

Weight Loss Centers



Introductory Patient Information

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Please note: In order for the doctor to thoroughly review your case prior to your initial consultation we must receive your completed paperwork 1 week prior to your consultation. If you were scheduled less than a week prior to your consult, please return completed paperwork ASAP.

NEW PATIENT CASE HISTORY

Name _____, Date _____
 Address _____
 City _____, State _____, Zip _____
 Home Phone _____, Work _____, Cell _____
 E-Mail _____, Best way to contact you? _____
 Fax number _____
 Age _____, Birth date _____, Sex M F, Status M S W D, No. of Children and ages _____
 Occupation _____, Employer _____, Years Employed _____
 Spouse's Name _____, Occupation _____, Employer _____
 Person responsible for this account _____, Referred by _____
 What is your major complaint? _____

Other complaint? _____

How long have you had these conditions? _____
 What seems to aggravate your conditions? _____
 In addition to the main reason you are consulting for today, what are your overall health goals once these complaints are resolved?

Have you ever been to another doctor who has put you on a Health Development Program? Yes No
 If yes, Who? _____ MD, DC, DQ Other _____
 What were the results? _____
 Were the results permanent? Yes No don't know
 Are you as healthy today or healthier than you were 5 years ago? Ye No don't know
 Do you feel you will stay as healthy as you are today 5 years from now? Yes No don't know
 If yes, what strategies will you implement to get there? _____
 How long has it been since you really felt good? _____

Wellness Commitment

At our clinic, we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% 20% ----- 30% ----- 40%-----50% -----60% ----- 70%----- 80% -----90% ----- 100%

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize **Weight Loss Centers of America™** to release my personal medical information to me.

Patient's Signature: _____ Date: _____

SUBJECTIVE QUESTIONNAIRE

Weight _____ Desired Weight _____ Height _____ Blood Pressure (if known) _____ % Body Fat (if known) _____ Desired % Body Fat _____
 Total Cholesterol _____ HDL _____ LDL _____ Triglycerides _____

REVIEW OF SYMPTOMS:

Circle only those items with which you identify, past or present. Ignore anything that does not apply to you.

GENERAL:

Fever.....	Now	Past
Chills.....	Now	Past
Aches/Pains.....	Now	Past
General Weakness.....	Now	Past
Difficulty Sweating.....	Now	Past
Swollen Glands.....	Now	Past

SKIN:

Cuts Heal Slowly.....	Now	Past
Bruise Easily.....	Now	Past
Rash.....	Now	Past
Pigmentation.....	Now	Past
Changing Moles.....	Now	Past
Other Skin Problems.....	Now	Past
Nails Split.....	Now	Past
White Spots /Lines on Nails.....	Now	Past
Crawling Sensation.....	Now	Past
Burning on Bottom of Feet.....	Now	Past

HEAD:

Poor Concentration.....	Now	Past
Confusion.....	Now	Past
Headaches.....	Now	Past
After Meals.....	Now	Past
Severe.....	Now	Past
Migraine Type.....		
Frontal.....	Now	Past
Afternoon.....	Now	Past
Occipital.....	Now	Past
Daytime.....	Now	Past
Nighttime.....	Now	Past
Relieved by:.....		
Eating Sweets.....	Now	Past
Concussion/Whiplash.....	Now	Past
Mental Sluggishness.....	Now	Past
Forgetfulness.....	Now	Past

Indecisive.....	Now	Past
Face Twitch.....	Now	Past
Poor Memory.....	Now	Past
Hair Loss.....	Now	Past
Pressure.....	Now	Past

EYES:

Sand In Eyes.....	Now	Past
Double Vision.....	Now	Past
Blurred Vision w/o Glasses.....	Now	Past
Poor Night Vision.....	Now	Past
Bright Flashes.....	Now	Past
Halos Around Lights.....	Now	Past
Eye Pains.....	Now	Past
Dark Circles Under Eyes.....	Now	Past
Strong Light Irritates.....	Now	Past
Watery Eyes.....	Now	Past
Cataracts.....	Now	Past
Floaters In Eyes.....	Now	Past

EARS:

