these statements.

### HIPPA Policy

I understand the HIPPA policy is available in the office and on the clinic website for all patients to review.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

### Medical History

Please check all that apply:

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Irritable Bowel Syndrome (IBS)
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	History of Colon Cancer
<input type="checkbox"/>	Edema (Swelling of legs)	<input type="checkbox"/>	Hernias
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Urinary Incontinence
<input type="checkbox"/>	Previous Stroke or Heart Attack	<input type="checkbox"/>	Trouble Urination/ Male BPH
<input type="checkbox"/>	Varicose veins or Venous Stasis	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	DVT or Pulmonary Embolus	<input type="checkbox"/>	History of Prostate Cancer
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Low Sex Drive
<input type="checkbox"/>	Snore	<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	Daytime Drowsiness	<input type="checkbox"/>	Eats Ice Frequently (PICA)
<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	Excess Facial Hair (Female)
<input type="checkbox"/>	Use CPAP or Bi-PAP	<input type="checkbox"/>	Abnormal Menstrual Cycle
<input type="checkbox"/>	Diabetes- Juvenile	<input type="checkbox"/>	Difficulty becoming pregnant
<input type="checkbox"/>	Diabetes- Adult Onset	<input type="checkbox"/>	Polycystic Ovarian Syndrome
<input type="checkbox"/>	Diabetes- Pregnancy	<input type="checkbox"/>	History of Breast Cancer
<input type="checkbox"/>	Always Thirsty	<input type="checkbox"/>	Underactive Thyroid
<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	Bipolar Disease	<input type="checkbox"/>	Sweating- Night Sweats or Excessive Sweating
<input type="checkbox"/>	Anxiety or High Stress	<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Depression- New Onset
<input type="checkbox"/>	Binge Eating	<input type="checkbox"/>	Depression- Chronic
<input type="checkbox"/>	Bulimia or Purging	<input type="checkbox"/>	Overactive Thyroid
<input type="checkbox"/>	Anorexia Nervosa	<input type="checkbox"/>	Significant Hair Loss
<input type="checkbox"/>	Restless Leg Syndrome	<input type="checkbox"/>	Pituitary Gland Disease
<input type="checkbox"/>	High Triglycerides	<input type="checkbox"/>	Adrenal Gland Disease
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Gallbladder Diseases	<input type="checkbox"/>	Gout
<input type="checkbox"/>	Heartburn/ Reflux/GERD	<input type="checkbox"/>	Chronic Diarrhea
<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	Arthritis/Osteoarthritis
<input type="checkbox"/>	History of Ovary or Uterine Cancer	<input type="checkbox"/>	Lower Back Pain
<input type="checkbox"/>	Need Assistance Walking	<input type="checkbox"/>	Numbness in Hands/Feet

Any other medical or psychiatric problems not listed:

\_\_\_\_\_



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### Medications

List all medications you currently take including vitamins, minerals, and herbs, hormones, birth control pills.

Name	Dose	How often?	Physician	Purpose

### Allergies

Do you have any medical or food allergies? \_\_\_\_\_

Do you have a primary physician or Internal Medicine doctor? YES or NO

Primary Care Doctor's Name: \_\_\_\_\_ City Located: \_\_\_\_\_

### Surgical History

Date	Surgery	Physician



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### OB/GYN History

Do you still have menstrual cycles? YES or NO

Have you had a hysterectomy, tubal ligation, or ablation? YES or NO

Are your periods heavy? YES or NO      How many days do your periods last? \_\_\_\_\_

Are you past menopause? YES or NO      History of Miscarriages? YES or NO

Ectopic Pregnancies? YES or NO      Date of last gynecologic exam: \_\_\_\_\_

Name of Gynecologist: \_\_\_\_\_

### Family History

Does anyone in your family have any of the following:

History	Family Member
Obesity	
High Cholesterol	
Diabetes	
Lung Disease/Asthma/Emphysema	
High Blood Pressure	
Bleeding Disorder	
Cancer	
Psychiatric (depression, eating disorder, alcoholism)	

### Social History

Married      Single      Divorced      Widowed

Number of children or grandchildren living with you? \_\_\_\_\_

Ages: \_\_\_\_\_

Have you ever smoked cigarettes? YES or NO      If yes, how much: \_\_\_\_\_

If you quit smoking, when did you stop? \_\_\_\_\_

History of drug use? YES or NO      Treatment? YES or NO

History of alcohol abuse? YES or NO      Treatment? YES or NO

How many hours do you typically sleep at night? \_\_\_\_\_

Occupation: \_\_\_\_\_      Working Hours: \_\_\_\_\_



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Do you work an overnight shift? YES or NO

