Performance Weight Loss

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 an 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:

	High Blood Pressure		Irritable Bowel Syndrome (IBS)
	Chest Pain		History of Colon Cancer
	Edema (Swelling of legs)		Hernias
	Congestive Heart Failure		Urinary Incontinence
	Previous Stroke or Heart Attack		Trouble Urination/ Male BPH
	Varicose veins or Venous Stasis		Frequent Urination
	DVT or Pulmonary Embolus		History of Prostate Cancer
	Shortness of Breath		Low Sex Drive
	Snore		Chronic Fatigue
	Daytime Drowsiness		Eats Ice Frequently (PICA)
	Sleep Apnea		Excess Facial Hair (Female)
	Use CPAP or Bi-PAP		Abnormal Menstrual Cycle
	Diabetes- Juvenile		Difficulty becoming pregnant
	Diabetes- Adult Onset		Polycystic Ovarian Syndrome
	Diabetes- Pregnancy		History of Breast Cancer
	Always Thirsty		Underactive Thyroid
	Cold Intolerance		Hot Flashes
	Bipolar Disease		Sweating- Night Sweats or Excessive Sweating
	Anxiety or High Stress		Sleep Problems
	Migraine Headaches		Depression- New Onset
	Binge Eating		Depression- Chronic
	Bulimia or Purging		Overactive Thyroid
	Anorexia Nervosa		Significant Hair Loss
	Restless Leg Syndrome		Pituitary Gland Disease
	High Triglycerides		Adrenal Gland Disease
	High Cholesterol		Kidney Disease
	Gallbladder Diseases		Gout
	Heartburn/ Reflux/GERD		Chronic Diarrhea
	Chronic Constipation		Arthritis/Osteoarthritis
	History of Ovary or Uterine Cancer		Lower Back Pain
	Need Assistance Walking		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 oblation? 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		YES		NO		Daily		Few per week		Rarely
Regular Fruit Juices		YES		NO		Daily		Few per week		Rarely
Soft Drinks		YES		NO		Daily		Few per week		Rarely
Hawaiian Punch		YES		NO		Daily		Few per week		Rarely
Kool Aid		YES		NO		Daily		Few per week		Rarely
Energy Drinks		YES		NO		Daily		Few per week		Rarely
Whole Milk		YES		NO		Daily		Few per week		Rarely
Alcohol		YES		NO		Daily		Few per week		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 1 ½ 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 it 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 test; know the actual estimated duration of the program.

I HAVE READ THE ABOVE STATEMENT ABOVE:

Patient's Signature: _____ Date: _____

Office Personnel/Witness: _____ Date: _____

AKNOWLEDGEMENT 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 white 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: _____

Performance Health & Wellness

680 Highway 51 Ste D, Ridgeland, MS 39157 (769) 251-1040

Name: _____ Date of birth: _____

MALE 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)
Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
Rapid hair loss or thinning	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total score	0				

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