Aches.....	Now	Past
Discharge.....	Now	Past
Pains.....	Now	Past
ringing.....	Now	Past
Buzzing.....	Now	Past
Deafness.....	Now	Past
Itching.....	Now	Past

NOSE:

Stuffy.....	Now	Past
Bleeding.....	Now	Past
Running.....	Now	Past
Discharge.....	Now	Past
Watery Nose.....	Now	Past
Block.....	Now	Past
Infection.....	Now	Past
Polyps.....	Now	Past

SINUSES:		
Draining.....	Now	Past
Trouble.....	Now	Past
Infections.....	Now	Past

MOUTH:		
Coated Tongue.....	Now	Past
Sore Tongue.....	Now	Past
Tooth Problems.....	Now	Past
Bleeding Gums.....	Now	Past
Tongue (Geographic).....	Now	Past
Mouth Problems.....	Now	Past
Canker Sores.....	Now	Past

THROAT:		
Mucus.....	Now	Past
Difficulty Swallowing.....	Now	Past
Frequent Hoarseness.....	Now	Past
Tonsillitis.....	Now	Past
Enlarged Glands.....	Now	Past
Soreness.....	Now	Past

NECK:		
Stiffness.....	Now	Past
Swelling.....	Now	Past
Lumps.....	Now	Past

CIRCULATION/RESPIRATION:		
Swollen Ankles.....	Now	Past
Sensitive To Hot.....	Now	Past
Sensitive To Cold.....	Now	Past
Extremities Cold or Clammy.....	Now	Past
Hands/Feet Go To Sleep/Numb.....	Now	Past
High Blood Pressure.....	Now	Past
Chest Pain.....	Now	Past
Pain Between Shoulders.....	Now	Past
Dizziness On Arising.....	Now	Past
Fainting.....	Now	Past
High Cholesterol.....	Now	Past
Numbness.....	Now	Past
Wheezing.....	Now	Past
Irregular Heartbeat.....	Now	Past
Heart Flutters.....	Now	Past
Low Exercise Tolerance.....	Now	Past
Frequent Coughs.....	Now	Past
Cough Up Blood.....	Now	Past
Breathing Heavily.....	Now	Past
Dizziness or Faintness.....	Now	Past
Sigh Frequently.....	Now	Past
Shortness of Breath.....	Now	Past
Night Sweats.....	Now	Past

GASTROINTESTINAL/DIGESTION:		
Canker Sores.....	Now	Past
Poor Smell/Taste.....	Now	Past
Ulcers.....	Now	Past
Poor Appetite.....	Now	Past
Excessive Appetite.....	Now	Past
Gall Bladder Attacks or Stones.....	Now	Past
Nervous Stomach.....	Now	Past
Full Feeling After Meal.....	Now	Past
Indigestion.....	Now	Past
Heartburn.....	Now	Past
Nausea.....	Now	Past
Vomiting.....	Now	Past
Vomiting Blood.....	Now	Past
Abdominal Pains or Cramp.....	Now	Past
Abdominal Distension.....	Now	Past
Gas.....	Now	Past
Diarrhea.....	Now	Past
Constipation.....	Now	Past
Bowel Habit Changes.....	Now	Past
Rectal Bleeding.....	Now	Past
Tarry Stools.....	Now	Past
Laxative Use Often.....	Now	Past
Incomplete Bowel Evacuation.....	Now	Past
Rectal Itch.....	Now	Past

KIDNEYS/URINARYTRACT:		
Burning Sensation.....	Now	Past
Frequent Urination.....	Now	Past
Blood in Urine.....	Now	Past
Nighttime Urination.....	Now	Past
Problem Passing Urine.....	Now	Past
Trouble Controlling Urine.....	Now	Past
Kidney Pain.....	Now	Past

GENITALIA:		
Male:		
Lump In Testicles.....	Now	Past
Sore On Penis.....	Now	Past
Penis Discharge.....	Now	Past
Erection Problems.....	Now	Past
Diminished Sex Desire.....	Now	Past
Hernia.....	Now	Past
Female:		
Fibroid Breasts.....	Now	Past
Breast Lumps.....	Now	Past
Nipple Discharge.....	Now	Past
Vaginal Itching.....	Now	Past
Vaginal Discharge.....	Now	Past
Non-Period Bleeding.....	Now	Past
Spotting.....	Now	Past
Hot Flashes.....	Now	Past

