PATIENT INFORMATION

CHART #1

Full Name ______________________________ Date of Birth ______________

Are you allergic to any vitamins? YES _____ NO _____ Social Security # ______________

Are you allergic to any medications? YES _____ NO _____

If so, please list them ______________________________

____

Are you currently taking any type of medication including oral contraceptives? YES _____ NO _____

If so, please list them and the dosage ______________________________

____

Personal History of: (Please answer)

Stroke	YES _____	NO _____
Heart Attack	YES _____	NO _____
Heart Murmur	YES _____	NO _____
Hypertension — (High Blood Pressure)	YES _____	NO _____
Diabetes	YES _____	NO _____
Heart Disease	YES _____	NO _____
Angina Pectoris — (Chest Pain after Exercise)	YES _____	NO _____
Thyroid Disease	YES _____	NO _____
Cysts of Breast or Ovaries	YES _____	NO _____
Epilepsy	YES _____	NO _____
Substance Abuse	YES _____	NO _____
Alcoholism	YES _____	NO _____
Migraine Headaches	YES _____	NO _____
Psychiatric Illness — (Nervous Problem)	YES _____	NO _____
Bipolar	YES _____	NO _____
Glaucoma	YES _____	NO _____

When was your last menstrual period? ______________________________

Do you have any reason to believe you are pregnant? YES _____ NO _____

____

Have you taken appetite suppressant medication before? YES _____ NO _____

I have answered the above questions to the best of my knowledge.

Signature: ______________________________ Date: ______________

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CHART #11

Date ____________________

INITIAL EVALUATION

1) How long have you had a weight problem? ______________________________________

____

2) Have you tried other methods of weight control? (please list) ____________________

____

____

3) Are you on a diet program at this time? ❐ Yes ❐ No

4) Have you been on a weight loss program in the last 12 months? If so, list. ❐ Yes ❐ No ____________

____

5) Are you on any diet medication at this time? ❐ Yes ❐ No

6) If you have been on a weight program before what is the most weight loss and how long was the program?

❐ Yes ❐ No How long? ❐ 1 month ❐ 3 months ❐ 6 months

7) Have you made a good faith effort at weight reduction on a bonafide program before consulting this program?

❐ Yes ❐ No

8) Have you ever been hospitalized for drug abuse or alcholism? ❐ Yes ❐ No

Patient's Signature: ______________________________

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

CHART #3

Please read this form thoroughly in order to understand the diet medication you may be prescribed and the potential side effects of this medication. If you do not understand any portion of this form, please enquire and we will explain any questions you may have.

In general terms, one part of the Alabama-One Weight Loss Program is the administration of medication to assist with weight loss.

Some side effects known to be associated with the administration of these medications are:
1) Restlessness
2) Palpitations
3) Hyperactivity
4) Nausea, dryness of mouth
5) Headache
6) Elevation of Blood Pressure
7) Elevation of pulse rate

These occur in less than 5% of patients and usually occur during the first week. In addition, more severe problems such as pulmonary hypertension and valvular heart disease can occur from prolonged use or abuse of this medication.

I understand I must avoid becoming pregnant and not take any other diet pills, energy pills, energy drinks, or decongestants while on this medication.

By reading and signing this form I understand the probability of occurrence of each of the foregoing risks as the result of or in connection with taking these medications and desire to proceed with treatment.

PRINT PATIENT NAME: ______________________________

SIGNATURE OF PATIENT: ______________________________ DATE: ______________

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION INJECTION FORM

CHART #4

Please read this form thoroughly in order to understand the injections you may choose to receive and the potential side effects of these injections. If you do not understand any portion of this form, please inquire and we will explain any question you may have.

In general terms, one part of the Alabama-One Weight Loss Program is the administration of injections to assist with weight loss. These injections consists of B-vitamins, essential amino acids and natural enzymes to speed up metabolism and induce weight loss. If you are allergic to any of these components, you cannot take these injections.

Some side effects known to be associated with the administration of these injections are:

1) Minor pain from the injection
2) Bruising or discoloration at the injection site
3) Rarely-a skin rash if you are allergic to the medication
4) Rarely-a localized infection from the injection

Please contact us if you have any serious reaction from the injection.

By reading and signing this form I understand the possibility of occurrence of each of the foregoing risks as the result of or in connection with taking these injections.

PRINT PATIENT NAME: ______________________________

SIGNATURE OF PATIENT: ______________________________ DATE: ______________

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prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment. We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Information provided to you. You have the right to review your chart. You have the right to request ammendments if you find any inaccuracies in your health information. Ammendment requests may be denied if the information is accurate and complete. You have the right to obtain copies of your health information at the cost of $.50 per page to cover the cost of copying and supplies.

Health-Related Services and Treatment Alternatives. We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to send you this information, or if you wish us to use a different address to send this information to you.

Right of Change. We reserve the right to change the terms of this privacy notice. You may obtain a copy of any corrected notices upon request.

Complaints. You have the right to report complaints to our office or to the Secretary of Health and Hospitals in writing. Our office will not retaliate against you for such complaints.

Disclosure. We will not use or disclose any protected health information in a manner that is inconsistent with this notice. Your health information will only be used and disclosed to carry out treatment, obtain payment and for other health care operations.

______________________________ (PATIENT'S NAME PRINTED) ______________________________ DATE

______________________________ PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) ______________________________ SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

______________________________ WITNESS (Optional) ______________________________ DATE

CHART #9 Date ______________

Name ____

Address ____

City ____________________ State __________ Zip __________

Phone (H) ______________(W) ______________(Cell) ______________

Height __________ DL # or Social Security # ____________________

Email Address: ____

How did you hear about us? (Check One)

- ❐ Public
- ❐ Radio
- ❐ Friend
- ❐ Phone Book
- ❐ Bill Boards
- ❐ Newspapers
- ❐ Signs
- ❐ Other __________

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