Are you a student? YES or NO If yes, Full time or part time? \_\_\_\_\_

Typical time you wake up: \_\_\_\_\_ Typical time you go to bed: \_\_\_\_\_

### WEIGHT AND DIET HISTORY

Desired Weight: \_\_\_\_\_ When did you begin gaining excessive weight? \_\_\_\_\_

Highest Weight: \_\_\_\_\_ Do you exercise? YES or NO How often? \_\_\_\_\_

Do you eat 3 meals a day? YES or NO If no, how many? \_\_\_\_\_

Which meals do you commonly miss? \_\_\_\_\_

How many times a week do you eat out? \_\_\_\_\_

Are you a nighttime eater? YES or NO If yes, what do you normally eat? \_\_\_\_\_

Are you a binge eater? YES or NO

History of purging after you binge? YES or NO If yes, are you purging through exercise, vomiting, laxatives, or diuretics? \_\_\_\_\_

Do you do the majority of the grocery shopping? YES or NO

Do you or other people think you eat too fast? YES or NO

Do you cook at home? YES or NO

Is your spouse, fiancée or partner overweight? YES or NO

Do you have any overweight children? YES or NO

If you are vegetarian, what foods will you not eat? \_\_\_\_\_

Have you used weight loss medications in the past? YES or NO If yes, please list them:  
\_\_\_\_\_

If you have taken weight loss medication in the past, how long did you take it? \_\_\_\_\_

If you have taken weight loss medication did you experience side effects? YES or NO If yes, please explain: \_\_\_\_\_

If you have taken weight loss medication in the past, how much weight did you lose? \_\_\_\_\_





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### DO YOU DRINK

Sweet Tea	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely
Regular Fruit Juices	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely
Soft Drinks	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely
Hawaiian Punch	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely
Kool Aid	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely
Energy Drinks	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely
Whole Milk	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely
Alcohol	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Few per week	<input type="checkbox"/>	Rarely

If you drink alcohol what type of alcohol do you drink? \_\_\_\_\_

### WEIGHT LOSS EFFORTS

Name of Diet	YEAR	Length of Effort	Weight Loss	Weight Regained



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## MEDICAL WEIGHT LOSS CONSUMER BILL OF RIGHTS

### WARNING:

Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program that is not supervised by a physician specializing in medical weight loss management. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual and estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual estimated duration of the program.

### I HAVE READ THE ABOVE STATEMENT ABOVE:

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Personnel/Witness: \_\_\_\_\_ Date: \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: \_\_\_\_\_

By signing this form, you acknowledge that Performance Health and Wellness office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. If there are any individuals with whom we are permitted to share your medical information, please provide their name(s) here:

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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## PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I, \_\_\_\_\_ authorize Performance Health and Wellness to assist me in my weight loss reduction efforts. I understand that my program consists of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications.

Other treatment options may include a very low-calorie diet and/ or protein meal replacements and other medical supplements. I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese.

Risks of the program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could, on occasion be serious or even fatal. Risks associated with the remaining overweight tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death.

I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

### WOMEN ONLY:

I understand that Adipex/Phentermine or any other weight loss medication should not be taken during pregnancy, due to the chances of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on medication. If I become pregnant, I will advise both the clinic and my OBGYN immediately.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been given all the time I need to read and understand this form.

If you have any questions regarding risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Print Name: \_\_\_\_\_ Witness: \_\_\_\_\_





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## PATIENT CONSENT FOR USE OF EMAIL/TEXT COMMUNICATIONS

Patients in our practice may be contacted via email/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice. \_\_\_\_\_ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request to change in writing. I authorize to receive text/email messages for appointments reminders, feedback, and general health reminders/information to the following cell phone number:

Cell: \_\_\_\_\_

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your additional information).

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information on the Patient Portal to the following email address:

Email: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Print Name: \_\_\_\_\_

## AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize Performance Health and Wellness and the Affiliated Providers to view external prescription history via the Mississippi Prescription Monitoring Program.

I understand that this organization and or providers may obtain prescription history going back several years from outside (non PHW) medical providers.

I have read this Authorization form and I understand it. By signing this consent form, I agree that Performance Health and Wellness can request and use my or the patient's prescription medication history from other healthcare providers for treatment purposes, and I release PHW, its employees, directors and medical staff from legal responsibility or liability for the release of medical information.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Print Name: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

# FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (night sweats or increased episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with thinking, concentrating or reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble thinking of the right word to describe persons, places or things when speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in frequency or intensity of headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss, thinning or change in texture of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all the time or have cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or difficulty losing weight despite diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry or wrinkled skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total score	0 _____				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80