GENITALIA:

Female:

Diminished Sex Desire.....	Now	Past
Pain With Intercourse.....	Now	Past
Change In Periods.....	Now	Past
Pain other than with period.....	Now	Past
Endometriosis.....	Now	Past
Possible Pregnancy.....	Now	Past

NEURO-MUSCULAR:

Can't Go To Sleep.....	Now	Past
Can't Stay Asleep.....	Now	Past
Poor Memory.....	Now	Past
Speech Problem.....	Now	Past
Leg or Arm Weakness.....	Now	Past
Balance Problems.....	Now	Past
Muscle Cramping Tight.....	Now	Past

STRUCTURAL:

Head Injury.....	Now	Past
Concussion.....	Now	Past
Neck Stiffness.....	Now	Past
Low Back Stiffness.....	Now	Past
Joint Pains.....	Now	Past
Joint Swelling.....	Now	Past
Muscle Weakness.....	Now	Past
Muscle Lumps/Swelling.....	Now	Past
Muscle Stiffness.....	Now	Past
Bump On Bones.....	Now	Past
Damp Weather Bothers You.....	Now	Past
Mobility Problems.....	Now	Past
Other.....	Now	Past

NUTRITIONAL:

Strong Appetite For:

Sweets.....	Now	Past
Fruits.....	Now	Past
Vinegar.....	Now	Past
Bread.....	Now	Past
Ketchup.....	Now	Past
Mustard.....	Now	Past
Spices.....	Now	Past
Coffee.....	Now	Past
Cola.....	Now	Past
Tea.....	Now	Past
Salt.....	Now	Past
Alcohol.....	Now	Past
Drugs.....	Now	Past
Abnormal Thirst.....	Now	Past
Brown Spots or Bronzing of Skin.....	Now	Past
Can't Work Under Pressure.....	Now	Past
Chronic Fatigue.....	Now	Past
Daytime Sleepiness.....	Now	Past
Sleepy After Meals.....	Now	Past

MEDICAL PROBLEMS:

Dysentery.....	Now	Past
Diabetes.....	Now	Past
Ear Infection.....	Now	Past

Pulse Speeds After Meals.....	Now	Past
Inward Trembling.....	Now	Past
Irritable Before Meals.....	Now	Past
Hungry right after meals.....	Now	Past
Feel pickup after exercising.....	Now	Past
Easily Fatigued.....	Now	Past

PSYCHOLOGICAL:

Is Your Life:

Satisfactory.....	Now	Past
Boring.....	Now	Past
Demanding.....	Now	Past
Unsatisfactory.....	Now	Past

Do You Worry Over:

Home life.....	Now	Past
Marriage.....	Now	Past
Children.....	Now	Past
Job.....	Now	Past
Income.....	Now	Past
Money Problems.....	Now	Past

Do You Often:

Feel Depressed.....	Now	Past
Have Anxiety.....	Now	Past

Do You Often:

Have Irrational Fears.....	Now	Past
Feel Upset.....	Now	Past
Feel Things Go Wrong.....	Now	Past
Feel Shy.....	Now	Past
Cry.....	Now	Past
Feel Inferior.....	Now	Past

Have You:

Seriously Considered Suicide.....	Now	Past
Attempted Suicide.....	Now	Past

MEDICAL PROBLEMS

Anorexia.....	Now	Past
Acne.....	Now	Past
Asthma.....	Now	Past
Abnormal Chest X-Ray.....	Now	Past
Abnormal Electrocardiogram.....	Now	Past
Angina Pectoris.....	Now	Past
Abnormal Stomach X-Ray.....	Now	Past
Anemia (Type:).....	Now	Past
Appendicitis.....	Now	Past
Arthritis.....	Now	Past
Bulimia.....	Now	Past
Blindness, Either Eye.....	Now	Past
Broken Bones.....	Now	Past
Cataracts.....	Now	Past
Chronic Bronchitis.....	Now	Past
Cirrhosis.....	Now	Past
Colon Or Bowel Trouble.....	Now	Past
Deafness.....	Now	Past
Beer: Ounces/Day ().....	Now	Past
Hard Liquor: Ounces/Day ().....	Now	Past
Narcotic Drugs.....	Now	Past
Do You Use:		

