Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

Date: _____

Name (Last, First, M.I.): _____ □ M □ F DOB: _____

Date of last physical exam: _____

Previous or referring doctor: _____

Present Health History

To the best of your knowledge, are you in good health at present time? □ yes □ no

Are you under a doctor's care at the present time? □ yes □ no

When was the last time, if ever, that you had laboratory blood test performed?

Are you currently pregnant? (female only) □ yes □ no

Are you currently on hormone replacement therapy or birth control pills (BCP)? If yes, please list below. □ yes □ no

Are you currently taking any vitamins or health supplements? If yes, please list below. □ yes □ no

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

NAME OF DRUG & STRENGTH	*DOSAGE*	*NAME OF DRUG & STRENGTH*	*DOSAGE*

Allergies to medications or substances such as latex

Name	*Reaction*	*Name*	*Reaction*

PAST MEDICAL HISTORY

Bleeding problems: □ Anemia □ Hemophilia □ Taking "blood thinners" □ Other:

Cancer/precancerous changes (dysplasia):

Circulation issues: □ Chest pain □ Heart attack □ Palpitations □ Pacemaker □ Hypertension □ Irregular heartbeat □ Bypass surgery □ Other:

Diabetes-related issues: □ Eye problems □ Kidney Problems □ Neurophathy □ Other:

Digestive issues: □ Nausea □ Reflux □ GERD □ Constipation □ Bloating □ Diarrhea □ Peptic □ Ulcers □ Gluten Sensitivity □ Gall Bladder Problems □ Other:

Eye issues: □ Glaucoma □ Cataracts Other:

Joint issues: □ Osteoarthritis □ Rheumatoid Arthritis □ Fibromyalgia □ Osteoporosis □ Other:

Kidney issues: □ Kidney Stones □ Urination Problems □ Prostate Problems □ Other:

Lung issues: □ Asthma □ COPD □ Sleep Apnea □ Other:

Neurological □ Migraines □ Stroke □ Other:

Psychological issues: □ Anxiety □ Depression □ Anorexia □ Bulimia □ Alcohol Abuse □ Drug Abuse □ Diagnosed Mental Illness □ Other:

Skin/Hair issues: □ Acne/Scarring □ Easy Bruising □ Excess Scarring
□ Wrinkles □ Cellulite □ Spider Veins

Surgery:	Specify:	Date:	Specify:	Date:
Surgery:	Specify:	Date:	Specify:	Date:

DIET/HEALTH HABITS

Exercise	Sedentary (no exercise)							How often:
	Mild exercise (climb stairs, walk 3 blocks, golf)							How often:
	Occasional vigorous exercise (work/recreation, less than 4x/week for 30mins)							How often:
	Regular vigorous exercise (work or recreation 4x/week for 30 mins)							How often:
	Do ever experience chest pain, heart palpitations, shortness of breath, back/neck							□ yes □ no
Diet	Are you dieting?							□ yes □ no
	If yes, are you on a physician prescribed medical diet?							□ yes □ no
	Number of meals you eat in an average day?							
	Rank salt intake	□ High □ Medium □ Low						
	Rank fat intake	□ High □ Medium □ Low						
Caffeine	□ none	□ coffee		□ tea		□ soda		note # of cups/cans
Alcohol	Do you drink alcohol?							□ yes □ no
	If yes, what kind?			How many drinks for a week?				
	Are you prone to "binge" drinking?							□ yes □ no
Tobacco	Do you use tobacco?							□ yes □ no
	□ Cigarettes Pks/day		□ Chew #/day	# of years?		Or year quit?		

What is the primary reason for your decision to lose weight?

□ want to look better □ Dr. told me to □ Concerned for my health □ Friends/relatives told me to □ For my job/special event

When did your weight problem start?

□ Childhood □ Adolescence □ After pregnancy □ After menopause □ Came on gradually □ Came on Suddenly

What was your heaviest weight and what was your age at the time?	Years:	lbs.:
Any urinary tract, bladder, or kidney infections within the last year?		□ yes □ no

Have you ever used any of the following weight loss methods?

Prescription Diet Pills	□ yes □ no	Type:
Natural Supplements	□ yes □ no	Type:
Food plans	□ yes □ no	Type:
Other:		

Do you awaken hungry at night? □ yes □ no If yes, number of times

Do you ever have eating binges? □ yes □ no What time of day or night are you the hungriest?

Describe your typical energy level over the past few months: (check the statement that best applies)

□ I sometime miss work because I am so tired.
□ I rarely miss work but I am usually too tired to do anything active when not working.
□ I do other activities when not at work but I am usually too tired to exercise.
□ I am not usually fatigued and I exercise 1-3 times per week.
□ I am not usually fatigued and I exercise 4 two more times per week.

Have you ever considered bariatric surgery? (stomach stapling, gastric bypass, gastric band) □ yes □ no

Please list your average daily food intake: Please be as specific as possible, including# of sodas, etc.)			
Breakfast:		Mid-afternoon Snack:	
Mid-morning Snack:		Dinner:	
Lunch:		Late Night Snack:	

Family Health History (Blood relative ever been diagnosed with any of the following medical conditions)?					
		Who?			Who?
Diabetes	□ yes □ no		Kidney Disease	□ yes □ no	
Glaucoma	□ yes □ no		Obesity	□ yes □ no	
Heart	□ yes □ no		Psychiatric Disorder	□ yes □ no	
High Blood Pressure	□ yes □ no		Thyroid Problems	□ yes □ no	

We offer a $25 referral credit for happy patients who would like to refer loved ones! If you both start our program, each receives a $25 credit. You can use it towards products and services. Referred patients must sign-up, pay initial start-up fee and present both patients' name(s). Credit cannot be transferred to other patients or used towards initial sign-up or used with other offers.