Emphysema.....	Now	Past
Enlarged Heart.....	Now	Past
Glaucoma.....	Now	Past
Gallstones.....	Now	Past
Gout.....	Now	Past
Goiter.....	Now	Past
Gonorrhea.....	Now	Past
Hay Fever.....	Now	Past
Heart Murmur, As Adult.....	Now	Past
Heart Attack.....	Now	Past
High Blood Pressure.....	Now	Past
Hepatitis.....	Now	Past
Hemorrhoids.....	Now	Past
Kidney Stones.....	Now	Past
Mononucleosis.....	Now	Past
Nervous Breakdown.....	Now	Past
Obesity.....	Now	Past
Parasites.....	Now	Past
Poor Blood Clotting.....	Now	Past
Polio.....	Now	Past
Phlebitis.....	Now	Past
Rheumatic Fever.....	Now	Past
Rectal Trouble.....	Now	Past
Recurrent Boils.....	Now	Past
Silver (Amalgam) Fillings.....	Now	Past
Stroke.....	Now	Past
Stomach or Duodenal Ulcer.....	Now	Past
Syphilis.....	Now	Past
Skin Disease.....	Now	Past
Serious Depression.....	Now	Past
Serious Emotional Problems.....	Now	Past
Toe Fungus.....	Now	Past
Tuberculosis.....	Now	Past
Thyroid Overactivity.....	Now	Past
Thyroid Underactivity.....	Now	Past
Varicose Veins.....	Now	Past
Venereal Disease.....	Now	Past
Warts.....	Now	Past

Infectious Diseases:

Surgeries:

Hospitalization(s):

Vitamins.....	Now	Past
Nail Polish.....	Now	Past
Cosmetics.....	Now	Past
Lotions.....	Now	Past
Regular Exercise.....	Now	Past

ALLERGIES/SENSITIVITIES:

Pollens.....	Now	Past
Molds.....	Now	Past
Foods.....	Now	Past
Carpet/Furniture.....	Now	Past
Fumigation.....	Now	Past
Pesticides.....	Now	Past
Smoke.....	Now	Past
Chemicals.....	Now	Past
Computer CRT's.....	Now	Past
Live Near Power Lines.....	Now	Past
Penicillin.....	Now	Past
Sulfa.....	Now	Past
Aspirin.....	Now	Past
Bufferin.....	Now	Past
Fluids.....	Now	Past
Dusts.....	Now	Past
Fabric.....	Now	Past
Metals.....	Now	Past

MEDICATIONS:

(List Name Of Medication)

Insulin	Now	Past
Thyroid	Now	Past
Blood Pressure Medicine	Now	Past
Hormones	Now	Past
Birth Control Pills	Now	Past
Digitalis	Now	Past
Other	Now	Past

PERSONAL HABITS:

Smoke: Packs/Day ()...	Now	Past
Coffee: Cups /Day ()...	Now	Past

BIRTH FACTORS:

C-Section.....	Yes	No
Premature.....	Yes	No
Forceps Delivery.....	Yes	No
Breach Delivery.....	Yes	No
Bottle-Fed.....	Yes	No
Breast-Fed.....	Yes	No
Birth Trauma: (Describe)		

ENVIRONMENTAL FACTORS:

Briefly describe where you have lived since childhood.

ELECTROMAGNETIC/RADIATION:

Lived Under or Near Electric
Transmission Wires..... Yes No

Work With Computers..... Yes No

If Yes On the Above Two,
How Long _____
When _____

Describe any other exposure to Electromagnetic Radiation sources:

DENTAL:

Root Canal.....	Yes	No
If Yes, How Many? _____		
If Yes, When? _____		
Teeth Extracted? Including Wisdom Teeth.....	Yes	No
If Yes, When? _____		
Bridges In Mouth	Yes	No
If Yes, Material Used?		

Fillings.....	Yes	No
If Yes, Material Used?		

Crowns.....	Yes	No
If Yes, Material Used?		