We also offer cosmological, spa, and medical services. Please check the one(s) that interest you. If you have any questions, please ask anyone of our staff!				
	□	Weight Loss	□	Varicose vein reduction
	□	Hormone Therapy (testosterone)	□	Tattoo removal
	□	Physical Exams	□	Lash extentions
	□	Fat Burner/Vitamin Shots	□	Waxing
	□	HCG	□	Hair
	□	Colonic	□	Facials
	□	Bemer	□	Skin care products
	□	Salt Floats		

I have read and completed this form to the best of my knowledge.

Signature of patient or parent/guardian _____ Date _____

Controlled Substances and Prescriptions

Controlled substance medications are closely monitored by various government agencies. Used properly, many medications under this classification can be highly effective for pharmacological therapeutic treatment of a variety of conditions. To ensure these medications are used correctly, I agree to the following:

1. I am responsible for my own medications. If prescription or medication is lost, stolen or misplaced, or used sooner than expected based on the prescription, I understand that the prescription will NOT be replaced.
2. I will not request nor accept controlled substance medication prescriptions from any other physician or individual while I am receiving such medications from My Place Wellness (unless I am hospitalized).
3. I understand there may be a turnaround time of 24-48 hours for fills of all prescription medications. Therefore, I understand I should not wait until my medications are completely used prior to requesting a fill. Prescriptions of controlled substances require an office visit and will ONLY be made during office hours.
4. I understand that violating ANY of these terms may result in my being discontinued as a patient.

I have read and agree to the policies of My Place Wellness, respectively.

_____ _____

Signature of patient or parent/guardian Date

Financial Policy

Returned Checks: A $50 fee will be charged for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's Office.

Refunds: My Place Wellness offers many services in addition to weight loss. In order to provide care to all of our patients, all appointments must be cancelled 24 hours prior to your scheduled appointment or there will be a $50 no-show/late-cancellation fee.

Refunds: My Place Wellness offers many services in addition to weight loss. Due to the nature of these services depending heavily on patient compliance, refunds are not given. We cannot be held responsible for choices and behaviors conflicting with our recommendations. Variables exist that are beyond our control, which can affect an outcome (a weight loss program participant who did NOT follow protocol, will not fare as well as one who did). To up hold the highest level of safety for all our patients, we cannot accept returns on any, open or unopened, products taken offsite. Products with manufacturers' defects will be exchanged for those of equal value, comparable products, or credit. Pre-payment of item(s)/service(s) NOT received may be credited for future use. In the event that a program cannot be completed due to medical reasons (becoming pregnant, etc.), a hold will be placed on services remaining. Those services will be available up to one year from the date of hold for future use. After the one year, ALL service(s)/program(s) is/are forfeited.

Our physician(s) vow to DO NO HARM and reserve the right to remove patients from certain programs due to continuing the program may cause complications, if so indicated. In those rare circumstances, a refund can be given or an exchange upon approval of physician. Understanding that our programs require consistency and commitment from inception, forfeiture of programs for reasons that are not medically necessary, will be subject to neither credit nor refund.

I hereby agree to financially responsible for all charges incurred. I have read and understand all financial policies.

Thank you for choosing My Place Wellness! Our team is committed to providing the safest, most effective way to improve your self-image. Physician monitoring is the key to the success and safety of this program.

_____ _____

Signature of patient or parent/guardian Date

Consultation	Our free consultations are designed to properly assess a patient specific treatment plan. Taking into account your health, history and tolerance to ensure efficacy.
Month 1	Beginning: Guidance on healthy eating habit will be given to ensure your success in the program. Includes: A complete review your medical & dietary history & a physical examination 4 weeks of each: nutritional guidance, lipotropic shot, and medication(s)
Month 2	At the end of your 1st month or by the 4th week, you will need to renew your prescription(s): A practitioner must approve renewal but an actual visit is not required within 6 weeks of last visit, unless physician requires the visit(s).
	At the end of the 2nd month or by the 8th week, you will be required to schedule a follow-up visit.
Month 3	A follow up visit is required every 6-8 weeks regardless of whether you get other weekly services.

We recommend that you see an eye doctor with expertise in checking for signs of myopia and/or glaucoma. These side effects are not common but have been reported with Topamax usage.

The specifics pertaining to your program's weekly injection routine will be explained during your orientation. Once the initial month's shot have been used, you may purchase more packages. Please ask us of any specials. If shots are not purchased in advance, you will be charged individually for each shot you receive. You MUST pay in ADVANCE to get the package discount.

All injections are subject to the guidelines explained herein: If you receive a shot that is not part of a package set that you have prepaid for, you must pay at check-out. Be advised that the office staff may not know whether you paid for your shots or not; documentation continues to be recorded in your chart without the payment information.

Although we strive to track each patient's progress with the utmost care and attention, it is ultimately the patient's responsibility to be aware of how many shots have been purchased, used, and/or remain before purchasing more.

I have read and understand My Place Wellness programs, policies, and shot procedures.

Signature of patient or parent/guardian _____ Date _____