Braces.....	Yes	No
If Yes, Material Used?		

Splint.....	Yes	No
If Yes, Material Used?		

TMJ (jaw problems).....	Yes	No
If Yes, describe		

What is your Heritage? (Irish, German, Spanish, etc..)

Check off any of the following that apply to you within the last 30 days:

_____ Do you feel nauseous?

_____ Do you have abdominal/intestinal pain?

_____ Do you have bloating?

_____ Do you get bloated after meals?

_____ Do you get heartburn?

_____ Do you have diarrhea?

_____ Do you have constipation?

_____ Do you travel outside of the U.S.?

_____ Do you have gas?

_____ Are your stools compact/hard to pass?

_____ Do you belch following meals?

_____ Do you have gurgles in your stomach?

_____ Do your bowel movements alternate between constipation and diarrhea?

Are you currently taking nutritional supplements? Yes _____ No _____

If "yes," please list all products and daily dosages (print clearly):

WORK HISTORY

Dates: _____ Type of Work:

Description of Duties/Tasks:

Dates: _____ Type of Work:

Description of Duties/Tasks:

Dates: _____ Type of Work:

Description of Duties/Tasks:

Describe any believed exposure(s) to environmental and/or chemical toxins:

Describe Your Hobbies and Forms of Recreation:

ESTABLISHING HEALTH GOALS

Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your visit with us?

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

Have you made the decision to change? To do what it takes to get well?

Yes _____ No _____

I have read something interesting: *“The definition of insanity is to keep doing the same thing and expecting different results”*. If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they've made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having “reasons” to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

List up to 5 things that you have *been unable* to do as a result of your present weight and symptoms. Please be specific. (Use extra pages if necessary)

CONSENT FORMS

IMPORTANT PATIENT INFORMATION

Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is the doctor's opinion that you should be well informed on our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, the doctor's would appreciate that you read the below steps and provide your signature. This would simply imply that you have read the *Patient Acceptance Policy* and understand what is expected of you.

1. Completion of the following forms:

- The Health Questionnaires**
- The Nutritional Assessment Questionnaire** This 322 question questionnaire was developed to gather important information about your body. It will help the doctor's assist in helping you. The medical questionnaire will allow the doctor's to quickly "**zero**" in on the probable causes of your health problems.
- The Diet Diary**

2. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain **comprehensive blood and/or saliva lab testing**.
3. Based on your medical history, questionnaire, medical records and initial consultation, it may be necessary to order additional medical laboratory tests. You will be presented with detailed information on the **specific tests recommended**. The cost for your initial Laboratory tests will be discussed at that time. **Payment can be made via check and/or credit card**. We accept **Visa, Master Card and American Express**. We also have an in-house medical credit card called **Care Credit** which can be used to cover the expense of any of your medical fees. Information on **Care Credit** can be obtained at my office and is subject to credit approval.
4. If you have not had a physical examination within the last two years or since the start of your most recent health problem, it is required to schedule an appointment with your primary physician.
5. Your weight loss program may consist of dietary and lifestyle changes as well as prescribed **Natural Pharmaceuticals**, which must be paid at the time of purchase.
6. **Abnormal laboratory tests** will need to be re-evaluated. The success of your program will not only be measured on the reduction of weight, but also the elimination of your physical symptoms, and normalized lab test results. For example: Many physicians will prescribe Lipitor for individuals suffering with high cholesterol. Your physician will also require periodic cholesterol blood tests to monitor the success of the medication. Laboratory fees can vary depending on what needs to be re-tested.

I, _____ have read and fully understand the **Patient Acceptance Policy**

Patient Signature

Weight Loss Centers of America™

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting Records of Doctor:

Name of Facility or Person: _____

Address: _____

Telephone number () ____ - _____ Fax number () ____ - _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to **Weight Loss Centers of America™** all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information. I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: Yes No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: Yes No

Genetic Testing Yes No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release **Weight Loss Centers of America™**, its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: _____ D.O.B. _____

Please Print

Signature: _____ Date _____

***PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT
ALONG WITH THE COMPLETED AND SIGNED FORM***

Records Requested by:

Doctor's Name: _____

Address: _____ Telephone number () ____ - _____

Signature: _____